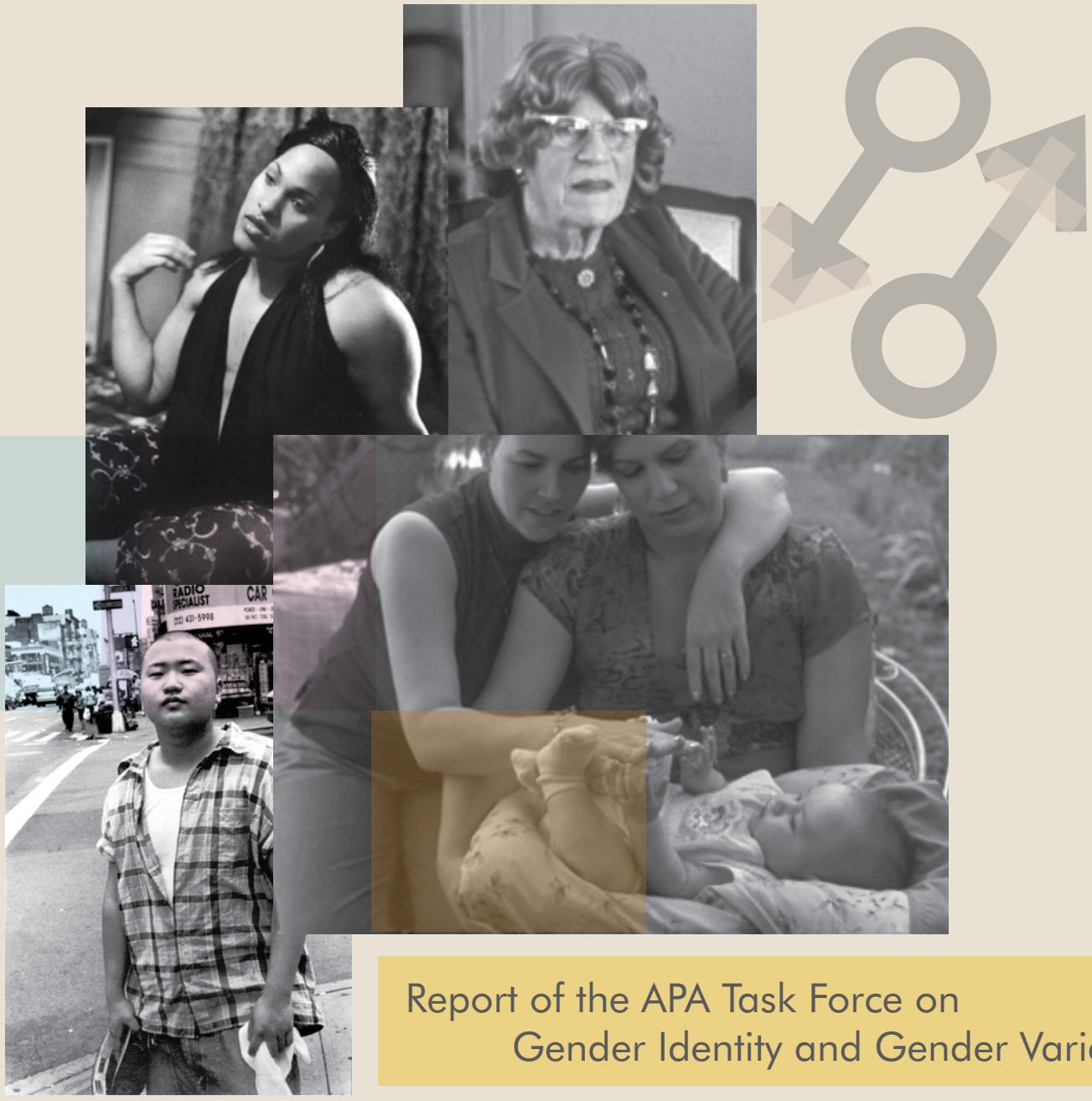

Report of the APA Task Force on Gender Identity and Gender Variance

American Psychological Association

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Executive Summary

In February 2005, the Council of Representatives of the American Psychological Association (APA) authorized the appointment of a Task Force on Gender Identity and Gender Variance.[1] The task force was changed with the following:

- Review extant APA policies regarding these issues and affected populations and recommend any indicated changes.
- Develop recommendations for education, training, and further research into these topics.
- Propose how APA can best meet the needs of psychologists and students who identify as transgender or gender variant.
- Recommend appropriate collaboration with other professional organizations concerning these issues.

Almost from the beginning of its work, the task force began to doubt whether it would be feasible to address both gender identity/gender variance and intersex conditions (now usually called disorders of sexual development, or DSDs) in one report. In particular, key informants advised us that attempting to address both issues in a single document might be perceived negatively by people with DSDs. Eventually, we decided not to address the issues of persons with DSDs in this report and instead recommended the creation of a separate task force for this purpose. Further, to avoid misrepresentation, we recommended to the Council of Representatives a change to the name of the task force, which the Council accepted.

To fulfill its charge concerning issues of gender identity and gender variance, the members of the task force conducted a survey of APA members, consulted with various APA committees and divisions, contacted other professional organizations that might have interests or expertise in these issues, and solicited the viewpoints and recommendations of transgender organizations and individuals. The resulting task

[1] The task force was originally called the Task Force on Gender Identity, Gender Variance, and Intersex Conditions and changed its name to the Task Force on Gender Identity and Gender Variance to remove "Intersex Conditions," consistent with the actual content of the report. The task force found the two populations to be too distinct from one another to address their unique issues and needs in a single report, and the task force members considered their expertise on intersex conditions to be too limited for them to handle the topic well.

force report reviews current research on gender identity and gender variance and makes several recommendations concerning policy development, education and training of psychologists, research, ways in which to address the needs of psychologists and students, and consultation with other professional organizations.

Introduction to Transgender Issues

Transgender and gender-variant people have a variety of concerns for which they may seek the assistance of psychologists. In addition to the usual problems that may bring any individual to therapy, transgender and gender-variant people often seek professional help in understanding their gender identities and patterns of gender expression and in addressing the complex social and relational issues that are affected by these. Transgender persons not uncommonly seek medical services to make their bodies more congruent with their gender identities; involvement of mental health professionals is often necessary or desirable in arranging such services. Moreover, many transgender and gender-variant people experience stigmatization and discrimination as a result of living in a gendered culture into which they often do not easily fit. They may not only experience an inner sense of not belonging but also discrimination, harassment, sometimes lethal violence, and denial of basic human rights. These issues, too, often bring transgender people into contact with mental health professionals.

In recent years, transgender people have increasingly been willing to identify themselves openly. Public awareness of transgender issues has increased dramatically, in part because of an increasing number of books, motion pictures, and television programs featuring transgender characters and addressing transgender issues. As a result, not only transgender people themselves but also their families and friends, employers, schools, and government agencies are increasingly turning to psychologists for help in addressing these issues on individual and community levels. At the same time, changes in service delivery systems related to transgender issues have resulted in transsexuals and other people with gender identity concerns more frequently turning to community mental health professionals for assessment and treatment. Consequently, it has become increasingly likely that psychologists will encounter people needing assistance with gender identity concerns. This trend underscores the need for psychologists to acquire greater knowledge and competence in addressing transgender issues.

The concerns of transgender and gender-variant persons are inextricably tied to issues of social justice, which have historically been important to APA. The stigmatization and discrimination experienced by transgender people affect virtually all aspects of their lives, including physical safety, psychological well-being, access to services, and basic human rights. This report highlights opportunities for APA to advance social justice as well as to support competent and ethical practice by promoting research, education, and professional development concerning transgender issues among psychologists, by creating a welcoming environment for transgender psychologists and students of psychology, and by supporting the human rights of all transgender citizens.

Review of Research

The focus of research concerning gender variance and transgender issues has changed and expanded over the last few decades. As with many mental health concerns, research in this field has historically been strongly clinical and positivistic. Beginning in the late 1970s, however, the scope of research has broadened to include critical analyses of sex, gender identity, and gender variance. It has also expanded to include methodologies focused on a wide range of issues, including life span, public health, community-based interventions, and sociopolitical issues. To some extent, the emergence of researchers and scholars who are themselves gender variant has influenced this expansion. Often these new directions in research have taken a more holistic approach to the lives of transgender people and have moved away from a focus on pathology. An emergence of alternate paradigms for understanding gender and gender

variance has occurred within psychology and related disciplines, although these are, at present, more evident in research on adults than in research involving children and adolescents.

Much of the research conducted with transgender adults concerns the treatment of individuals who experience both an intense cross-gender identification and a sense that their sexed bodies or assigned gender roles are incongruent with their gender identities, resulting in clinically significant distress or functional impairment; this constellation of symptoms defines *gender identity disorder* (GID). Much of the adult research literature addresses GID-related issues, including typologies, developmental patterns, associated features and comorbidity, the efficacy of various aspects of transition-related health care, and the widely recognized *Standards of Care*, published by the World Professional Association for Transgender Health (WPATH; formerly the Harry Benjamin International Gender Dysphoria Association) (Meyer et al., 2001).

Research on children with gender issues has focused largely on clinical samples. There have been a number of studies on the characteristics of children with gender identity issues, such as the proportion of boys versus girls, concomitant behavioral problems, developmental trajectories, and the relationship of childhood GID to sexual orientation. Treatment modalities used with children have focused on modifying children's cross-gender behavior or on assisting children to feel more satisfied or less distressed with their natal sex and associated gender roles. These modalities include behavior modification, psychotherapy, and cognitive–behavioral approaches. The comparative efficacy of these various approaches has not yet been adequately studied.

The research literature has documented that many transgender people experience discrimination and rejection by society, family, friends, coworkers, health care providers, and communities of faith. Transgender adults experience high rates of verbal harassment, physical violence, and employment and housing discrimination; transgender youth also appear to be at risk for these. There has been inadequate research concerning the workplace experiences of transgender persons, despite the fact that transgender people who undergo sex reassignment increasingly transition on the job rather than change jobs during the transition period.

There is little published research on the family issues of adult transgender people, in spite of the importance of social support from families for satisfactory mental health. There is, however, a growing literature on psychosocial issues of transgender youth, particularly as they arise because of stigmatization. These issues include relationships with their families; harassment and abuse, particularly in school settings; access to transgender-related health care; and HIV prevention. There is an urgent need to develop and evaluate effective interventions with transgender youth.

Custodial settings for transgender adults (e.g., prisons), many of which are segregated by gender, raise a number of concerns. One is housing transgender people safely and appropriately. Another is providing transgender-specific health care for transgender inmates—in particular, continuation or reinstitution of previously prescribed hormone treatment to transsexual inmates. Research involving these issues has been minimal.

Studies of the mental health of transgender individuals are often limited by the use of convenience samples, so the findings of some studies may not be generalizable to broader segments of the transgender population. Some studies demonstrate high rates of substance abuse, depression, and suicidal ideation or suicide attempts among transgender people. Qualitative research suggests that stigma is a significant factor that negatively impacts transgender people's mental health.

There is a range of sexual identifications, behaviors, and concerns among transgender people. Transgender-specific sexual concerns include managing gender dysphoria in a sexual relationship, concerns relating to erotic cross-dressing, the impact of hormone therapy and sex reassignment surgery on sexual desire and functioning, reproductive issues (e.g., sperm preservation), coming out to partners, and safer sex negotiation.

Many topics related to transgenderism and gender variance that involve both applied and

theoretical issues merit additional research. Methodological issues, such as conducting controlled clinical trials ethically, sampling, compliance, and potential confounding variables, must be more adequately addressed. Priority areas for research include more rigorous evaluations of the *Standards of Care* (Meyer et al., 2001), life span studies that include the aging population, and more inclusive studies of transgender physical and mental health, with an emphasis on health disparities.

Policy Recommendations

The task force reviewed APA policy documents, including bylaws, association rules, policies and procedures, the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002), practice guidelines, criteria for continuing education content and sponsorship, resolutions, and the *Guidelines and Principles for Accreditation of Programs in Professional Psychology* (APA Committee on Accreditation, 2006). On the basis of this review, we made specific policy recommendations in a number of areas. We proposed, among other things, the development of practice guidelines for transgender and gender-variant clients. Although there may not be sufficient research concerning many transgender issues to develop empirically based guidelines related to all important areas of practice, we believe that there is adequate research concerning discrimination and stereotyping to support the development of clinical guidelines addressing these issues specifically.

The task force noted that APA is in a position to advocate on behalf of transgender people in the same way it advocates on behalf of many other disadvantaged groups: through activities such as lobbying and filing amicus briefs. Specific policy areas that would appropriately be a focus of such advocacy include access to transition-related health care, appropriate placement and treatment within sex-segregated facilities, and access to appropriate legal documents. Among our recommendations is the Resolution on Transgender, Gender Identity, and Gender Expression Nondiscrimination, which outlines potential areas for advocacy (see pp. 65–69).

Education and Training Recommendations

APA sponsors a variety of education and training activities and services for members, including hosting conventions, providing continuing education opportunities, publishing books and journals, and accrediting training sites. To meet its public education mandate, APA also publishes brochures, reports, periodicals, and Internet materials designed for laypersons. Accordingly, we believe that APA is well positioned to address the educational needs of its members and the general public regarding issues of transgender and gender variance.

To address the needs of psychologists, students, and interested members of the public, we outlined three levels of information, including specific products that should be available at these levels:

- Basic information on transgender issues would be readily available to all psychologists and students of psychology as an element of cultural competence and would also be available to interested members of the public.

- Intermediate-level information concerning transgender issues is important for psychologists who work with transgender clients and for interested members of the public; such information would address clinical presentations, prevalence, etiology, life span development, assessment and treatment, comorbidity, and aspects of cultural competency.

- Advanced or specialized information concerning transgender issues would include a more in-depth consideration of the topics listed under intermediate-level resources; this information would be most relevant to clinicians working intensively with transgender clients and to students with particular interests in transgender issues.

We concluded that very few psychologists and students currently possess high-level or specialized information on transgender issues.

We developed several specific recommendations for creating and disseminating educational materi-

als, including brochures, books, journals, practice guidelines, videos, and convention programming. In support of these aims, we created an educational brochure concerning transgender issues, intended for APA members and the general public (and also a brochure addressing issues of persons with DSDs, prior to our decision to limit our focus). We further developed specific recommendations for proposed language to be included in the next edition of the APA *Publication Manual*.

Meeting the Needs of Transgender Psychologists and Students

The task force surveyed transgender psychologists and students and identified several broad categories of needs related to their status as transgender persons. These included more education, training, and research devoted to transgender issues; greater protection from discrimination; greater acceptance, mentoring, advocacy, and demonstration of ally status by colleagues; and increased recognition that transgender persons are experts regarding their own issues.

We identified a variety of specific needs related to educational and workplace settings. These included promotion of education regarding transgender issues in accredited training programs and internships sites; access to facilities that are typically segregated by sex, such as restrooms; confidential document management that reflects the individual's gender identity; and access to appropriate medical care and health insurance.

Within APA itself, specific needs included collection of demographic information regarding transgender status in relevant surveys of APA members; review of existing APA employment policies to ensure that they support equal employment opportunities for transgender people; and review of health insurance programs offered to APA members to ensure that they include transgender-related health care.

We also concluded that to address the needs of transgender psychologists and students most effectively—indeed, to address most of the issues raised in this report—it is imperative to have one or more designated "homes" for transgender issues within APA. The most appropriate entities for this purpose are the Committee on Lesbian, Gay, Bisexual, and Transgender Concerns, which adopted transgender issues during the tenure of this task force; and Division 44, the Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues. We believe that it is essential for specific entities within APA to take responsibility for leadership in promoting awareness of and action around transgender issues within APA. Once homes are established for these issues, APA will become a more welcoming and relevant organization for transgender psychologists and students, as well as for those who work with this client population.

Recommendation for Collaboration With Other Organizations

The task force identified six professional organizations with substantial expertise in transgender issues and with which APA should consider collaboration: (a) HBIGDA, now known as the World Association for Transgender Health, (b) the Society for the Scientific Study of Sexuality, (c) the Council on Sexual Orientation and Gender Expression of the Council on Social Work Education, (d) the American Psychiatric Association, (e) the International Association for Social Work Research, and (f) the American Public Health Association. We also identified several other professional organizations and community-based organizations that have an interest in these issues and that could be considered for collaboration.

Introduction

The submission of this report marks an historic occasion for the American Psychological Association (APA). APA's first sustained consideration of issues related to gender identity took place in 1996–1998, when the then-Committee on Lesbian, Gay, and Bisexual Concerns (CLGBC),[2] the Committee on Children, Youth, and Families (CYF), and the Committee on Women in Psychology (CWP) jointly reviewed concerns that had been brought to APA's attention about the diagnosis of "gender identity disorder" (GID) in the fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–IV*; American Psychiatric Association, 1994). After consulting with the American Psychiatric Association Committee on Gay, Lesbian, and Bisexual Issues, the committees concurred in postponing further action on the GID diagnosis until the next *DSM* revision. However, CLGBC identified transgender issues as one of its priority issues and initiated a series of consultations with the Board for the Advancement of Psychology in the Public Interest (BAPPI) and its committees and with Divisions 9, 35, 37, 41, 44, 45, and 51 during 1991–2001. The Division 44 Transgender Task Force was also becoming active in this period.

These consultations led to the formation of the Gender Identity Working Group in 2002 that developed the proposal for the Task Force on Gender Identity and Gender Variance, which was introduced in August 2003 and approved by the Council of Representatives in February 2005. By forming the Task Force on Gender Identity and Gender Variance, APA demonstrated a commitment to taking a leadership role among the mental health professionals, scientists, and scholars who are addressing the complex issues surrounding transgenderism, gender identity, and gender variance.

This report contains a wide range of recommendations for the education and training of psychologists, research, consultation with other professional organizations, addressing the needs of psychologists and psychology students, and development of policy. As background, this introduction provides an overview of (a) our

[2] In 2007, the Committee on Lesbian, Gay, and Bisexual Concerns (CLGBC) became the Committee on Lesbian, Gay, Bisexual, and Transgender Concerns (CLGBTC). Both references to this committee will be used in this report, depending on which one is historically correct in the context of the particular discussion.

interpretation of our charge, (b) the cultural context surrounding the issues addressed, (c) our interpretation of our constituency, and (d) questions related to terminology.

Interpreting Our Charge

The charge of the Task Force on Gender Identity and Gender Variance was to develop recommendations, based upon a review of current research on gender identity and intersexuality, relative to the following:

- How APA should address these issues, including recommendations for education, training, and further research.
- How APA can best meet the needs of psychologists and students who identify as transgender, transsexual, or intersex, including which entities have interest or expertise in these issues, and how to develop ongoing dialogue and sensitivity training in these areas.
- How APA's extant policies with regard to these populations can be updated.
- Ways in which APA can collaborate with other professional organizations in this area.

Almost from the beginning of our work, we confronted questions about whether it would be feasible to address both *gender variance* and *intersex conditions* (the preferred term is now *disorders of sexual development,* or DSDs, which we use in this report) in one report. We observed that the issues confronting transgender and gender-variant people principally concern matters of identity, stigma, and discrimination resulting from visible or self-perceived gender variance. While not denying the potential for stigma among people with DSDs, we recognized that their concerns were primarily related to medical procedures and treatments they sometimes undergo and to matters of patient and family education, disclosure decisions, and so forth.

We also noted that the perceived linkage between gender identity concerns and DSDs that had developed during the late 1990s, when transgender and DSD advocates and activists routinely cooperated, had in recent years been deemphasized or discouraged within both the transgender and the DSD communities. In addition, we were advised by key informants that attempting to address transgender and DSD issues in a single document might be perceived negatively by people with DSDs and their families and might even discourage their involvement with psychologists.

We were thus reluctant to jettison what we perceived as an important element of our charge. We felt strongly that psychologists have an important role to play in addressing the needs of people with DSDs and their families, and we were repeatedly told that there was a great need for appropriately trained psychologists to work in this area. Ultimately, however, we concluded that the issues of people with DSDs and their families and the issues of transgender and gender-variant people were different in so many important respects that it would not be feasible to try to address them in the same document. On that basis, and consistent with the advice of key informants, we decided to omit a general consideration of the issues of people with DSDs from our report. Because a minority of individuals with DSDs may experience concerns related to gender variance or transgender issues at some time in their development and may encounter problems with stigma and discrimination similar to those experienced by other gender-variant individuals, some of the topics we address in this report may nevertheless be relevant to a subset of individuals with DSDs.

Although this document does not attempt to address the needs and issues of most people with DSDs and their families, we recognize that psychologists, particularly those involved with pediatric, developmental, and health psychology, have an important role to play in providing care to this population. Some key informants emphasized to us that individuals within this population and their families could benefit greatly from the expertise of appropriately trained psychologists, who appear to be few in number. We believe that APA can play an important role in encouraging relevant and appropriate training of psychologists in this area and also in policy development and advocacy on behalf of this population. We suggest that APA develop ways of assisting psychologists to address these issues.

Further, we recommended to the Council of Representatives a change to the name of the task force in order to avoid misrepresentation; the Council accepted our recommendation.

The Cultural Context Surrounding Transgender Issues

It is important to understand the broad cultural context in which APA made the decision to create the task force and in which the task force conducted its work. We briefly highlight three important aspects of that cultural context:

- Increased public awarness of transgender issues
- Decentralization of assessment and treatment for people with gender identity concerns
- The influence of community activism

Over the last decade, public awareness of transgender[3] issues increased dramatically, in large part because of the increasing number of books, motion pictures, and television programs featuring transgender characters and addressing transgender issues. For example, in 1999, Hilary Swank received an Academy Award for Best Actress for her role as a female-to-male transsexual in the motion picture *Boys Don't Cry*, and in 2005, Felicity Huffman received an Academy Award nomination for Best Actress for her portrayal of a male-to-female transsexual in the motion picture *Transamerica*. *The Oprah Winfrey Show*, ABC's *20/20*, and *Dr. Phil* featured segments or episodes focused on transgender issues. Transgender issues were also the subject of a *Newsweek* cover story in May 2007. Internet sites addressing transgender concerns likewise proliferated. All of these resources contributed significantly to increased public awareness of and interest in these issues. Despite this increased availability of information, however, it is also our observation that many individuals find transgenderism and gender variance to be challenging or difficult to understand. This suggests that the need for clear and accurate information about transgender issues has not been fully met.

Transgender people are increasingly willing to identify themselves openly and, in some cases, to undergo gender transition or sex reassignment without "going stealth." As a result, transgender people, their families and friends, employers, schools, and government agencies are increasingly turning to psychologists for help in addressing these issues. This includes not only psychologists with expertise in assessment and treatment of transgender people but also those with expertise and interest in organizational policies, community development, clinical research, and human rights issues. We see this trend as underscoring the need for psychologists to acquire greater knowledge and competence in addressing transgender issues, and we believe that the creation of the task force reflects APA's recognition of this need.

We believe that APA can play an important role in encouraging relevant and appropriate training of psychologists in this area and also in policy development and advocacy on behalf of this population.

Changes in service delivery also provide context for this report. In the United States, assessment and treatment services for transgender people with gender identity concerns became increasingly decentralized over the last 2 decades. Many, but not all, of the large, university-based programs that once treated most people seeking sex reassignment closed during the 1980s, increasingly referred clients to community practitioners for the provision of services, or re-

[3] We use the term *transgender* in this report to refer to a variety of people who are gender variant in relation to cultural norms in significant ways. While the descriptor *transgender* typically brings to mind someone who wants to transition to the other sex/gender both socially and physically through surgical procedures, it can also refer to people who express gender atypicality along a continuum, including, for example, cross-dressers, those who present as gender ambiguous, or those who live in the role of the other gender without surgical or hormonal intervention. To emphasize the range of people subsumed under this umbrella, we at times refer to gender variance and transgender issues, together, throughout this report.

structured, moving services to an arms-length relationship with the university (Bockting, Robinson, Benner, & Scheltema, 2004). Other important factors affecting the delivery of care to people seeking sex reassignment include controversies regarding appropriate treatment, reduced third-party reimbursement for services, and a general trend toward community-based health care. As a result, transsexuals and other people with gender identity concerns increasingly turned to community mental health professionals and community physicians for assessment and treatment. Consequently, it has become more likely that individual psychologists will encounter people requesting assessment and treatment for gender identity concerns; at the same time, there is less certainty about appropriate sources for consultation and referral. We believe that recognition of this trend was yet another factor leading to the creation of the task force.

Transgender activists followed in the footsteps of earlier social movements, including the civil rights, feminist, and the lesbian, gay, and bisexual (LGB) movements.

Last, but certainly not least, educational and political activism by transgender persons and community organizations influenced the attitudes of many helping professionals and some members of the general public concerning transgender issues. Transgender persons described their experiences and feelings in books, magazine articles, Web pages and blogs, plays and performance art, and many other media. They engaged in scholarly research concerning topics of importance to their communities, including needs assessments, HIV/AIDS, and outcomes of sex reassignment. Transgender persons and organizations representing them created educational materials and programs to inform care providers and the public about transgender issues. They lobbied local, state, and national government bodies and nongovernmental organizations for civil rights for transgender communities and the prohibition of discrimination on the basis of gender identity and/or gender expression. In so doing, transgender activists followed in the footsteps of activists involved in earlier social movements, including the civil rights, feminist, and the lesbian, gay, and bisexual (LGB) movements. In particular, the activism of transgender persons and community organizations, sometimes in concert with their LGB allies, played a significant role in bringing transgender issues to the attention of psychologists who recognized their responsibility to address these concerns with competence and sensitivity.

Notwithstanding some tensions between transgender communities and mainstream mental health care providers, transgender people have a variety of concerns for which they may seek the assistance of psychologists. In addition to the usual problems that may bring any individual to therapy, transgender people face the task of determining how they want to live their lives either as gender-variant people or as normatively gendered men or women, and they must address the complex decisions that go with that determination. The stigmatization and discrimination that many transgender people regularly experience further complicate these issues.

Transgender people experience stigmatization and discrimination as a result of living in a gendered culture into which they often do not easily fit. Many not only experience an inner sense of not belonging but also harassment and discrimination, including verbal and physical abuse and reduced access to education, employment, housing, medical care, and other social services. A disproportionate number of violent and sometimes lethal acts are directed against transgender and other gender-variant people. Gendered facilities such as restrooms, athletic facilities, college dormitories, group homes, shelters, and prisons sometimes pose extraordinary barriers for transgender people. The ubiquitous use of binary gender categories on birth certificates, drivers' licenses, passports, job application forms, and so forth, can also be challenging to people who do not easily fit into one of two gender categories.

As these examples illustrate, the needs of transgender people are inextricably linked to broader issues of human rights and social justice, issues with which APA is greatly concerned. It is through this lens that we examine these issues.

Interpreting Our Constituency

The charge of the Task Force on Gender Identity and Gender Variance as written states the following:

> Our mission is to assist APA in addressing transgender issues in training, education, research, and policy, including the specific needs of APA members, both psychologists and students, who identify as transgender.

In short, APA and its membership constituted our nominal constituency.

We expected, of course, that our recommendations would affect more than just APA and its members. In particular, we hoped that our recommendations would positively affect transgender people generally, not just within APA. We believed that if APA members developed greater cultural competency in transgender issues and became more aware of effective and appropriate interventions with this population, transgender clients would receive improved services. Moreover, we believed that promoting research involving transgender issues, generally enhancing the profile of transgender scholarship, and ensuring a supportive milieu within APA for transgender members and others with interests in this area would benefit transgender people generally by providing a more solid scientific basis for the delivery of psychological services and would also advance evidence-based advocacy and policy development.

As our work progressed, we found it useful to think about our constituency in somewhat broader terms, especially since we had been asked to make recommendations concerning APA policy. We were mindful of APA's long-standing ethical commitment to taking policy positions on behalf of minority groups that had experienced stigma and discrimination based on characteristics such as sexual orientation, ethnicity, or disability. We believed that transgender people deserved the same kind of ethical commitment from APA. Consequently, the way we thought about our constituency expanded at times to include transgender people generally.

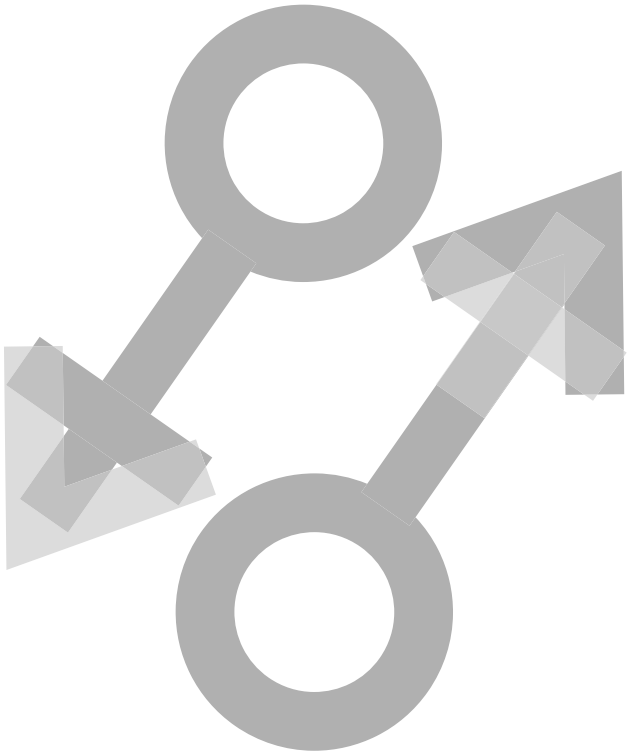
After the existence of the task force became publicly known in the summer of 2005, it was apparent to us that many transgender people and organizations believed that they were the task force's primary constituency. There was a hope, and perhaps an expectation, that the task force would advocate on behalf of particular positions and issues about which some of these individuals and organizations held strong opinions. For example, we received many written statements urging us to advocate that the diagnosis of gender identity disorder be removed from the *DSM–IV–TR* (American Psychiatric Association, 2000) as a step toward depathologizing and destigmatizing gender variance. Regardless of whether this type of advocacy was appropriate for the task force given its charge, we came to understand that transgender communities had their own perceptions about the relationship between our work and their interests and that in addressing our charge, we would need to avoid defining our constituency too narrowly.

Consequently, in the service of our nominal constituency, we sought to develop recommendations that would provide APA and its members with increased awareness of transgender issues and better tools for addressing these issues as researchers, practitioners, and policymakers. In the service of a more broadly construed constituency, we sought to encourage APA and its members to think about transgender issues within a broad social and political context, enabling them to advocate more effectively on behalf of transgender people and communities. Thus, we hoped that our recommendations would not only serve our nominal constituency but transgender people and the wider public interest as well. Our framework defined our constituencies and articulated our social justice and human rights perspective that reflected APA's mission to work on behalf of professional and public interests. From this framework we approached our work and the creation of this report. This framework also led us to develop the Resolution on Transgender, Gender Identity, and Gender Expression Nondiscrimination, which is a key component of our recommendations (see pp. 65–69).

Questions of Terminology

We discuss terminology and provide definitions of several key terms relevant to transgender and gender variance in the Review of Research section of this report. It seems prudent to note at the outset, however, that we found it challenging, if not impossible, to write about the issues relevant to our charge using terminology that was simultaneously (a) internally consistent, (b) consistent with established "terms of art" in the field of transgender care, (c) consistent with the typical usage of scholars in related fields, and (d) respectful of the diverse identities of transgender and gender-variant persons. Often we found it especially problematic to decide whether to use the term *sex* or *gender*. For example, is it more accurate to say that transsexuals receive *cross-sex* hormone therapy or *cross-gender* hormone therapy?

We believe a case could be made for either, depending on whether the intent was to describe the hormones themselves or the process they facilitate. Is it preferable to call dissatisfaction with one's primary and secondary sex characteristics *sex dysphoria* (arguably more accurate) or *gender dysphoria* (the established term of art in the field)? Are pretransition adult female-to-male transsexuals more appropriately called *biologic females* (arguably more consistent with their identities) or *women* (arguably more consistent with usual APA style, and not redundant)? In our report, we attempted to balance the competing goals of consistency, recognition of established terms of art, respect for the expectations of scholars in related disciplines, and respect for the identities of transgender persons while realizing that our use of terminology will inevitably not please everyone at every point.



Consultation and Fact Finding

The members of the Task Force on Gender Identity and Gender Variance possess a wide range of experience with transgender issues, including research, scholarship, practice, and, in some cases, lived experience. One of our first fact-finding activities was to compile, on the basis of our own expertise, a collection of key resources with which we felt we should all be familiar. These included journal articles, book chapters, books, and videos related to theory, research, and practice.

Notwithstanding our collective knowledge and experience, we recognized the need to consult with other experts, organizations, and interested individuals in order to carry out our charge. Accordingly, we engaged in consultation within APA, including conducting a survey of APA members and consulting with various APA committees and divisions; contacted other professional organizations that might have interest or expertise in these issues; and solicited the viewpoints and recommendations of transgender organizations and individuals. The order in which we conducted these consultations was directly related to the responsibilities laid out in our charge and to our understanding of our constituencies.

Consultation Within APA

Survey of APA Members

In order to help determine how APA can best meet the needs of psychologists and students who identify as transgender or gender variant, we conducted a survey of APA members to learn about their experiences and concerns regarding these issues (see Appendix A).

Method

The survey was distributed at the August 2005 APA convention in Washington, DC, and an Internet version was publicized in the October 2005 issue of the APA *Monitor*. All members of APA were invited to participate. The survey included basic demographic questions about the respondents, their professional experience regarding transgender people in the workplace, and their academic programs. Transgender participants answered questions relevant to their experience as gender-variant people in their work and academic settings. The questionnaire also included similar questions regarding intersex conditions; these are not included here, however, for reasons outlined in the introduction.

Respondents

Two hundred ninety-four APA or American Psychological Association of Graduate Students (APAGS) members responded to the survey, either online or by returning a hard copy. Another 109 individuals who did not belong to APA or APAGS also answered the survey. The following information pertains to the 294 psychologists and students only.

Among APA/APAGS respondents, 205 indicated that they were psychologists, and 80 were graduate students. Doctoral degrees were held by 211 of the respondents. Fifty-six had completed a master's degree, and 56 their bachelor's degree. These individuals worked in a wide range of employment settings, including university or academic environments (40%), independent practice (21%), and hospitals (11%). Smaller percentages of these individuals worked in counseling centers, school or government offices, business, and industry. Twenty-six APA and APAGS members identified as transgender or gender variant; 268 did not.

The racial composition of the sample was 84% White/Caucasian, 6% Hispanic/Latino, 3% Asian/Pacific Islander, 2% Native American/Alaskan, 1% Black/African American, and 6% "other." Written "other" responses included Brazilian, Appalachian, mixed or biracial, Middle Eastern, Eurasian, Persian American, Arab American, Jewish, Afro-Caribbean, and White European.

Responses of Transgender and Nontransgender Psychologists and Students

The experiences of all 294 psychologists and students concerning transgender issues are summarized in Table 1. Seventy-one percent of the respondents had known at least one transgender individual when they were students. Fifty-two percent had had the opportunity to learn about transgender issues in school, and another 52% reported having had professional opportunities to learn about those issues. In spite of these training opportunities, only 27% reported that they "feel sufficiently familiar with transgender issues." When asked about experience in the workplace, 29% reported that they had worked with at least one transgender colleague. Four percent had worked with a colleague who transitioned on the job, and 2% had had a transgender supervisor.

Participants' open-ended responses reflected a wide variety of concerns. Many expressed the need for education about transgender issues, including the development of training materials and the use of APA's publication venues for disseminating information. Some noted the need for guidance

Table 1

Experience With Transgender, Transexual, and Gender-Variant (TGTSGV) Issues

Item	*n*	%
Knew at least one TGTSGV student when I was a student	210	71
Went to school with someone who transitioned	22	8
Had opportunity in school to learn about TGTSGV issues	153	52
Had professional opportunity to learn about TGTSGV issues	153	52
Feel sufficiently familiar with TGTSGV issues	80	27
Have worked with at least one TGTSGV colleague	86	29
Have worked with a colleague who transitioned on the job	12	4
Have had a supervisor in my workplace who was TGTSGV	6	2
Have supervised at least one TGTSGV student in an academic setting	30	10
Supervised at least one TGTSGV student in practicum or internship	13	4

regarding correct language usage when discussing transgender issues. Competent health care and psychological services were other prominent issues, in terms of access to care for transgender people as well as competent provision of care on the part of service providers. Particular concerns included access to medical treatment (e.g., hormones and surgery) and requisite insurance coverage. There was concern expressed about the perceived gate-keeping function of some health care facilities. Some respondents called for practice guidelines, establishment of best practices, or providing resources for consultation when indicated.

There was a ubiquitous call for acceptance and the provision of supportive environments. Respondents who were not transgender asked for suggestions regarding how to provide supportive environments in general and within APA specifically. Specific issues included the inclusion of gender identity in nondiscrimination policies; provision of gender-neutral facilities such as housing, bathrooms, and so forth; record-keeping procedures sensitive to the needs of people transitioning from one gender to the other; and the recognition of transgender issues as an aspect of diversity in curricula and in research.

Many comments pertained to promoting research on transgender issues. Establishment of a "home" for transgender issues within APA was mentioned as a way of supporting research, as were finding ways to promote cross-divisional collaboration and greater funding of research.

Responses of Transgender Psychologists and Students

Transgender-identified psychologists and students were asked to (a) list two or three things that had been helpful to them as transgender people in school or work settings, (b) suggest two or three things that would help provide a more supportive experience for transgender people in school and work settings, and (c) describe two or three outstanding experiences or challenges they had experienced as transgender people in school and work settings. We received 67 written responses to these questions.

The needs that were identified, explicitly or implicitly, in these 67 responses fell into eight general categories:

- More education and training about transgender issues across a wide range of school, institutional, workplace, and professional settings
- Greater acceptance of transgender people in these settings
- More mentoring, advocacy, role modeling, and demonstration of ally status by people in authority in these settings
- Greater protection against prejudice and discrimination based on gender identity and gender variance
- Increased and visible support for research concerning transgender people and issues
- Recognition of transgender people as experts concerning their issues and identities as transgender people
- Better access to competent medical services and mental health services for transgender-related conditions, problems, and issues
- Greater availability of gender-neutral facilities (e.g., restrooms, locker rooms, housing)

Discussion

The survey respondents almost certainly did not constitute a representative sample of APA membership. Rather, these respondents represented those members with sufficient interest in these issues who took the time to complete the questionnaire. In terms of numbers, this is not an insignificant group, and it is noteworthy that even among these interested respondents, relatively few felt they had sufficient information about transgender issues. This speaks to the information needs of psychologists generally, especially given the likelihood that psychologists providing mental health services are likely to encounter at least one or two clients with transgender issues at some point in their career.

Consultations With APA Divisions and Committees

Overview

The task force identified and consulted with APA committees and divisions that we believed might have a particular interest in transgender issues. One member of the task force contacted the chair or president of each of these committees and divisions. In addition, we sent an e-mail to the presi-

dents of every other APA division, inviting them to contact the task force if their divisions had an interest in transgender issues (see Appendix B for a list of divisions and committees with which we had contact). The topics we discussed in our consultations included professional development, education and training, research priorities, practice guidelines, and existing resources. We also hoped to identify individuals within these committees and divisions who were especially interested in these issues.

Committee on Lesbian, Gay, and Bisexual Concerns

The consultation with the then-CLGBC was informal, because task force member Randall Ehrbar, PsyD, was appointed to the committee for a 3-year term beginning in 2006. With Dr. Ehrbar's appointment, the committee initiated a thorough consideration of whether to include transgender within its mission and decided to propose a change to the committee's name and mission. This proposal was adopted by the Council of Representatives in February 2007. Thus, the committee is now the Committee on Lesbian, Gay, Bisexual, and Transgender Concerns.

Division 44 (Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues)

As is evident from its history, Division 44 has been the de facto home for transgender issues for at least a decade, providing forums for presentations on the topic, including keynote addresses as well as continuing education opportunities at APA's annual convention. The division currently has a standing committee on transgender issues, the Committee on Transgender and Gender Variance Issues. In 2002, Katherine Rachlin, PhD, and Jamison Green, PhD, conducted a transgender training for the division's executive committee at its midwinter meeting.

During the tenure of the task force, Division 44 was engaged in dialogue about formally including transgender issues in its mission statement, prompted at least in part by consultations with the task force. Task Force Chair Margaret Schneider, PhD, was a member of Division 44's executive committee until August 2006 and, in that role, maintained communication with the division. Although we anticipate that the addition of transgender to CLGBC's name and mission and the increased interest in formalizing Division 44's interest will provide the focus that is needed to bring interested psychologists together, there is a question as to whether a majority of Division 44's membership would be willing to formally adopt transgender issues as their own.

As might be expected from a division with so much historical involvement with transgender issues, when Dr. Schneider raised this issue at the division's midwinter meeting in January 2006, there was considerable enthusiasm, although some members had reasons for remaining lukewarm. Some felt that they did not know enough about the issues to have an informed opinion, and others wanted a sound theoretical and scientific foundation for linking LGB and transgender issues. In fact, this report proposes that gender variance is the linking foundation between LGB and transgender issues (Minter, 2006).

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The most contentious issue was the concern that a division devoted to LGB issues might find itself inappropriately involved in what could be perceived as being heterosexual issues (i.e., male-to-female transgender people attracted to males or female-to-male transgender people attracted to females). This confounding of presumably heterosexual and LGB issues has been the basis of often-heated and divisive debates in LGB communities, and Division 44 would not necessarily be an exception. In its Spring 2007 newsletter, however, the division extended an explicit welcome to transgender people and affirmed its commitment "to address and include the concerns of all sexual minorities" (APA Division 44, 2007).

We hoped that our consultation with Division 44 would encourage the executive committee and

membership to begin a dialogue about the place of transgender issues in the division. Opinions within the division appear to vary, but regardless of whether Division 44 broadens its mandate to include transgender issues, it will continue to be one of the strong advocates for these issues in terms of research, education, and training.

Other APA Divisions and Committees

The representatives of other divisions and committees that we contacted reported a range of interest in transgender issues. There were no other divisions or committees that viewed these issues as central to their mandate or mission statement, although the chair of the Committee on Psychology and AIDS (COPA) reported a significant interest in transgender issues among some researchers and practitioners in HIV prevention. The Committee on Aging (CONA) indicated interest in issues for the elderly transgender population and suggested that this topic would generate interest from Division 12/Section 2 (Clinical Geropsychology) and Division 20 (Adult Development and Aging).

Although one might have expected considerable interest from the entities involved with gender issues, representatives speaking for both Division 35 (Society for the Psychology of Women) and the Committee on Women and Psychology (CWP) reflected a mixed reception to transgender issues. Although there have been dialogues about the place of transgender issues within both groups, in the context of an analysis of power as conferred by gender, adopting transgender issues as a whole becomes problematic because it captures individuals raised with gender privilege (even though they abandoned it as a result of transitioning) as well as those who benefit from gender privilege following transition. In short, what to do with male privilege in the midst of entities devoted to the study of the psychology of women is a contentious issue—one that is also replicated in lesbian communities, often resulting in the ostracizing of transgender people who consider themselves to be part of these communities. There is, however, a conspicuous difference of opinion according to age, with younger and early career scholars in the area of the psychology of women more likely to be sympathetic to and embracing of transgender issues, in comparison to members who are more advanced in their careers.

Representatives from other divisions reported that there were individual members who were interested in, or involved with, transgender issues but that the divisions as a whole were not necessarily involved in or committed to this area. However, some representatives believed that members of their divisions might see these issues as relevant in specific contexts. Representatives from Division 17 (Society of Counseling Psychology) and Division 51 (Society for the Psychological Study of Men and Masculinity) saw a very obvious link between the focus of their divisions and transgender issues. In addition, the task force noted that psychologists in Division 8 (Society for Personality and Social Psychology) and Division 9 (Society for the Psychological Study of Social Issues) might be drawn to transgender issues from the perspective of social justice, prejudice, and equality. Developmental psychologists from Division 7 might be interested in the developmental trajectories of transgender people, and community psychologists from Division 27 might be interested in studying community development and social action within transgender communities.

In other words, a number of divisions and committees have some potential connection to transgender issues, but none had sufficient numbers of interested members to take a leadership role. Although some executive members of various divisions expressed interest, we recognized that as divisional leadership changed, the commitment to transgender issues might wax and wane. Conversely, we were also aware of instances in which division executives did not respond to our e-mail solicitation, when in fact there were LGBT interest groups or committees within the division. Therefore, the key to engaging various divisions is to identify specific individuals within these divisions who are willing to keep the issues on the table. In this report, we make recommendations for ways to encourage those individuals interested in transgender issues to network and collaborate.

Consultations With Other Professional Organizations

Pursuant to its charge to make recommendations for collaborations with other organizations, the task force contacted professional organizations

outside of APA that we believed might have interest or expertise in transgender issues, including organizations that dealt specifically with transgender issues, based on their mission statements (see Appendix B for a list of organizations). In some instances, we were able to identify a potential key informant within an organization and contacted him or her directly. In other cases, we contacted the organization through information found on its Web site. As in our consultations with APA committees and divisions, we asked about the organizations' existing resources and approaches to professional development, education and training, research, practice guidelines, and standards of care. We sought to identify specific individuals within each organization who had responsibility for, or an interest in, these issues and to determine whether the organizations had working groups devoted to transgender issues.

The landscape of professional organizations outside of APA mirrors the situation within APA. Few organizations systematically develop or provide transgender-related resources for their membership. There are a number of organizations, however, that demonstrated significant interest in or awareness of transgender issues, either through advocacy or the development of their own policies or by promoting research or providing educational and professional development opportunities. Among these organizations, six were considered to be key.

World Professional Association for Transgender Health

The World Professional Association for Transgender Health (WPATH; formerly the Harry Benjamin International Gender Dysphoria Association) is a professional organization devoted to the understanding and treatment of gender identity disorders. WPATH has approximately 500 members from around the world—in fields such as psychology, medicine, law, social work, counseling, psychotherapy, family studies, sociology, anthropology, voice therapy, sexology, and other related fields—who specialize in transgender health. WPATH's guidelines, the *Standards of Care for Gender Identity Disorders* (see Meyer et al., 2001), are for the clinical management of gender identity disorders, including eligibility and readiness criteria that clients in many cases need to meet in order to access sex reassignment services. WPATH offers continuing education opportunities through biennial scientific conferences, a peer-reviewed journal, the *International Journal of Transgenderism*, and an interactive Web site (www.wpath.org) with information and referral services, including a members-only section and a medical listserv. The mission of WPATH also includes advocacy and public policy initiatives and the promotion of access to transgender-specific health care, transgender equality, and human rights. WPATH board members expressed a great deal of support for the work of the task force and also a keen interest in future collaboration, particularly with regard to implementation of our recommendations.

Society for the Scientific Study of Sexuality

The Society for the Scientific Study of Sexuality (SSSS) is another key organization. Scientific conferences of this international organization typically include several presentations and workshops on scholarship and research in the area of gender identity, gender variance, and transgenderism, with an emphasis on the translation of research findings into clinical practice and education. In addition to these annual conferences (one international conference and two U.S.-based regional conferences), SSSS has a Web site that includes resources for training and networking of sexual scientists (www.sexscience.org), and it publishes a peer-reviewed journal, the *Journal of Sex Research,* and the *Annual Review of Sex Research*.

American Psychiatric Association

The American Psychiatric Association is in a unique position because it provides definitions and diagnostic criteria for GID and related conditions in its publication, the *DSM*. The American Psychiatric Association, however, does not recognize transgender psychiatrists as an interest group. Furthermore, transgender psychiatrists are not included on committees examining GID as a disorder, since, as our key informant explained, it is not policy to have individuals with a disorder examin-

ing the *DSM*. It is important to note, however, that the American Psychiatric Association's annual conferences include a number of presentations on transgender issues that seemed to be transgender-positive, so there are clearly individuals within the organization who have an interest in these issues that goes beyond diagnosis. In short, it would be hard to imagine not consulting with the American Psychiatric Association, especially around diagnostic issues.

Council on Social Work Education, Council on Sexual Orientation and Gender Expression

The Council on Sexual Orientation and Gender Expression of the Council on Social Work Education (CWSE) has a mandate that includes transgender issues. The council is very active on many fronts, including advocacy, social work education, and professional development, and is interested in collaboration with the task force.

International Association for Social Work Research

The International Association for Social Work Research (IASWR) promotes social work research, with the goal of strengthening the evidence base of social work practice. Although it has not directly addressed transgender issues, IASWR is closely associated with other social work organizations, including the National Association of Social Workers (NASW) and the CWSE, that are more directly active regarding transgender issues. It would be useful to pursue liaisons with IASWR in order to explore possibilities for research collaboration.

American Public Health Association

The American Public Health Association (APHA) has been actively involved in advocating for greater visibility on behalf of transgender communities, including developing policy statements, participating in document creation and review and in local and national organizations, and programming at its annual conference. APHA has two relevant policy statements regarding the need for public health research on gender identity and sexual orientation and the need for acknowledging transgender people within research and clinical practice.

Other Professional Organizations

Other organizations have occasionally provided professional development opportunities at conferences or through other types of presentations to expose their membership to transgender issues. The American Association of Sexuality Educators, Counselors, and Therapists has a few committed members who have worked diligently to ensure that these issues are kept on the agenda. One example is Sandra Cole, PhD, who organized two 13-hour continuing education courses with CE credits. The courses were well-attended.

Finally, some professional organizations that have not been particularly active in terms of transgender issues nonetheless have included transgender issues in relevant policy statements. These include the American Medical Association, NASW, and the Gay and Lesbian Medical Association (GLMA). We noted that GLMA has collaborated on two documents that include these issues—*Lesbian, Gay, Bisexual, and Transgender Health: Findings and Concerns* (Dean et al., 2000) and the *Healthy People 2010: Companion Document for Lesbian, Gay, Bisexual, and Transgender (LGBT) Health* (GLMA, 2001). Historically, GLMA has promoted research and collaboration with other organizations and should be included in any collaborative effort, especially pertaining to transgender health.

The interest in transgender issues among other professional organizations reflects a pattern similar to that within APA. Some organizations have a clear interest in these issues, whereas within other organizations, the interest is sustained by a few committed individuals. Therefore, the key to collaborating with other organizations is to identify specific individuals who will keep their organizations involved and find ways for these individuals to network and collaborate on behalf of their organizations.

Consultation With Transgender Community-Based Organizations and Individuals

Process and Overview

The task force also solicited the viewpoints and recommendations of transgender community-based organizations and individuals. By the end of our first meeting in June 2005, we had agreed to solicit input from transgender communities directly and began this process by using our individual contacts within the transgender communities. We left the discussion of a more systematic consultation strategy for our next meeting. Just prior to our second meeting in November 2005, we received a series of e-mails expressing concern about the apparent lack of a formal mechanism by which transgender organizations and individuals could provide recommendations to the task force directly. Ultimately, we received an open letter urging us to actively solicit the views of transgender organizations and individuals. The letter was fortuitous, because it included the names of many organizations that would be obvious choices in our consultation process.

At the task force meeting in November 2005, we decided that the best strategy was to contact all who had sent correspondence and invite comments on the issues set forth in the task force's charge, as well as solicit recommendations for educational resources and request further dissemination of our invitation to other interested parties. The deadline for responses was the end of January 2006. We also made a commitment to send a draft of our report to interested parties for comment. We received responses from approximately 25 people (both as individuals and as representatives of transgender organizations). Most of the communications urged APA to work toward destigmatizing transgender people, to advocate for civil rights for transgender people, and to use its influence to remove gender identity disorder from the *DSM*.

In August 2007, the task force completed and widely distributed a draft report to approximately 35 transgender advocates and individuals within transgender communities, to psychologists with expertise in the area, and to relevant APA divisions. The draft was placed on the cross-cutting agenda for the Fall 2007 consolidated meetings. We received substantial feedback from these consultations, much of which was taken into consideration when producing the second draft.

The community response made it apparent that the report continued to be viewed by many as a vehicle for advocacy rather than as an internal document, written to help APA better fulfill its mandate as it pertains to transgender issues. Thus, some of the feedback, while thought provoking, was not directly related to the charge of the task force. For example, the report's description of the ambivalent positions articulated by some divisions' representatives was viewed as hurtful to transgender people and as unnecessary. On that basis, one reviewer suggested that it be omitted, but we believe that understanding the range of attitudes within APA is a key component of framing an action plan for addressing our recommendations.

Most of the communications urged APA to work toward destigmatizing transgender people, to advocate for civil rights for transgender people, and to use its influence to remove gender identity disorder from the *DSM*.

Many of the peer reviewers focused on the research section in particular. We reviewed all of these comments and integrated them in the revised report when we believed they had merit. Many of the reviewers suggested more detailed discussions of some research topics and included detailed analyses of various research perspectives. However, we viewed our task as raising issues that, in our view, required further research, rather than as attempting to come to a definitive conclusion in the absence of consensus on a particular topic. Altogether, we received well over 100 pages of comments. After much consideration, a second draft was developed and put on the cross-cutting agenda in Spring 2008.

A second stream of community comments revolved around redefining the Resolution on Transgender, Gender Identity, and Gender Expression Nondiscrimination. In Fall 2007, we invited 20 people involved in transgender communities and organizations across the country—particularly those involved in human rights—to comment on its content and wording. This resulted in several modifications as well.

Examples of Notable Community-Based Organizations

A number of community-based organizations concerned with transgender issues have expertise in policy development and in the development of educational materials. They also have creative ideas about the kind of applied research that would benefit their constituencies and client populations. Of the many community-based organizations that we consulted, three were especially helpful in providing resources for professional development opportunities and in generating ideas for further research.

Sylvia Rivera Legal Project

The Sylvia Rivera Legal Project (SRLP) is an organization focused on legal and human rights and justice issues for transgender people living in New York City, particularly those who are doubly stigmatized by virtue of race/ethnicity, socioeconomic status, disability, age, and so forth. SRLP's priority issues include Medicaid's coverage of services, prisoners' rights, immigration, age of consent for medical care and its impact on underage youth, and discrimination law, particularly in relation to gender-segregated facilities such as homeless shelters, drug-treatment facilities, and foster care group homes. All of these areas hold potential for applied psychological research.

A number of topics that would be intrinsically interesting to psychologists would help generate information that might inform civil actions—for example, research addressing the mental health consequences of living according to one's gender identity regardless of surgical status; the mental consequences of access to transition-related care, specifically the benefits of hormone treatment and surgical intervention for transgender people, including youth; the impact on mental health when hormone treatment is inappropriately withdrawn or surgery is withheld; and the impact on children and/or adolescents of having a transgender parent. These examples demonstrate the potential value of collaborating with groups such as SRLP.

Transgender Law and Policy Institute

The second group, the Transgender Law and Policy Institute, is concerned with laws and policies, both public and private, that affect transgender people. Currently, the organization is particularly interested in policy concerning identity document issues. Given its perspective, the Institute would be interested in collaborative research regarding the proportion of individuals who transition with or without medical intervention, including hormones and various types of surgery (particularly because policymakers often believe that female-to-male transsexuals should have phalloplasty before they can obtain the appropriate ID); costs to insurance companies of including full coverage for transition-related care; and the influence on children of having a transgender parent.

Parents, Families and Friends of Lesbians and Gays

The third group, Parents, Families and Friends of Lesbians and Gays (PFLAG), has well-developed and extensive resources for transgender-related education and training. A section of its Web site is devoted to transgender issues, and the organization has an affiliate called the Transgender Network. In addition, a chapter in the Cleveland area focuses specifically on transgender issues and is a significant resource for PFLAG's network of 500 chapters. The PFLAG publication, *Our Trans Children* (2007), is a significant resource and is available in both Spanish and English. A research priority for PFLAG would be the development of best practices for responding to gender dysphoria in children and/or adolescents, including the role of hormones and surgery. The PFLAG board of directors adopted a policy stating that it will only support legislation that provides explicit inclusion of all groups included in the PFLAG mission statement.

As the brief descriptions of these few, select organizations illustrate, collaboration with communi-

ty-based groups has the potential to be very helpful in generating ideas for research programs, in identifying human rights issues that are within APA's mandate to address, and in providing educational and training resources for psychologists working in mental health. It would be advantageous for psychologists to identify and collaborate with similar organizations in their own geographic area.

Communications Received From Individuals and Community-Based Organizations

As noted earlier, the task force received a number of communications from individuals and representatives of community-based organizations. Some of these were unsolicited, while others were received in response to the invitation we offered in November 2005. These communications, for the most part, raised many of the same concerns that were expressed by participants in the task force's survey, particularly the need for education and competent practice. As noted earlier, many individuals urged the task force to work toward the removal of GID from the *DSM* and to generally work toward depathologizing gender variance. [4]

Many of these communications also expressed a sense of marginalization and disenfranchisement. In particular, many respondents objected to what they perceived as a lack of consultation and expressed a sense of being left out of the process, which seemed to recapitulate their everyday experience. We hope that the consultation process involving the first draft of this report helped to address this concern.

Review of Existing APA Policies

Introduction

The task force was charged with reviewing APA policy regarding transgender populations and making recommendations for changes. This section addresses the first part of that charge.

In a variety of ways, APA aligns itself with disadvantaged groups by adopting policies that guarantee their rights within APA and by advocating for their rights in society generally. It is APA's practice to adopt resolutions that state official positions on psychological or sociocultural issues. Often these resolutions advocate for civil rights for particular groups—for example, the *Resolution on Sexual Orientation and Marriage* (Paige, 2005). Once adopted, these resolutions become APA policy. APA's history of addressing discrimination through policy statements goes back nearly 4 decades. An early example is the *Resolution on Discriminatory Practices and Vendor Programs* passed in 1969 (APA Committee on Women in Psychology, 2004); a more recent example is the *Resolution on Prejudice, Stereotypes, and Discrimination* (Paige, 2007).

APA also advocates on a broader level through a variety of activities, including lobbying representatives in Congress and in the executive branch of government and encouraging APA members to contact their congressional representatives and individuals in other organizations. APA also prepares amicus briefs in relevant court cases.

Policy concerns for transgender people are similar to the concerns of many other disadvantaged groups, although there are also important differences. Laws and policies prohibiting gender discrimination are often interpreted as not protecting transgender people. Because of this tendency toward narrow interpretation, it is important to have specific reference in law or policy to "gender identity" and/or "gender expression" to ensure that transgender people are fully protected. This principle has important implications for APA internal policies, as well as APA positions on public policy issues.

Existing APA Policy Relevant to Transgender People

The term *APA policy* covers a broad range of policies, including APA bylaws, association rules, policies and procedures, the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002), practice guidelines, criteria for continuing education content and sponsorship, and the *Guidelines and Principles for Accreditation of Programs in Pro-*

[4] We did not reach consensus on this issue. This report does examine the arguments for and against including GID in the *DSM*, and in the Recommendations section we call for a reexamination of the issue.

fessional Psychology (APA Committee on Accreditation, 2006).

There are currently a number of APA policies that include transgender people via explicit mention of gender identity. These include the *Resolution on Child Custody or Placement* (APA, 1975), The *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002), the *Guidelines and Principles for Accreditation of Programs in Professional Psychology* (APA Committee on Accreditation, 2006), Article III Section 2 of the *Bylaws of the American Psychological Association* (APA Members Bill of Rights; APA, 2006a), the Resolution on Hate Crimes (Paige, 2005), and the Resolution on Prejudice, Stereotype and Discrimination (Paige, 2007). This list demonstrates APA's leadership in promoting equity for transgender people.

In January 2008, APA's executive management group decided to add gender identity and expression to APA's equal employment opportunity policies, consistent with the laws of the District of Columbia (*Policies and Procedures Manual,* B1.01, B1.02, B1.08, and B8.02; APA, 2006b). However, the Guidelines to Reduce Bias in Language section in the *Publication Manual of the American Psychological Association* (APA, 2001) does not include a discussion of gender identity issues.

Moreover, it is unclear whether prohibiting discrimination based on gender identity is sufficient to protect all gender-variant people. Although this language would clearly protect transsexuals, it might not be sufficient to protect other gender-variant people, such as cross-dressers who may wish to express themselves in a way that is not consistent with their gender identity (e.g., male-identified biological males who wish to dress in female attire on certain occasions). For example, in 2002, a Federal court in Louisiana ruled that it was "not discriminatory for Winn-Dixie to fire Peter Oiler for occasionally cross-dressing *outside* of work" [italics added] (Currah, Juang, & Minter, 2006, p. xiv). Civil rights experts (Z. Arkles, personal communication, February 28, 2006) suggest that while the spirit of a law referring to *gender identity* might seem to protect both transgender people and cross-dressers, these individuals might not, in fact, be afforded protection if a case went to court. The inclusion of *gender expression* would be more likely to do so.

Including the term *gender expression* along with *gender identity* in APA written policies would send a strong message concerning APA's intention is to be inclusive; it would also provide a model for other organizations to follow. We note that in 2001, APA's Board for the Advancement of Psychology in the Public Interest (BAPPI) approved in principle a proposal from the CLGBC that "gender expression and identity" be added to APA's nondiscrimination policies and other relevant policies in which dimensions of human diversity are specifically identified. However, in all instances, only *gender identity* has been specified. For the reasons outlined previously, we recommend that this wording be revised to include *gender expression* as well as *gender identity.*

In this section we have outlined APA's existing policy relevant to gender identity and transgender issues. In the Conclusions and Recommendations section, we provide a more extensive discussion of policy, particularly as it pertains to APA's advocacy role.

Review of Research

The task force was charged with making recommendations based on a review of current research; here we present a summary of this review.

As noted earlier, the landscape of research on gender variance and transgender issues has changed and expanded over the last few decades. As is the case for many mental health concerns, research in this field was strongly clinical and positivistic. In recent years, however, the scope broadened to include scholarly critical analyses of sex, gender identity, and gender variance. It also expanded to include a variety of methodologies that have focused on a wide range of issues, including life span, public health, community-based interventions, and sociopolitical issues. To some extent, the emergence of researchers and scholars who are themselves gender variant has influenced this expanded body of research. This new direction in research has taken a more holistic approach to the lives of transgender people and has moved away from a focus on pathology. The emergence of this alternate paradigm took place within psychology and in other disciplines as well.

Some transgender people, particularly some community activists, have been disillusioned by traditional research. As noted in the introduction to this report, from their perspective, the clinical language, the inclusion of some types of gender variance in the *DSM*, the apparent focus on prevention, and the perceived gatekeeping role of some research are alienating and stigmatizing. At the same time, however, some of what is regarded as traditional research has resulted in expanding the range of people who are viewed as good candidates for transition. We raise this point to highlight the different extant perspectives on research into gender identity and gender variance.

The growth of research on gender identity and gender variance is reminiscent of the state of research on lesbian and gay people in the 1970s. It was not until gay men and lesbians became actively involved in research about themselves and there was a critical mass of gay and lesbian psychologists and scholars in other disciplines that mainstream research on sexual orientation could be described as positive and affirming. Rather than continuing to pursue causal factors, comorbidity, psychopathology, and personality differences, researchers began to focus on the experiences of gay and lesbian people and asked the questions that were most relevant to their lives. That is not to say that questions about the etiology of sexual orientation and so on are not legitimate questions, only that when the body of research became more affirming, those questions were superseded by others or were articulated in different ways (e.g., what causes sexual orientation rather than what causes homosexuality; what causes gender identity rather than what causes gender identity disorder). It is fair to say that the politicized nature of some research on sexual orientation brought a critical analysis to the research that ultimately strengthened it.

Research regarding oppressed and stigmatized groups ultimately has sociopolitical implications as well as the usual clinical ones; at times, politics and science seem to pull in two different directions, both appearing to be a significant feature of the research landscape. A case in point is the debate about whether GID should be a diagnostic category in the *DSM*. Although this is a question subject to scientific analysis, it is also a question of stigma, as is the debate regarding the biological basis of gender variance. The challenge for researchers is to conduct methodologically sound work that is also respectful of the population that is being studied. The problem for the task force was that in reviewing the extant psychological research, we at times found ourselves using the same language and reproducing a perspective that risked reifying the aspects of the research to which some transgender people (and some psychologists) so strenuously object. However, we believed that it was important to reflect the state of psychological research in order to support our recommendations.

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Introduction

Although the formal study of transgenderism is relatively new, it is a myth that little research has focused on these issues and the affected populations. Since the beginning of the 20th century, numerous reports have been published in the scientific literature describing various aspects of these phenomena (Denny, 1994). Until recently, most of these reports have been clinical in nature.

German sexologist Magnus Hirschfeld coined the terms "transvestite" (1910/1991) and "transsexual" (1923). Hirschfeld is considered one of the founders of sexology, a gender studies pioneer, a feminist, and a gay liberation hero. As with homosexuality, Hirschfeld medicalized transgender behavior in an attempt to counter the strong societal rejection and condemnation of sexual variance. He

conceptualized transvestism and related conditions as an inborn anomaly beyond an individual's control and called for compassion and acceptance. Nevertheless, transvestism and transsexuality continued to be viewed by many as perverse or deviant (Gelder & Marks, 1969; Greenson, 1964).

Within the medicalized context, psychodynamic therapy for transvestism and transsexuality aimed to resolve underlying psychodynamic conflict, and behavioral therapy aimed to recondition behavior to reduce cross-gender behavior and increase comfort with the sex assigned at birth. By and large, these therapies failed (Cohen-Kettenis & Kuiper, 1984; Pauly, 1965). The widely publicized surgical sex reassignment of Christine Jorgensen in 1953 marked the beginning of a new era (Hamburger, Sturup, & Dahl-Iversen, 1953); sex reassignment became a viable option for the treatment of gender dysphoria, and fostering self-acceptance became a common treatment goal for transvestism (Benjamin, 1966).

During the same period, Money, Hampson, and Hampson (1955) coined the term "gender role" to refer to "all those things that a person says or does to disclose himself or herself as having the status of a boy or man, girl or woman." Money and Ehrhardt (1972) later defined gender identity as "the sameness, unity, and persistence of one's individuality as male, female, or ambivalent in greater or lesser degree, especially as it is experienced in self-awareness and behavior."

Since the late 1970s, the focus of research on transgender issues has broadened beyond the earlier clinical focus, although this is much more the case in terms of research on adults than on children and adolescents. Spurred by the growing visibility of the transgender movement, scholars and researchers developed a strong interest in the diversity of sex, gender identity, and gender expression. Studies emerged that approached transgender issues from such disciplines as psychology (e.g., Kessler & McKenna, 1978) anthropology (e.g., Bolin, 1988), sociology (e.g., Devor, 1997a, 1997b), and the humanities (e.g., Garber, 1992). And since the 1990s, a public health research agenda has developed in response to the impact of the HIV/AIDS epidemic on some segments of the transgender community (e.g., Bockting & Avery, 2005; Bockting & Kirk, 1999). The number of publications in this area grew substantially, reflecting a variety of scientific and scholarly approaches ranging from case reports, grounded theory (e.g., Ekins, 1997), feminist analysis (e.g., Heyes, 2003), cross-sectional surveys and interviews (e.g., Nemoto, Operario, Keatley, Han, & Soma, 2004), and longitudinal and intervention studies (e.g., Bockting, Robinson, Forberg, & Scheltema, 2005; Smith, van Goozen, & Cohen-Kettenis, 2001).

Below we summarize areas of research relevant to the charge given to the task force. This is by no means an exhaustive review of the literature, nor does it comprehensively reflect the sizable body of research available on transgender issues. Rather, we focus on areas of research that merit further investigation or provide the background and justification for our recommendations. Our review includes a brief discussion of some controversial areas in which consensus is lacking (e.g., the diagnosis of GID, the concept of autogynephilia, the length of real-life experience as an eligibility criterion for access to sex reassignment surgery). Some of these controversies are related to differences in what interests researchers (e.g., the implications of transgenderism for an understanding of the development of sex, gender, and sexual orientation more generally) and what would be useful knowledge for clinicians and counselors (e.g., when to recommend a client for hormone therapy or surgery), educators (e.g., how to explain the differences among groups that fall under the transgender umbrellas—for example, transvestites and transsexuals), and transgender people themselves (e.g., to improve access to care or to advocate for human rights). We believe that psychologists and other readers of this report will benefit from knowing what the areas of controversy are to better serve the needs of transgender clients, students, and colleagues and to contribute to the discourse and research on these areas of controversy.

Terminology

Several terms are used throughout this review: *sex, gender, gender identity, gender role (masculinity–femininity), sexual orientation, gender expression, transgender/gender variant, gender dysphoria, gender identity disorder (GID)*, and *transsexualism*. These terms are defined in the scientific literature in

various ways. For the purpose of this report, we use the following definitions.

Sex

Sex refers to attributes that characterize biological maleness and femaleness. In humans, the best known attributes that constitute biological sex include the sex-determining genes, the sex chromosomes, the H-Y antigen, the gonads, sex hormones, the internal reproductive structures, the external genitalia, and secondary sexual characteristics (Grumbach, Hughes, & Conte, 2003; MacLaughlin & Donahoe, 2004; Money & Ehrhardt, 1972; Vilain, 2000). To distinguish between a person's sex and gender (discussed below), the terms *male* and *female* are used to describe sex; the words *boy* or *man* and *girl* or *woman* are used to describe gender.

Gender

Gender refers to the psychological, behavioral, or cultural characteristics associated with maleness and femaleness (Kessler & McKenna, 1978; Ruble, Martin, & Berenbaum, 2006).

Gender Identity

Gender identity refers to a person's basic sense of being male, female, or of indeterminate sex (Stoller, 1968).

Gender Role

Gender role refers to behaviors, attitudes, and personality traits that a society, in a given historical period, designates as masculine or feminine—that is, more typical of the male or female social role (Ruble et al., 2006).

Gender Expression

Gender expression refers to the way in which a person acts to communicate gender within a given culture; for example, in terms of clothing, communication patterns, and interests. A person's gender expression may or may not be consistent with socially prescribed gender roles, and may or may not reflect his or her gender identity.

Sexual Orientation

Sexual orientation refers to the tendency to be sexually attracted to persons of the same sex, the opposite sex, both sexes, or neither sex.

Transgender/Gender Variant

Transgender or gender variant refers to the behavior, appearance, or identity of persons who cross, transcend, or do not conform to culturally defined norms for persons of their biological sex.

Gender Dysphoria

Gender dysphoria refers to the "aversion to some or all of those physical characteristics or social roles that connote one's own biological sex" (American Psychiatric Association, 2000, p. 823).

Gender Identity Disorder

Gender identity disorder is a psychiatric diagnosis defined in the *DSM–IV–TR* (American Psychiatric Association, 2000). Its principal diagnostic criteria are gender dysphoria and a strong and persistent cross-gender identification, resulting in clinically significant distress or impairment in social or occupational functioning.

Transsexualism

Transsexualism is the "desire to live and be accepted as a member of the opposite sex, usually accompanied by a sense of discomfort with or inappropriateness of one's anatomic sex, and a wish to have surgery and hormonal treatment to make one's body as congruent as possible with one's preferred sex" (World Health Organization, 1992, p. 365). This definition is consistent with historical usage and represents one possible contemporary usage by people who self-identify as transsexual. Others who self-identify as transsexual use the word more broadly to refer to anyone who lives socially as a member of the opposite sex, regardless of which, if any, medical interventions they have undergone or may desire in the future.

Gender Identity Disorder in Adults

Descriptive Data and Demographics

Prevalence

Estimating the size of the transgender population is challenging because of the scarcity of reliable prevalence data.[5] Based on referrals to a national,

[5] Olyslager and Conway (2007) suggested that the figures cited here are low. Their paper, however, seems to represent a minority position among researchers, although transgender activists tend to endorse the study.

government-subsidized gender identity clinic in the Netherlands, the prevalence of gender identity disorder in adults was estimated to be 1:11,900 for male-to-female transsexuals and 1:30,400 for female-to-male transsexuals (Bakker, van Kesteren, Gooren, & Bezemer, 1993). A review of several European countries suggests an annual incidence rate ranging from 0.15 to 1.58 per 100,000 (Olsson & Moller, 2003; van Kesteren, Gooren, & Megens, 1996). Recent Internet studies can help estimate the size of the broader transgender population. In a random sample of 7,544 visitors to the North American MSNBC Web site, 0.2% identified as transgender (Mathy, 2002); the LGBT Web site PlanetOut has 115,000 transgender-identified U.S. members 18 years of age or older. These Internet data suggest that the size of the U.S. adult transgender population could range anywhere from 115,000 to 450,000.

Male-to-female transsexuality is 1.5 to 3 times more prevalent than female-to-male transsexuality (Bakker et al., 1993; Garrels et al., 2000; Olsson & Moller, 2003; P. Wilson, Sharp, & Carr, 1999). The reason for this is unknown, although some speculate that the narrower definition of the masculine gender role compared to the feminine gender role gives gender-nonconforming females greater freedom to integrate cross-gender expression into the female gender role (Hiestand & Levitt, 2005). Others propose that the observed sex difference in prevalence reflects the fact that, for a proportion of male-to-female transsexuals, gender dysphoria arose out of a history of transvestic fetishism (Blanchard, 1989b; Lawrence, 2003; Levine, 1993). Transvestic fetishism is a paraphilia, and in general, paraphilias are much more common among men than among women (Money, 1986), accounting for what seems to be the rarity of this type of transsexualism among females (Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005).[6]

Although the prevalence of people identifying as transgender and/or with a diagnosis of GID is low, there is anecdotal evidence to suggest that the likelihood of psychologists and other mental health professionals encountering transgender people in their clinical practice, in work and academic settings, and in research is greater than one might initially suppose. Therefore, issues for these populations merit attention from psychologists in a variety of areas.

Transgenderism and sexual orientation

Transgender people, like nontransgender people, may be sexually oriented toward men, women, both sexes, or neither sex, and like most people, usually experience their gender identity (who they feel themselves to be) and their sexual orientation (whom they are attracted to) as separate phenomena (Bockting & Gray, 2004; Chivers & Bailey, 2000; Coleman & Bockting, 1988; Coleman, Bockting, & Gooren, 1993; Docter & Fleming, 2001; Docter & Prince, 1997; Feinbloom, Fleming, Kijewski, & Schulter, 1976; Lawrence, 2005). In describing the sexual orientation of transsexual people, scientists, practitioners, and members of the transgender community are divided. While some define the sexual orientation of transsexuals on the basis of sex assigned at birth (e.g., Blanchard, 1989a; Blanchard, Clemmensen, & Steiner, 1987; Chivers & Bailey, 2000; Lawrence, 2005), others define transsexuals' sexual orientation on the basis of gender identity (e.g., Coleman & Bockting, 1988; Coleman et al., 1993; Pauly, 1990). The different ways of labeling are in part related to theories about the relationship between sexual orientation and gender identity, which in turn are related to theories about the etiology of gender dysphoria—all areas in which consensus is lacking. Labeling is particularly controversial because defining sexual orientation on the basis of sex assigned at birth is perceived by some in the transgender community as invalidating their gender identity and efforts to change their sex.

Sexual orientation and gender identity are sometimes described as independent phenomena, but in reality, sexual orientation and gender variance appear to be linked. For example, most

[6] Erotic cross-dressing is common in men. A recent population-based survey (Langstrom & Zucker, 2005) found that 2.8% of men reported having experienced sexual arousal in association with cross-dressing. This figure is consistent with data from several previous studies that used convenience samples, which suggested that at least 2–3% of men often engage in cross-dressing or cross-gender fantasy as a sexual practice (e.g., Hsu et al., 1994; Person, Terestman, Myers, Goldberg, & Salvadori, 1989; Spira, Bajos, & ACSF Group, 1994).

boys who display marked femininity in childhood grow up to have a same-sex sexual orientation (R. Green, 1987), and childhood gender nonconformity is the strongest predictor of a same-sex sexual orientation in men (Bell, Weinberg, & Hammersmith, 1981). A similar relationship between sexual orientation and gender variance is seen in women, albeit less consistently. However, it is important to note that in studies by both R. Green (1987) and Bell et al. (1981), there were exceptions to the trend, including, in the latter study, a significant minority of gender-variant children who were heterosexual as adults, and a significant minority of gay men and lesbians were not markedly gender-variant as adults (Bell & Weinberg, 1978). Six other empirical studies, reviewed by M. Schneider (1988), serve to raise questions about the relationship between gender variance and sexual orientation; however, as M. Schneider (1988) pointed out, the methodological problems inherent is this body of work (including sampling, operational definitions, and measurement) make it difficult either to support definitively the existence of the relationship or to refute it conclusively.

Nonetheless, the correlations that do exist suggest to some researchers that there is a link between gender variance and sexual orientation that has a biological basis. Some have proposed that most forms of "gender transposition"—homosexuality, bisexuality, transsexualism, transvestism, and other transgender phenomena—are related, to the extent that they can all be explained in terms of varying degrees of masculinization and defeminization of the brain (e.g., Pillard & Weinrich, 1987). Other experts regard these gender transposition theories as overly simplistic, in that they emphasize biological factors to the exclusion of psychological, familial, and cultural influences (e.g., Coleman, Gooren, & Ross, 1989). For example, Harry (1982), whose study did reveal a correlation between sexual orientation and gender role, suggested that once a person is "unstuck" from social expectations regarding gender role, it is easier to become unstuck from other social pressures such as expectation of heterosexuality, so that people who are gender variant are more likely to recognize and act upon their same-sex attractions.

Furthermore, a unitary biological explanation does not account for the considerable number of male-to-female transsexual people who are oriented toward women (Docter & Fleming, 2001; Docter & Prince, 1997; Lawrence, 2005) and the significant minority of female-to-male transsexual people who are oriented toward men (Chivers & Bailey, 2000; Coleman et al., 1993). This led some experts to suggest a typology of transsexuality based on sexual orientation (e.g., American Psychiatric Association, 2000; Blanchard, 1989a, 1989b; Blanchard et al., 1987; Lawrence, 2004, 2008).

Taken together, this research suggests some relationship between sexual orientation and gender identity, although the association is a complex one, with both scientific and cultural significance. It also has importance for the work of the task force in terms of finding a home within APA for transgender issues. Historically, psychologists have turned to Division 44 (Society for the Psychological Study of Lesbian, Gay, and Bisexual Issues) and CLGBC to fulfill this role, but we believe there needs to be a clear rationale for doing so. Scientifically, there is a sufficient linkage between sexual orientation and gender identity to support a rationale for this role, but in addition to the scientific issues, there are cultural issues as well. Ultimately, the stigmatization of gay and lesbian people and of transgender and other gender-variant people is attributable to their gender variance by virtue of their social presentation and identity and/or their sexual attraction. In fact, a number of studies found that the most significant factor related to homophobia was rigid gender role stereotyping (Henley & Pincus, 1978; McDonald &

Sexual orientation and gender identity

are sometimes described as independent phenomena, but in reality, sexual orientation and gender variance appear to be linked.

Games, 1974; Minnigerode, 1976). Although Devor (2003) made a somewhat different argument about the cultural confounding of sexual orientation and gender identity, he proposed that issues for gay, lesbian, and transgender people are "inextricably bound." This, in addition to the scientific perspectives, led us to our conclusions about an appropriate home within APA for transgender and gender variance issues.

Typologies

A number of typologies have been suggested to categorize transgender individuals. Although several studies have found meaningful differences between groups of transgender individuals, it remains unclear what accounts for these differences or, in other words, which typology best explains the variance found among this diverse population. Research has classified transgender individuals on the basis of whether they experienced sexual arousal associated with cross-dressing in the case of natal males (American Psychiatric Association, 2000; Buhrich & McConaghy, 1979; Docter, 1988), the age of onset and development of their gender dysphoria (Doorn, Poortinga, & Verschoor, 1994; Person & Ovesey, 1974a, 1974b), their sexual orientation (Blanchard, 1985b, 1989a, 1989b, 1990, 1991, 1993a, 1993b; Blanchard et al., 1987; Lawrence, 2004), or the degree of childhood gender nonconformity (Bockting & Coleman, 2007; Bockting & Fung, 2005). Collectively, this research suggests that there are systematic differences among various groups of transgender and other gender-variant people. One way of understanding these variations is to understand the development of a transgender identity and develop models of the process, as Devor (2004) has done, and as Rosario (2004) has described in relation to Latino/Latina populations.

Collectively, this research suggests that there are systematic differences among various groups of transgender and other gender-variant people.

Some of these typologies were controversial—for example, some members of the transgender community felt that the typology of homosexual versus nonhomosexual gender dysphoria, particularly as described by Bailey (2003), did not adequately reflect or represent their experiences, whereas others felt that Bailey's description accurately represented their feelings and experiences. Related to this is autogynephilia (Blanchard, 1989a, 1989b, 1991, 1993a, 1993b; Lawrence, 2004, 2006a, 2007a), which conceptualizes some forms of male-to-female transgenderism as the outgrowth of a paraphilia. It is one explanation for the development of some types of male-to-female transsexual people, particularly those who are attracted to females. A survey of transgender community-based Web sites reveals this concept to be controversial within the transgender population. Again, part of this controversy is related to differences between the interests and expectations of researchers (i.e., defining a typology grounded in theory) and the interests and expectations of the target population (e.g., validation of identity and experience).

The Diagnoses of Gender Identity Disorder and Transvestism

The *DSM–IV–TR* (American Psychiatric Association, 2000) and the *International Classification of Diseases* (10th revision; World Health Organization, 1992) include diagnoses for those transgender individuals who are distressed by gender dysphoria (gender identity disorders or transsexualism), cross-dress without a desire for sex reassignment (dual-role transvestism), or experience distress associated with cross-dressing for sexual arousal (transvestic fetishism).

Diagnoses related to gender identity problems have been included in the *DSM* since 1980. According to the *DSM-IV* (American Psychiatric Association, 1994), the diagnostic criteria for GID include (a) a strong or a persistent cross-gender identification, (b) persistent discomfort with one's sex or a sense of inappropriateness in the gender role associated with one's sex, and (c) clinically significant distress or impairment in functioning. Separate descriptions of the manifestations of the

first two criteria were provided for children versus adolescents and adults, reflecting the observation of age-related developmental differences in clinical presentation.

Some experts advocate elimination or "reform" of the GID diagnosis (Hill, Rozanski, Carfagnini, & Willoughby, 2005; Lev, 2005a; Winters, 2005). They contend that the diagnosis harms transgender people by promoting stigmatization, which, in turn, contributes to their distress (see Bockting & Ehrbar, 2005, for a discussion of this issue). This distress, they believe, is not intrinsic to being transgender, and for this reason, they contend, GID does not meet definitional criteria for a mental disorder within the *DSM.* Opponents further note that the GID diagnosis, by promoting stigma, can result in harassment, violence, and discrimination. The diagnosis may also be misused in order to withhold civil rights (e.g., in child custody cases).

Proponents of the GID diagnosis argue that GID does meet the definitional criteria for a mental disorder within the *DSM*, in that it represents a condition that is "in the person" and causes significant distress or impairment in functioning (Fink, 2005; Spitzer, 2005). In particular, they argue that gender dysphoria, the feeling of being "wrongly embodied" relative to one's gender identity, would be distressing even in the absence of social stigma. Proponents further note that virtually all mental health diagnoses are stigmatizing and argue that if "associated stigma" were considered a sufficient basis for removing a mental health diagnosis from the *DSM*, then almost all mental health diagnoses would have to be removed. Finally, proponents argue on purely pragmatic grounds that the GID diagnosis is essential to facilitate coverage of transgender-related health services by third-party payers. Additionally, sometimes a GID diagnosis can facilitate access to rights for transgender people (e.g., through state disability laws) (Levi & Klein, 2006).

The debate over the GID diagnosis is complicated by the perception, especially among some LGB psychologists and heterosexual allies, that the issues are similar to those surrounding the removal of homosexuality from the *DSM* in 1974. Opponents of the GID diagnosis argue that these similarities are compelling and that the removal of homosexuality from the *DSM* provides a strong precedent for removing GID as well. Proponents of the GID diagnosis argue that, despite some similarities, homosexuality and GID are not really comparable.

Transgender-Specific Health Care

Medical necessity

Transgender people who meet criteria for a diagnosis of GID experience clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2000). For individuals who experience such distress, hormonal and/or surgical sex reassignment may be medically necessary to alleviate significant impairment in interpersonal and/or vocational functioning. Indeed, when recommended in clinical practice, sex reassignment surgery is almost always medically necessary, not elective or cosmetic (Bockting & Fung, 2005; Meyer et al., 2001).

Standards of care

Since the 1970s, the WPATH (formerly the Harry Benjamin International Gender Dysphoria Association) has set forth the *Standards of Care for Gender Identity Disorders* for the treatment of GIDs (Meyer et al., 2001) (see Table 2). The *Standards of Care* delineates eligibility and readiness criteria for transition-related treatment while explicitly stating that these criteria are meant as guidelines for flexible treatment directions (including a harm-reduction approach); individual health providers may modify criteria because of a client's particular characteristics or situation (Meyer et al., 2001). In addition, the standards offer guidelines for competence and practice of health providers (including psychologists). To ensure quality of care and increase the likelihood of positive outcome, the standards require that one mental health professional should evaluate and recommend hormone therapy and that two should evaluate and recommend sex reassignment surgery before these services are rendered.

The *Standards of Care* reflects the consensus in expert opinion among professionals in this field on the basis of their collective clinical experience as well as a large body of outcome research reviewed in greater detail below. A recent review

of the evidence (De Cuypere, in press) concluded that a favorable outcome of sex reassignment was associated with adequate preoperative psychotherapy (R. Green & Fleming, 1990; Michel, Ansseau, Legros, Pitchot, & Mormont, 2002; Pfäfflin & Junge, 1998), consistent use of hormones (Carroll, 1999), and a real-life experience of one year or longer (Botzer & Vehrs, 1995; R. Green & Fleming, 1990). However, the specific eligibility and readiness criteria were not adequately evaluated (Cohen-Kettenis & Gooren, 1999). Only one published study of 232 male-to-female transsexuals specifically attempted to evaluate whether adherence to the eligibility criteria predicted postoperative satisfaction (Lawrence, 2003). The study suggested that adherence to some or all of the criteria may not be as critical as previously assumed. However, research on groups of transsexuals who followed the standards have shown low rates of regret (Caroll, 1999; Pfäfflin, 1992). The study by Lawrence underscores the need to evaluate which specific aspects of the *Standards of Care* are most helpful in promoting a positive outcome for both male-to-female and female-to-male transsexuals (Cohen-Kettenis & Gooren, 1999; Lawrence, 2003).

The fact that sex reassignment can, in theory, only be accessed with a referral from a mental health professional has been criticized by some members of the transgender community as unnecessarily pathologizing (e.g., Pollack, 1997; Stryker, 1997). Concerns include the stigmatizing effects of a diagnosis of GID, whether a period of psychotherapy should be required before sex reassignment, whether a period of real-life experience before hormone therapy is helpful or potentially harmful, and the value and length of the real-life experience before surgery (Denny & Roberts, 1997; Gagné, Tewksbury, & McGaughey, 1997; Lawrence, 2001, 2003; Pollack, 1997; Stryker, 1997).

Indeed, the *Standards of Care* is sometimes perceived as a barrier to accessing care, and the mental health professional's gatekeeper role poses a challenge to establishing and maintaining a trusting and productive therapeutic relationship (Bockting et al., 2004; Rachlin, 2002). Some clients may have thought long and hard before seeking assistance toward beginning to physically transition and may experience additional delay in finding relief and achieving their goal as intolerable. Lawrence (2001) argued that no real-life experience or a shorter real-life experience could lead to better workplace acceptance, less fear of physical harm, and greater freedom to pursue significant relationships.

Given these concerns, it is not surprising that hormone use (and to a lesser extent, surgery) without adherence to the *Standards of Care* is not uncommon; reports of illicit hormone use in needs-assessment studies range from 29% to 71% (Clements, Katz, & Marx, 1999; Nemoto, Operario, & Keatley, 2005; Xavier, Bobbin, Singer, & Budd, 2005). Furthermore, a growing number of health providers with varying levels of competence in transgender-specific health care may prescribe hormones and provide access to surgery while making exceptions to or ignoring the *Standards of Care* (Dean et al., 2000; Denny, 1992; Lombardi, 2001). Nonetheless, the *Standards of Care* may be, at least in part, responsible for the lack of regret among patients who have medically transitioned (see *Outcome studies* section, p. 36).

Hormone therapy

Feminizing hormone therapy typically consists of a combination of estrogens and anti-androgens. Feminizing hormone therapy results in breast development, redistribution of body fat (rounder face, hips), decreased muscle mass and upper body strength, softening of the skin, decrease of body hair (yet no substantial decrease of facial hair), and a decrease in libido and erectile functioning (Asscheman & Gooren, 1992; Dahl, Feldman, Goldberg, & Jaberi, 2006). Feminizing hormone therapy administered after puberty does not have an effect on the pitch of the voice. Psychological effects of feminizing hormone therapy include an increase in positive emotions (Cohen-Kettenis & Gooren, 1992; Slabbekoorn, van Goozen, Gooren, & Cohen-Kettenis, 2001).

The most serious risk of feminizing hormone therapy is the development of venous thrombosis or pulmonary emboli (blood clots), especially in smokers and patients older than age 40. Other potential risks and side effects include cardiovascular disease, liver disease, gallstones, pituitary tumors, depression, and reduced fertility (Assche-

Table 2
Summary of the Standards of Care for the Treatment of Gender Identity Disorders

Guidelines for providers	Mental health professional	Physician prescribing hormones	Surgeon performing sex reassignment surgery
Competence	• Master's or doctoral degree • Documented supervised training in psychotherapy • Specialized training in the treatment of sexual disorders • Continuing education in the treatment of gender identity disorders	• Well versed in the relevant medical and psychological aspects of treating patients with gender identity disorders	• Board-certified urologist, gynecologist, plastic or general surgeon competent in urological diagnosis • Documented supervised training in sex reassignment surgery • Continuing education in sex reassignment surgery

Guidelines for applicants[a]	Eligibility criteria	Readiness criteria
Hormone therapy	• Legal age of majority • Completion of 3 months of real-life experience[b] OR psychotherapy for a duration specified by a mental health professional (usually 3 months)[c] • Demonstrable knowledge of effects and side-effects, social benefits, and risks of hormones and documented informed consent	• Further consolidation of gender identity during psychotherapy or the real-life experience • Progress in mastering other identified problems leading to stable mental health • The patient is likely to take hormones in a responsible manner
Female-to-male chest surgery	• Legal age of majority • Completion of 3 months of real-life experience[b] OR psychotherapy for a duration specified by a mental health professional (usually 3 months) • Demonstrable knowledge of the potential risks and benefits of chest surgery and documented informed consent	• Further consolidation of gender identity during psychotherapy or the real-life experience • Progress in mastering other identified problems leading to stable mental health
Male-to-female breast surgery	• Legal age of majority • Completion of 3 months of real-life experience[b] OR psychotherapy for a duration specified by a mental health professional (usually 3 months) • Hormonal breast development has been achieved (usually after 18 months)[d] • Demonstrable knowledge of the potential risks and benefits of breast surgery and documented informed consent	• Further consolidation of gender identity during psychotherapy or the real-life experience • Progress in mastering other identified problems leading to stable mental health
Genital reconstructive surgery and surgery affecting the reproductive system	• Legal age of majority • At least 12 months of continuous full-time real-life experience[b] • At least 12 months of continuous hormone therapy[c] • Demonstrable knowledge of the cost, required lengths of hospitalizations, likely complications, and postsurgical rehabilitation requirements of the various surgical approaches and documented informed consent • Awareness of different competent surgeons	• Demonstrable progress in consolidating one's gender identity • Demonstrable progress in dealing with work, family, and interpersonal issues resulting in a significantly better state of mental health

man, Gooren, & Eklund, 1989; Schlatterer et al., 1998; Toorians et al., 2003; van Kesteren, Asscheman, Megens, & Gooren, 1997). Van Kesteren et al. (1997) found an increase in morbidity in hormone-treated male-to-female transsexuals, specifically including venous thrombosis, elevated prolactin levels, elevated liver enzymes, and gallstones. Mortality, however, was not increased.

Masculinizing hormone therapy typically consists of testosterone only. It results in redistribution of body fat (around the waist), an increase in muscle mass and upper body strength, male-pattern facial and body hair growth, cessation of menses, permanent lowering of the voice, and clitoral enlargement (Asscheman & Gooren, 1992; Dahl et al., 2006). Possible risks and side effects include acne, metabolic changes including higher cholesterol and blood sugar, endometrial hyperplasia, and reduced fertility (Elbers, Asscheman, Seidell, & Gooren, 1999; Elbers, Asscheman, Seidell, Megens, & Gooren, 1997; Morgenthaler & Weber, 2005). It is not known whether masculinizing hormone therapy increases the risk of ovarian cancer, but some authorities (e.g., Gooren, 1999) recommend that testosterone-treated female-to-male transsexuals undergo ovariectomy to prevent this complication. Psychological effects of masculinizing hormone therapy include an increase in aggressiveness and sexual feelings (Slabbekoorn et al., 2001). Van Kesteren et al. (1997) found no increase in morbidity or mortality in hormone-treated female-to-male transsexuals.

Surgical procedures

Which transition-related surgical procedures persons undergo during gender transition is an individualized decision, based on a variety of factors, including personal priorities, the balance of risks and benefits, financial resources, and access to health care.

For male-to-female transsexuals, surgical procedures may include breast augmentation, reduction thyroid chondroplasty, suction-assisted lipoplasty of the waist, rhinoplasty, facial bone reduction, rhytidectomy, blepharoplasty, orchiectomy, and feminizing genitoplasty, usually called vaginoplasty or simply male-to-female sex reassignment surgery. The most common technique for vaginoplasty is penile-inversion (Karim, Hage, & Mulder, 1996). In this technique, the outer skin of the penis becomes the inner lining of the vagina, the labia are created from scrotal skin, and the glans of the penis is reduced to form a clitoris.

Complications of the penile-inversion technique include stenosis (narrowing) of the vagina, urethral stenosis, and genital pain (Krege, Bex, Lümmen, & Rübben, 2001; Lawrence, 2006b, 2007b). An alternative is the recto-sigmoid vaginoplasty technique, in which colon tissue is used to create the inner lining of the vagina. However, this technique has other possible complications, including excessive mucosal discharge and malodor and is generally not recommended as a first choice. It may, however, be a viable option for those who have previously undergone penectomy or who have an unfavorable outcome of a previous

Note to Table 2. The *Standards of Care for Gender Identity Disorders* (6th version) (SOC) was developed by the World Professional Association for Transpersonal Health (WPATH) (formerly the Harry Benjamin International Gender Dysphoria Association) (Meyer et al., 2001) "to articulate this international organization's professional consensus about the psychiatric, psychological, medical, and surgical management of gender identity disorders. Professionals may use this document to understand the parameters within which they may offer assistance to those with these conditions. Persons with gender identity disorders, their families, and social institutions may use the SOC to understand the current thinking of professionals. All readers should be aware of the limitations of knowledge in this area and of the hope that some of the clinical uncertainties will be resolved in the future through scientific investigation."

[a]The guidelines summarized here pertain to adults. Guidelines for children and adolescents are somewhat different and can be found at www.wpath.org. [b]The real-life experience is a period of living continuously and full time in the preferred gender role. [c]In selected circumstances, hormones may be prescribed to patients who have not completed a real-life experience or psychotherapy (e.g., to facilitate the provision of monitored hormone therapy using hormones of known quality as an alternative to black-market or unsupervised hormone use). [d]Exceptions can be made (e.g., in case of medical contraindications to hormone therapy).

vaginoplasty that used the penile-inversion technique (Kwun Kim et al., 2003).

For female-to-male transsexuals, transition-related surgeries may include mastectomy and chest reconstruction; liposuction to reduce fat in hips, thighs, and buttocks; oophorectomy (removal of ovaries) and hysterectomy; and masculinizing genitoplasty, usually called phalloplasty or simply female-to-male sex reassignment surgery. The most common technique for phalloplasty is the radial forearm flap (Hage, Bouman, de Graaf, & Bloem, 1993). A flap of skin and subcutaneous tissue are taken from the forearm to create the penis, and the labia become the scrotum, in which testicle implants are inserted. The vagina is closed and the urethra extended. A penile implant is needed for the penis to become erect. Sensation is limited following the procedure, and loss of some of the transplanted tissue is a serious possible complication. An alternative is metoidioplasty (clitoral release), which does not require a skin graft and maximizes sexual sensitivity (Hage, 1996).

In the United States, many female-to-male transsexuals chose not to have genital surgery due to concerns about high rates of complications, inconsistency in functional and aesthetic outcomes, and expense (Rachlin, 1999). Among transsexual men who have access to sex reassignment procedures through national health systems (e.g., in Europe), the prevalence of genital surgery is higher, although possible complications and functional and aesthetic limitations still influence the decision-making process.

Outcome studies

Many studies have shown that the vast majority of transsexuals are satisfied with the outcome of sex reassignment. One review noted that satisfaction rates ranged from 87% for male-to-females to 97% for female-to-males (R. Green & Fleming, 1990). Most of these studies were retrospective, and only one study used a control group. Mate-Kole, Freschi, and Robin (1990) found that transsexuals who were operated on relatively soon after diagnosis were socially more active and showed less neuroticism than those who were kept on a waiting list for at least 2 years. Predictors of satisfaction identified in some but not all follow-up studies include (a) age at time of reassignment, (b) participation in counseling and psychotherapy, (c) living in the desired gender role (real-life experience), (d) hormone therapy, (e) legal change in name and sex, and (f) family support (Blanchard, 1985a; Blanchard, Clemmensen, & Steiner, 1983; Carroll, 1999; Eldh, Berg, & Gustafson, 1997; Hoenig, Kenna, & Youd, 1970; Kockott & Fahrner, 1987; A. J. Kuiper, 1991; B. Kuiper & Cohen-Kettenis, 1988; Landen, Walinder, Hambert, & Lundstrom, 1998; Lawrence, 2003; Lindemalm, Korlin, & Uddenberg, 1986; Lothstein, 1980; Lundström & Wålinder, 1984; McCauley & Ehrhardt, 1984; Ross & Need, 1989; Walinder, Lundstrom, & Thuwe, 1978).

Dissatisfaction and postoperative psychopathology were associated with inadequate surgical results (Lawrence, 2003; Ross & Need, 1989). Regrets and reversal to the original gender role were rare—in fact, less than 1.0% among female-to-male transsexuals and less than 1.0–1.5% among male-to-female transsexuals (Pfäfflin, 1992; Pfäfflin & Junge, 1998). Regrets were associated with poor differential psychiatric diagnosis, failure to carry out the real-life experience, and unsatisfactory surgical results (Pfäfflin, 1992).

Sex reassignment resulted in improved mental health, socioeconomic status, relationships, and sexual satisfaction (Fleming, Cohen, Salt, Jones, & Jenkins, 1981; Mate-Kole et al., 1990; Pfäfflin, 1992; Pfäfflin & Junge, 1992/1998). However, few studies prospectively examined adjustment in the new gender role. Of 264 applicants for sex reassignment followed over a 4-year period, those who were more cross-gender-identified, who were more convincing in the role of the other sex, and who had lived full time in the cross-gender role before intake were more successful after reassignment than those who were ambiguous, and therefore more nonconforming, in their gender identity and presentation (Doorn, 1997). Although further research is needed regarding variables related to a successful outcome of sex reassignment, the available evidence indicates that sex reassignment is a legitimate and helpful treatment for gender dysphoria. This is an important conclusion, given the difficulties that transgender people have with insurance coverage for sex reassignment.

An Alternative Paradigm

Since the time of the first sex reassignment procedures in the United States, an alternative paradigm has emerged regarding the meaning and associated clinical approach to sex reassignment (Bockting, 1997b; Denny, 2004). In the 1960s and 1970s, treatment was guided by a dichotomous understanding of gender (male vs. female, man vs. woman, masculine vs. feminine); the focus of sex reassignment was to assist males to become women and females to become men (Hastings, 1969, 1974). Indeed, the effectiveness of sex reassignment was evaluated on the basis of how well transsexuals were able to function as members of the "opposite" sex without being identifiable as transgender (Hastings & Markland, 1978). A change in one's genitalia signified the ultimate change in sex.

Being transgender now means having a distinct identity, and the focus of treatment, at least in some treatment programs, has shifted toward facilitating a transgender coming-out process.

The alternate paradigm began to emerge in the 1980s when Virginia Prince coined the term "transgenderist" to refer to males who live full time as women without undergoing genital reconstructive surgery (Feinberg, 1996). A growing number of transgenderists and a generation of postoperative transsexuals began to question the dichotomous understanding of gender. Sandy Stone (1991), a postoperative male-to-female transsexual, was one of the first to call for transsexuals to come out and affirm their unique identity and experience "from outside the boundaries of gender, beyond the constructed oppositional nodes" of male versus female (p. 295). Rather than starting a new life as a member of the other sex, some individuals began to claim a transgender or transsexual identity that continues beyond the transition or sex reassignment phase.

This alternative paradigm gave birth to increasingly visible transgender communities, which offer peer support and empowerment for transgender and transsexual people and their families. For example, sometimes in coalition with the gay, lesbian, and bisexual community, the transgender community has been able to counteract part of the social stigma associated with gender nonconformity and has successfully advocated for the adoption of human rights legislation that protects them from discrimination in some cities and states. For many, being transgender now means having a distinct identity, and the focus of treatment, at least in some treatment programs, has shifted toward facilitating a transgender coming-out process (e.g., Bockting & Coleman, 2007). This process may or may not include hormone therapy and/or sex reassignment surgery. Hormone therapy is no longer necessarily followed by genital surgery; hormone therapy has become a valid option in and of itself (Bockting, 1997a, 1999; Meyer et al., 2001). Conversely, clients who do not want or need hormone therapy still might undergo surgery (e.g., orchiectomy, mastectomy/chest surgery).

The tasks of the mental health professional may now include preparing the client for living life as a transgender or transsexual person. Blending in as a member of the other sex is no longer an overriding concern for some individuals. Some clients already embrace a transgender identity when they present for hormones or surgery. Others struggle to accept their transgender identity as a consequence of the social stigma attached to their gender nonconformity and, as a result, may suffer from internalized transphobia (i.e., discomfort with one's own transgenderism stemming from internalized normative gender expectations).

The fact that male-to-female transgender people are increasingly able to live as women without genital surgery does not mean that such surgery is becoming obsolete. For some patients, the motivation for undergoing genital surgery has shifted from being the ultimate change in sex to a change in genitals for itself. Whereas in the past male-to-female transsexuals may have been satisfied with genital reconstructive surgery despite limited functionality (e.g., lack of depth of the neovagina and even the absence of a clitoris or inability to orgasm; see also Turner, Edlich, & Edgerton,

1978), today sexual function, along with aesthetic appearance, has become even more important in patient satisfaction.

It should be noted that there are many individuals for whom surgery is out of reach because of obstacles such as inability to afford the surgery or health problems. Their surgical choices are limited by concerns that have nothing to do with gender identity or feelings about their bodies. For many transgender men, removal of the breasts and the creation of a male-appearing chest are important to living successfully as a transgender or transsexual man. Most, however, do not opt for phalloplasty or metoidioplasty and instead live as transsexual men without a penis. This does not mean that female-to-male genital reconstructive surgery is not important. It reflects the fact that current female-to-male genital surgical options are expensive, carry a high risk of complications, and are inconsistent in their aesthetic and functional outcomes (Rachlin, 1999). Some transgender men who do not undergo "bottom surgery" nonetheless identify as having penises by reconceptualizing the clitoris (especially when enlarged through the use of testosterone) as a penis. However, even if social change toward greater acceptance of gender diversity continues, there will still be individuals who experience a strong, visceral aversion to their primary sex characteristics and/or desire genitalia that are considered to be more standard for their gender identity and who can benefit greatly from genital reconstructive surgery.

In reality there is no single pathway or protocol for gender transition, and transgender persons must find a way to utilize transitional options to find what is best for them.

In reality there is no single pathway or protocol for gender transition, and transgender persons must find a way to utilize transitional options to find what is best for them. It is incorrect to assume that there is a uniform measure of a completed transition. They may opt for hormone treatment only, for partial surgery, or for a combination. They may want to live in the role of the other sex or may occupy a gender-ambiguous or gender-neutral position in between the two sexes. They may refer to themselves as men or women, as trans-men or women, or simply as transgender people. Especially among the younger generation, transgender individuals may also refer to themselves as gender queer in an attempt to avoid being categorized in accordance with the prevailing gender binary.

Although this alternative paradigm has had a profound impact on clinical practice, particularly in the United States, there is little research assessing the adjustment of transgender people who are less concerned about appearing convincingly as a nontransgender woman or man but would rather affirm a distinct transgender identity. The outcome studies summarized previously are limited to transsexuals who have completed both hormonal and surgical sex reassignment and do not include individuals who have had only one of these procedures. Thus, transgender people must be understood as a heterogeneous group, and assumptions about their treatment as a "lifestyle preference" should be avoided.

Cross-Cultural Research

The alternative paradigm that transcends Western culture's binary understandings of gender, affirms a transgender identity, and recognizes a spectrum of gender variance is in many ways consistent with the findings of research conducted in other cultures. In cultures ranging from India (e.g., Nanda, 1990), Thailand (Costa & Matzner, 2007; Taywaditep, Coleman, & Dumronggittigule, 1997), Myanmar (Coleman, Colgan, & Gooren, 1992), Saudi Arabia (Rowsen, 1991), New Guinea (e.g., Herdt & Stoller, 1990), Mexico (e.g., Stephen, 2002), but also among Native Americans (e.g., Roscoe, 1991), gender was traditionally more complex, and individuals who we now would describe as transgender were (and in some of these cultures still are) an integral part of the social fabric of these societies. Of note is that historically, gender variance in these cultures appears less stigmatized, in some

cases even revered, compared to the considerable stigma imposed on transgender individuals today. One of the lessons from this body of cross-cultural research is that the gender binary is not a universally accepted fact. Rather, in addition to the role of biology, sociocultural norms play an important role in the expression of gender, the formation of identity, and the socioeconomic and health issues that transgender people face.

Guidelines for Care Beyond the Treatment of Gender Dysphoria

The *Standards of Care* (Meyer et al., 2001) is limited to the treatment of gender dysphoria, and within that, focus is primarily on transition services. The care needs of transgender people, however, go far beyond physically transitioning:

- Not all transgender individuals experience gender dysphoria—that is, their gender identity and/or gender role varies from what would be expected on the basis of their assigned birth sex, yet they do not experience this as an intense conflict, nor do they feel the need to feminize or masculinize their bodies through medical treatment (i.e., hormones and/or surgery).

- Sex reassignment transitioning is only one of several options to alleviate such dysphoria; other options range from containing or integrating transgender feelings into a gender role that is consistent with sex assigned at birth, to episodic cross-dressing, to living part or full time in the new gender role without hormone therapy or sex reassignment surgery (Bockting & Coleman, 1992; Carroll, 1999). (Especially in the context of difficulties with insurance coverage, however, it is important to note that for some people, sex reassignment is the only approach that will alleviate dysphoria.)

- Transgender people have other mental health, social service, and advocacy needs that are not addressed by the *Standards of Care* (Kammerer, Mason, & Connors, 1999; Kenagy & Bostwick, 2005; Nemoto et al., 2005). Hence, there is a need for broader guidelines of care, particularly given the lack of available training in transgender health care.

Several authors have published guidelines for transgender care. Israel and Tarver (1997) went beyond the *Standards of Care* and described more fully the diversity found among the transgender population, their varying needs, the impact of stigma, the therapeutic and practical challenges in working with this population, and the wider health and social service needs (HIV/AIDS, substance abuse, placement in residential treatment settings, legal issues, human rights, and health care coverage). From a social work and family therapy perspective, Lev (2004) formulated therapeutic guidelines for transgender people and their families in the context of stages of transgender emergence or coming out. Finally, in Vancouver, British Columbia, guidelines for multidisciplinary transgender care were developed as a basis for training a community-based network of transgender care providers (Bockting & Goldberg, 2006). These guidelines went through extensive review by experts and community representatives. The development of guidelines referring to a broader range of transgender people and their needs again raised the issue of the need to empirically assess their efficacy. They also highlighted the lack of research that includes the full spectrum of transgender populations.

Transition-Related Research, Social Processes, and Psychosocial Issues

Stigma and coming out

Many transgender individuals experience intense stigma for their gender nonconformity and transgender expression. Such stigma is exacerbated for transgender people, who also face other sources of stigma and discrimination, either related to their race/ethnicity, sexual orientation (being transgender and gay/lesbian/bisexual), or sex (being transgender and a woman) (Gutierrez, 2004; Masequesmay, 2003; Mathy, 2001). Transgender people often face discrimination and rejection by society, family, friends, coworkers, health care providers, and their community of faith (Bockting & Cesaretti, 2001; Bockting, Robinson, & Rosser, 1998; Bullough & Weinberg, 1988; Gagné & Tewksbury, 1996; Gagné el al., 1997; Kammerer et al., 1999; Namaste, 1996, 1999). Also, because

of trends toward increasing connectivity of personal data (e.g., the Real ID Act), there are more and more practical limitations on to what extent it is possible for people to maintain privacy regarding their pretransition past.

Data from convenience samples of transgender people across the United States indicate high rates of verbal harassment, physical violence, and employment and housing discrimination (Clements et al., 1999; Keatley, 2003; Lombardi, Wilchins, Priesing, & Malouf, 2001; Reback, Simon, Bemis, & Gatson, 2001; Xavier et al., 2005). Transgender youth, as well as adults, are at risk (D'Augelli, Grossman, & Starks, 2006; Gay, Lesbian, and Straight Education Network, 2004; Grossman, D'Augelli, & Salter, 2006). Few studies have focused on attitudes toward transgender people, although one study indicated that once people personally know a transgender person, their attitudes shift in a positive direction (Kendel, Devor, & Strapko, 1997).

Data from convenience samples of transgender people across the United States indicate high rates of verbal harassment, physical violence, and employment and housing discrimination.

To cope with stigma, transgender people apply strategies that range from concealment to disclosure or coming out (Gagné et al., 1997). Transgender people may conceal their transgender identity by hiding their feelings and continuing to live in the gender role consistent with their birth sex. Alternatively, they may conceal their transgender identity by living convincingly in the role of the other sex, without disclosing their transgender status. However, concealment may lead to feelings of isolation, fraud, and fear of discovery (Goffman, 1963). Withholding personal information from others can impede the development and maintenance of relationships, insofar as self-disclosure is considered one of the essential ingredients of a meaningful relationship (Derlega & Berg, 1987). Indeed, findings from previous research with transgender individuals indicate that concealment is associated with shame, secrecy, isolation, invisibility, and low self-esteem (Bockting et al. 1998). It is no surprise then that transgender individuals may not disclose their transgender history because of fear of potential violence, harassment, discrimination (e.g., employment and housing), and the need for personal privacy.

Since the 1990s, many transgender individuals have come forward to challenge the emphasis on blending in with the nontransgender world, calling on their peers to come out and define their transgender identity outside the boundaries of male or female, man or woman, masculine or feminine (Bockting, 1999; Feinberg, 1996; J. Green, 2004; Stone, 1991; Warren, 1993). Qualitative research of transgender people's experiences and clinical observation resulted in a number of stage models of transgender coming out (Bockting & Coleman, 2007; Devor, 2004; Emerson & Rosenfeld, 1996; Gagné et al., 1997; Lev, 2004; Lewins, 1995).

It is important to note some underlying assumptions of the alternative paradigm and the focus on a coming-out process for transgender people. In the same way that the coming-out genre in the LGB psychological literature of the 1970s and 1980s (see M. Schneider, 2001, for a review) emphasized being openly gay or lesbian as the ultimate stage of a healthy coming-out process, the new paradigm seems to value being out as a transgender person. However, there are limits to the analogy between LGB coming out and transgender coming out. Adopting the term *coming-out process* from the LGB experience implies that the ultimate healthy outcome is to be out as a transgender person, which itself implies that transgender people are not really men or women but occupy some alternate space as transmen or transwomen. While it is true that some transgender people feel that it is part of their identity to be openly transgender, others feel that it is more consistent with their posttransition gender identity to simply blend in. We would not want to imply that one way of actualizing one's gender identity is better than another.

Workplace issues

The alternative paradigm that emphasizes coming out rather than concealment has also had an impact on workplace issues for transgender people. Rather than changing jobs or positions, transgender people are increasingly making the transition of gender roles on the job (Bockting, 1997a). Some consultants have specialized in working with human resource professionals to facilitate an employee's transition for those who choose to transition on the job (Bockting & Coleman, 2007; D. Cole, 1992; Kirk & Rothblatt, 1995; Walworth, 1998). In a number of states and cities in the United States, transgender people are included in human rights legislation, protecting them from employment discrimination. However, harassment and discrimination continue in the workplace and increasingly come to the attention of the courts (Currah, Minter, & Green, 2000). Despite that employment issues are of great importance for transgender people and their families, virtually no research exists in this area (Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Risser et al., 2005; Xavier et al., 2005).

Family issues

Little research has been published on family issues of adult transgender people, and virtually none exists on the reproductive impact of transitioning. The existing literature focuses mainly on the impact of disclosure and coming out on partners, children, and extended family and the subsequent adjustment process. This is an important area, as discovery of a family member's transgender identity has been the focus of a number of family law cases involving divorce, child custody, and inheritance rights (Currah et al., 2000). For example, transgender individuals' ability to parent was been challenged in the courts, but research has shown that children of transsexual parents are not directly negatively affected by their parents' transsexuality (R. Green, 1978, 1998).

Several studies examined the adjustment of wives of cross-dressers and found denial, anger, confusion, sacrifice of personal self, and low self-esteem (Brown, 1994; Brown & Collier, 1989; Docter, 1988; Wise, Dupkin, & Meyer, 1981). Finding out about a husband's cross-dressing after (rather than before) marriage was associated with poorer acceptance (Brown & Collier, 1989; Bullough & Weinberg, 1988; Talamini, 1982). Relationships of female-to-male transgender people with women are described in the literature as stable and their longevity has been noted (Kockott & Fahrner, 1987; Lothstein, 1980), although female partners who identify as lesbian may struggle considerably with their partner's gender role transition because it may threaten their (perceived) lesbian identity and community affiliation (Devor, 1997a, 1997b).

Little research exists on the male partners of male-to-female transgender people, and the literature that does exist focuses on HIV, with findings showing high HIV prevalence (17–19%), a range of sexual risk behaviors, compulsive sexual behavior, and drug use (Bockting, Miner, & Rosser, 2007; Caceres & Cortinas, 1996; Coan, Schrager, & Packer, 2005; Schifter & Madrigal, 1997; Vennix et al., 2002). Virtually no research exists on the male partners of female-to-male transgender people.

Several authors developed stage models of family adjustment (Ellis & Eriksen, 2002; Emerson & Rosenfeld, 1996; Lev, 2004) and likened the process to the stages of bereavement described by Kübler-Ross (1969):

- **Stage 1** may include denial, shock (Lantz, 1999), posttraumatic reactions (S. Cole, Denny, Eyler, & Samons, 2000), and trying to bargain with the transgender individual for the gender issues to disappear (Covin, 1999).
- **Stage 2** may include anger at the transgender individual, feelings of betrayal, fear of others' reactions (Bullough & Weinberg, 1988; Lantz, 1999; Reynolds & Caron, 2000), and fear about how the transgender individual will be treated (Samson, 1999). Parents may blame themselves, assuming their child is transgender because of a failure in parenting (Lantz, 1999).
- During **Stage 3**, family and loved ones are able to start to grieve the losses (e.g., the loss of a husband or father figure; Lombardi et al., 2001) and may seek support from others who are in similar situations.
- **Stage 4** involves self-discovery and change; couples decide at this stage whether they can continue their relationship.

- **Stage 5** is a time for acceptance and welcoming the transgender individual into daily life.
- **Stage 6** is pride in the loved one's courage. This pride may take the form of advocating for transgender people and educating others about them (Lantz, 1999).

Families are an important source of social support for transgender people. Research shows that transgender people often have low levels of social support and that support from family and peers buffer the negative effects of social stigma and discrimination on transgender people's mental health (Bockting, Coleman, & Benner, 2007; Bockting, Huang, Ding, Robinson, & Rosser, 2005; Huxley, Kenna, & Brandon, 1981; Nemoto et al., 2004). Moreover, one study found that lack of familial support was predictive of regret following sex reassignment surgery (Landen et al., 1998). Yet the overwhelming number of individuals report satisfaction posttransition, and there is very low rate of regret (Carroll 1999; Pfäfflin, 1992).

Transgender People in Custodial Settings

Little has been written about transgender people in custodial settings, and few empirically based reports exist. Most of the literature primarily focuses on the issues of male-to-female transgender individuals, with only occasional mention of the unique challenges for female-to-males. However, taken together, two main concerns have been identified and documented (Whittle & Stephens, 2001).

The first concern pertains to placement segregated by gender. Edney (2004) and Findlay (1999) proposed that transgender inmates be housed on the basis of their gender identification (regardless of genital status), provided that this is safe. This presents a problem for female-to-male transgender people (especially those who have not had genital surgery), who would be vulnerable to harassment and sexual assault when housed in a men's facility. Transgender women who have not had genital surgery are often denied placement in women's facilities based on the belief that they would pose a threat to other inmates. Therefore, in some instances, transgender inmates have been placed in protective custody. However, the consensus in the literature is that solitary confinement is not a satisfactory solution because of the severe psychological stress associated with long-term isolation (Edney, 2004; Findlay, 1999).

The second concern pertains to access to transgender-specific health care for transgender inmates. The failure to continue or reinstitute previously prescribed hormone treatment to transsexual inmates amounts to the withholding of necessary medical care. This is true whether they were receiving such care prior to incarceration or whether they request such treatment while in custody. In response to anecdotal evidence of transgender individuals whose care was discontinued upon entering prison or who have requested the commencement of hormone therapy or sex reassignment surgery, the *Standards of Care* (Meyer et al., 2001) recommends the following:

> People who are receiving treatment for gender identity disorders should continue to receive appropriate treatment following these Standards of Care after incarceration. For example, those who are receiving psychotherapy and/or cross-sex hormonal treatments should be allowed to continue this medically necessary treatment to prevent or limit emotional lability, undesired regression of hormonally-induced physical effects and the sense of desperation that may lead to depression, anxiety and suicidality. Prisoners who are subject to rapid withdrawal of cross-sex hormones are particularly at risk for psychiatric symptoms and self-injurious behaviors. Medical monitoring of hormonal treatment as described in these Standards should also be provided. Housing for transgendered prisoners should take into account their transition status and their personal safety. (p. 14)

In an international survey of custodial settings (including 28 U.S. states), only 40% had formal (20%) or informal (20%) policies regarding hormone therapy (Petersen, Stephens, Dickey, & Lewis, 1996); only half of those would maintain previously prescribed hormone therapy. A further discussion of policies regarding sex-segregated facilities in general is continued later in this report.

Mental Health

Studies on the mental health of transgender individuals are limited by the use of convenience samples and may not be generalizable to the overall transgender population. Qualitative research

suggests that stigma is one of the main factors negatively impacting transgender people's mental health (Bockting et al., 1998; Minnesota Department of Health, 1994; Nemoto et al., 2005). Studies of gay and lesbian people have demonstrated the negative impact of stigmatization (Brooks, 1981); therefore, it is not surprising that many markers of minority stress can be found in transgender populations.

Data from convenience samples of transgender people across the United States have indicated high rates of substance abuse, depression, and suicidal ideation or attempts (29–64%) (Clements-Nolle, Marx, Guzman, & Katz, 2001; Nemoto & Keatley, 2002; Xavier et al., 2005). However, whereas pretransition suicide attempts in clinical samples ranged from 19% to 25% (Dixen, Maddever, Van Maasdam, & Edwards, 1984), in a review of more than 2,000 transsexuals who had transitioned, only 16 possible suicide deaths were identified (Pfäfflin & Junge, 1998).

A few studies compared the mental health of transgender people to controls. A clinical sample of 31 male-to-female transsexuals reported significantly more symptoms on the General Severity Index (GSI) of the Brief Symptom Inventory (Deorgatis, 1975) than did nontransgender controls; further analyses of the transsexuals' data indicated clinically significant levels of anxiety and depression, along with increased feelings of self-consciousness and distrust of other people (Derogatis, Meyer, & Vazquez, 1978). A small clinical sample of 20 female-to-males showed no significant differences in GSI compared with nontransgender controls; scores on subscales of anxiety and interpersonal sensitivity were elevated, but not above the clinical threshold (Derogatis, Meyer, & Boland, 1981). Van Kesteren and colleagues (1997) found a disproportionate number of suicide deaths among Dutch transsexuals receiving hormone therapy compared with a general population, and Mathy (2002) found higher rates of suicidal ideation and attempts among transgender individuals compared with psychologically matched nontransgender controls. Finally, among sexual health seminar participants, transgender individuals were twice as likely to report depression and suicidal ideation as gay, lesbian, and bisexual men and women (Bockting, Huang, et al., 2005).

Some studies have suggested that there may be an increased incidence of severe personality disorders, psychoses, and other severe mental illnesses in clinical samples of transgender people (Beatrice, 1985; Bodlund, Kullgren, Sundbom, & Höjerback, 1993; Derogatis et al., 1978; Dixen et al., 1984; Hartmann, Becker, & Rueffer-Hesse, 1997). Eating disorders were reported among both male-to-females and female-to-males (Fernández-Aranda et al., 2000; Hepp & Milos, 2002; Surgenor & Fear, 1998; Winston, Acharya, Chaudhuri, & Fellowes, 2004). Other studies, however, found no relationship between gender dysphoria and other psychiatric diagnoses (see e.g., C. M. Cole, O'Boyle, Emory, & Meyer, 1997).

Substance Abuse

Studies across North America have indicated that alcohol and drug use are common among transgender people (Clements et al., 1999; Kenagy, 2002; Kenagy & Bostwick, 2005; McGowan, 1999; Nemoto et al., 2004; Risser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Simon, Reback, & Bemis 2000; Simon, Reback, Gatson, & Bemis, 1999; Xavier et al., 2005). For example, a 1999 survey among the transgender community in San Francisco found that, in the preceding 6 months, the most commonly used drugs among male-to-female transgender individuals were marijuana, speed, and crack cocaine; among female-to-males, 43% reported marijuana use (Clements et al., 1999). These studies are limited, however, by the use of convenience samples in urban settings and are therefore not generalizable to the overall transgender population. Qualitative research revealed that lack of educational and job opportunities as well as low self-esteem were important factors contributing to drug and alcohol abuse (Clements, Wilkinson, Kitano, & Marx, 1999).

Sexual Health

As in the general population, there is a range of sexual identifications, behaviors, and concerns among transgender people (Bockting, Robinson, et al., 2005; Chivers & Bailey, 2000; Coleman et al., 1993; Devor, 1993; Lawrence, 2005). Transgender-specific sexual concerns may include

managing gender dysphoria in a sexual relationship, concerns relating to erotic cross-dressing, the impact of hormone therapy or sex reassignment surgery on sexual desire and functioning, reproduction (i.e., sperm banking), coming out to partners, sexual orientation, and safer sex negotiation.

Hormone therapy and sex reassignment surgery can affect the patient's sexual functioning. Feminizing hormones tend to reduce sexual desire. Erections may become more difficult to obtain or maintain and are sometimes painful. Masculinizing hormones tend to increase sexual desire and, as such, can have an impact (both positive and negative) on primary relationships. Although many male-to-female transsexuals maintain their ability to reach orgasm after genital surgery, some do not (Lawrence, 2005; Lief & Hubschman, 1993), as is also the case for female-to-male transsexuals. Erratic hormone use can result in mood swings and sexual acting-out behaviors (Kammerer, Mason, Connors, & Durkee, 2001).

The prevalence of HIV infection among certain subgroups of the male-to-female transgender population is high, not in small part due to the proportion who engage in survival sex. Studies using inner-city convenience samples, not generalizable to the overall U.S. transgender population, found HIV prevalence rates ranging from 10% to 35% (Clements-Nolle et al., 2001; Kenagy, 2002; Kenagy & Bostwick, 2005; McGowan, 1999; Nemoto et al., 2004; Risser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Simon et al., 1999, 2000; Xavier et al., 2005). Incidence rates are as high as 7.8 HIV infections per 100 person-years (Kellogg, Clements-Nolle, Dilley, Katz, & McFarland, 2001; Simon et al., 2000). Predictors of HIV-positive status included age (> 25), education (< high school), low income (< 12k), African American race/ethnicity (which may be related to income), injection drug use, a higher number of sexual partners, and unprotected receptive/insertive anal sex (Clements-Nolle et al., 2001; Elifson et al., 1993; Inciardi, Surratt, Telles, & Pok, 1999; Kellogg et al., 2001; Nemoto et al, 2004; Simon et al., 2000; Spizzichino et al., 2001).

Although the prevalence of HIV appeared lower among female-to-male transgender people (2–3%), female-to-male people may engage in unprotected anal (4%) or vaginal (13%) intercourse with men who have sex with men, particularly to explore their male sexuality, nurture their masculinity, and satisfy their curiosity and longing for a functioning penis (Clements et al., 1999; Hein & Kirk, 1999; Xavier et al., 2005). Risk behaviors of male-to-female transgender people included unprotected anal or vaginal intercourse and injection drug, hormone, and silicone use (Clements et al., 1999; Kenagy & Bostwick, 2005; McGowan, 1999; Nemoto et al., 2004; Risser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Simon et al., 1999, 2000; Xavier et al., 2005). Potential HIV risk cofactors for both male-to-female and female-to-male transgender people identified in qualitative research included social stigma, low self-esteem, isolation and loneliness, compulsive sexual behavior, and substance abuse (Bockting et al., 1998).

The World Professional Association for Transgender Health (WPATH; formerly the Harry Benjamin International Gender Dysphoria Association) issued a resolution stating it is unethical to deny availability or eligibility for sex reassignment surgery solely on the basis of blood-seropositivity for HIV or any other blood-borne diseases (Meyer et al., 2001). This resolution was necessary because some surgeons denied surgery on the basis of HIV status alone. Guidelines for surgery on HIV-positive transsexuals include coordination with the physician treating the patient's HIV, evaluation of the patient's medical history and lab data, and discussion of the most recent treatment regimen (Kirk, 1999). When these guidelines and the proper precautions against infection of health care workers are followed, the outcome of sex reassignment surgery for HIV-positive transsexuals is satisfactory (A. N. Wilson, 1999).

Gender Identity Disorder in Children and Adolescents

The research on gender identity issues for children and adolescents is largely clinical in nature and focuses on treatment and intervention of gender identity disorder (GID) as described in the *DSM*. There is very little research and commentary on psychosocial issues for children and adolescents with gender identity issues, although that is slowly changing.

Demographics

The prevalence of GID in children and adolescents has not been formally studied by means of epidemiological methods. There are, however, some data regarding comparative referral rates in boys and girls in clinical populations.

Although cross-gender behaviors are more common for girls than boys in the general population (H. J. Cole, Zucker, & Bradley, 1982; Sandberg, Meyer-Bahlburg, Ehrhardt, & Yager, 1993; Zucker, 1985), boys are referred more often than girls for concerns regarding gender identity (Cohen-Kettenis, Owen, Kaijser, Bradley, & Zucker, 2003). This may be due to social factors. For example, in childhood, it is well-established that parents, teachers, and peers are less tolerant of cross-gender behavior in boys than in girls (Fagot, 1985; Sandnabba & Ahlberg, 1999), which might result in a sex-differential in clinical referral (for review, see Zucker & Bradley, 1995).

Among adolescents, however, the sex difference in referral rates narrows. While this may reflect a change in the prevalence of GID in males and females between childhood and adolescence, this remains a matter of conjecture. It may be that in adolescence, extreme cross-gender behavior is subject to more equivalent social pressures across sex, resulting in a decrease in the bias toward a greater referral of boys. It is also possible that gender dysphoria in adolescent girls is more difficult to ignore than it is during childhood, as the intensification of concerns with regard to physical sex transformation becomes more salient to parents and other adults involved in the life of the adolescent (see, e.g., Cohen-Kettenis & Everaerd, 1986; Streitmatter, 1985).

Diagnosis and Assessment of GID

Reliability and validity

Various versions of criteria for GIDs have appeared in the *DSM* since 1980. There are very few studies, however, addressing the reliability and validity of the GID diagnosis. Reliability is better when specialists, as opposed to nonspecialists, diagnose children (Ehrbar, Witty, Ehrbar, & Bockting, 2008; Zucker, Finegan, Doering, & Bradley, 1984). No studies, however, have evaluated the reliability of the diagnosis for adolescents (Zucker, 2006). This reflects the general dearth of empirical research for adolescents when compared to their child counterparts with GID (Cohen-Kettenis & Pfäfflin, 2003). The odds of making a misdiagnosis of GID, however, are probably not high, because the frequent wish to be of the other sex is quite rare in both referred and nonreferred samples (Achenbach & Edelbrock, 1983).

Over the past 30 years, a variety of measures have been used to assess sex-typed behavior in children referred clinically for GID. These include free-play tasks, semi-projective or projective tasks, a structured interview schedule, and several parent-report questionnaires. Comparison groups include siblings of GID probands, clinical controls, and nonreferred controls (for a summary and review of measures, see Zucker 1992, 2005a). These studies have demonstrated strong evidence for the discriminant validity of the various measures (for a summary and review, see Cohen-Kettenis et al., 2006; Wallien, Cohen-Kettenis, Owen-Anderson, Bradley, & Zucker, 2007; Zucker, 1992, 2005a).

Gender identity disorder as disorder

Over the years, critics have contested the general legitimacy of GID as a disorder (e.g., Hill et al., 2005; Isay, 1997). Critics of GID as a disorder suggest that GID is nothing more than normal variation, albeit extreme, in gender-related behavior (i.e., gender variance), that children with GID usually show little evidence of distress and/or impairment, and that if they do, this is not inherent in the condition but rather a reaction to social disapproval. Because of this, critics claim that GID does not meet the definition of a mental disorder in the *DSM–IV–TR* (American Psychological Association, 2000).

Proponents of the diagnosis argue that the gender dysphoria exhibited by adolescents who meet the GID criteria is not simply due to the reaction of others: It is the marked separation between physical sex characteristics and psychological gender that causes their distress and motivates such individuals to seek out treatment. With children, the measurement of distress is more complicated; proponents argue, however, that these children manifest distress by virtue of their strong desire to become a member of the other sex (as expressed verbally or by their repeated enactment of cross-gender fantasies). Indeed, they suggest that a

child's consistently expressed belief that he or she should become a member of the other sex is, *ipso facto*, a valid marker of distress and therefore signifies a candidate for treatment and intervention. However, as a number of the reviewers of earlier versions of this report have pointed out, this position raises questions. First, is this a fair assumption? Second, should a child who does not appear to be distressed nonetheless be diagnosed with GID and, more important, be subjected to intervention and treatment?

In adolescents or adults diagnosed with GID, gender dysphoria usually includes an intense desire to obliterate the sex-specific characteristics of the individual's natal sex and to acquire the sex-specific characteristics of the desired sex, by means of cross-sex hormones and sex reassignment surgery (e.g., mastectomy and phalloplasty in females; penectomy, castration, and vaginoplasty in males). Here again, proponents of the diagnosis argue that the eagerness, and at times the desperation, of adolescent and adult transsexuals to undertake these expensive, painful, and potentially dangerous medical and surgical interventions is persuasive evidence that they experience genuine distress and arguably that they would experience distress even in a society completely tolerant of gender variance. Their often relentless pursuit of physical transformation, it is argued, belies the notion that intense gender dysphoria is simply a manifestation of social pressure or is merely a "normal variant" (Bockting & Ehrbar, 2005).

Children with GID seem to have more trouble than other children with basic cognitive concepts concerning their gender. They are more likely than controls to identify themselves as being the other gender (i.e., biological males are more likely to identify as girls, and vice versa) (Zucker et al., 1993), and there is evidence of a "developmental lag" in the acquisition of gender constancy (Zucker et al., 1999). While this evidence might suggest impairment to some experts, all of this is likely to be concomitant aspects of gender dysphoria rather than signs of implicit impairment.

Thus, whether gender identity disorder belongs in the *DSM* is a point of contention. What is not in contention is that gender dysphoria is often a source of psychological distress, above and beyond the influence of societal attitudes, and as such must be addressed with some form of treatment or intervention. It is an interesting theoretical debate as to whether the desire to be or to assume the gender role of the other sex should be considered a disorder if it does not cause the individual to feel distress; however, the real issue is that children and adolescents who are extreme in wishing for or adopting a cross-gender role need assistance to avoid the negative impact of stigmatization and to ensure that whatever decisions they make, or are made on their behalf, about their gender role will ultimately be in their best interests. Interventions have traditionally involved attempts to ameliorate the unconventional gender-related behavior, but in recent years, in some quarters, it has involved modifying the environment (e.g., the school setting so that other individuals are more tolerant, if not accepting, of the behavior) (Lelchuk, 2006). Most, if not all, of the research on childhood and adolescent gender identity issues reflect the former.

Other mental health concerns

Children with GID show, on average, as many other behavioral problems as do other clinic-referred children; however, clinic-referred boys and girls with GID show significantly more general behavior problems than do their siblings and nonreferred children (Zucker & Bradley, 1995; see also Cohen-Kettenis et al., 2003). They also have significantly more peer relationship difficulties in comparison to controls (Zucker et al., 1997). This is particularly the case for boys with GID, compared to girls with GID (Cohen-Kettenis et al., 2003), which is consistent with studies showing that cross-gender behavior in boys is subject to more negative social pressure than is cross-gender behavior in girls (Zucker, Wilson-Smith, Kurita, & Stern, 1995). Nonetheless, poor peer relations is the strongest predictor of behavior problems in both boys and girls with GID (Cohen-Kettenis et al., 2003), suggesting that social ostracism within the peer group may well be a potential mediator between cross-gender behavior and behavior problems.

Although these general behavior problems may contribute to their difficulties in the peer group—as is true of other children with behavior problems (B. H. Schneider, 2000)—it is probable that the marked cross-gender behavior of children with

GID is particularly salient in eliciting negative reactions from their peers.

Recent normative studies indicate that there are both concurrent and predictive relationships between measures of gender identity and psychological adjustment. Children who score lower on self-rating of "gender typicality" and "gender contentedness" tended to internalize behavior problems (although this is more typical of boys with GID; Cohen-Kettenis et al., 2003; Zucker & Bradley, 1995), had lower ratings of global self-worth and self-perceived social competence (Carver, Yunger, & Perry, 2003), and a decrease in psychological well-being at the one-year follow-up (Yunger, Carver, & Perry, 2004). Other studies have shown that boys with GID are more prone to anxiety (Wallien, van Goozen, & Cohen-Kettenis, 2007), including separation anxiety (Coates & Person, 1985; Zucker et al., 1996). Lastly, Wallien et al. (2007) provided some evidence that children with GID showed more negative emotions and a higher stress response than did normal controls. It is unclear, however, whether these difficulties are intrinsically linked to GID or whether they are the outcome of feelings of stigmatization and peer rejection.

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Other controlled studies have shown that age is an intervening variable; adolescents with GID have more behavioral problems than children (Cohen-Kettenis et al., 2003; Zucker & Bradley, 1995; Zucker, Owen, Bradley, & Ameeriar, 2002), which may be due to increased peer ostracism with age (R. Green, 1976; Zucker et al., 1995). Clearly, an important correlate of general behavior problems in children with GID is likely poor peer relations. However, some researchers are also investigating familial risk factors (e.g., Marantz & Coates, 1991; Zucker, 2005b) as a possible source of difficulty.

Coexisting psychiatric conditions occur frequently among children referred for clinical evaluation. One systematic study (Wallien, Swaab-Barneveld, & Cohen-Kettenis, 2007) and a few case reports (e.g., Mukaddes, 2002; Perera, Gadambanathan, & Weerasiri, 2003; Williams, Allard, & Sears, 1996) have suggested that children with GID are somewhat likely to meet the criteria for another *DSM* diagnosis as well. The reasons for this are not known.

Developmental Trajectories

Studies of developmental trajectories have largely focused on the relationship between childhood cross-sex-typed behavior and later diagnosis of GID, as well as its relationship to sexual orientation. Adolescents with GID, particularly those who are attracted to members of their own natal sex, almost invariably recall a pattern of cross-sex-typed behavior during childhood that corresponds to the *DSM* criteria for gender identity disorder (e.g., Blanchard & Freund, 1983; Doorn et al., 1994; Ehrhardt, Grisanti, & McCauley, 1979; Freund, Langevin, Satterberg, & Steiner, 1977; R. Green, 1974; Smith et al., 2005).

Boys with GID in childhood

In a comprehensive follow-up study, behaviorally feminine boys were more likely than controls to have a same-sex or bisexual orientation in adolescence, although only one youth at age 18 was gender dysphoric to the extent of considering sex reassignment surgery (R. Green, 1987). However, other data (summarized in Zucker & Bradley, 1995) yielded higher estimates of persistent GID but lower estimate*s* of a bisexual or same-sex sexual orientation. In the most recent follow-up study of boys with GID, Wallien and Cohen-Kettenis (2007) reported that 20% showed persistence of GID in mid-adolescence—higher

than rates reported by R. Green (1987) and comparable to rates reported by Zucker and Bradley (1995).

Girls with GID in childhood

Unfortunately, the long-term follow-up of girls with GID remains very patchy. In part, this reflects the comparatively lower rate in child samples of referred girls to referred boys with GID. In two recent follow-up studies of girls with GID (Drummond, Bradley, Badali-Peterson, & Zucker, 2008; Wallien & Cohen-Kettenis, 2007), the rates in adulthood of GID, and of a same-sex or bisexual sexual orientation without co-occurring gender dysphoria, were likely to be higher than the base rates of these two aspects of psychosexual differentiation in an unselected population of women.

Follow-up studies of adolescents

When comparing rates of persistence between patients first seen in childhood for GID as opposed to in adolescence, the data appear to show a higher rate in the latter group (Zucker, 2003). This suggests, therefore, that there is a considerable narrowing, with age, of plasticity with regard to long-term gender identity differentiation. In two different studies (Cohen-Kettenis & van Goozen, 1997; Smith et al., 2001), one half and two thirds of the adolescents with GID went on to have sex reassignment surgery (SRS). In both studies, those who did not receive SRS either did not meet the diagnostic criteria for GID or, for a variety of reasons, had to postpone the real-life experience (i.e., living for a time as the other sex, prior to the institution of cross-sex hormonal treatment and surgery).

These data suggest a very high rate of persistence of GID, eventually treated by SRS. It should be noted that the persistence rate could be even higher, since there was no follow-up information in the Cohen-Kettenis and van Goozen (1997) study on the individuals not recommended to proceed with the real-life experience or unable to implement it. Smith et al. (2001) suggested that a substantial number of the patients who did not receive SRS were still gender dysphoric at the time of a follow-up assessment that occurred, on average, 4 years later.

Understanding variation in the natural history of GID appears to be a legitimate empirical question for which there are, at present, few answers. Like other aspects of the self, however, gender identity appears to become progressively more fixed in the course of development, and this consolidation probably contributes to the high rate of persistence among adolescents.

Disjunctions Between Retrospective and Prospective Data

A key challenge for developmental theories of psychosexual differentiation is to account for the disjunction between retrospective and prospective data with regard to GID persistence; it is clear that only a minority of children followed prospectively show a persistence of GID into adolescence and young adulthood, yet virtually all adolescents with GID engaged in significant cross-gender behavior as children. Thus, for the majority of children with GID, the condition apparently remits by adolescence, if not earlier. This may be due to the natural evolution of childhood gender identity issues or to earlier intervention (R. Green, 1974) at a time when gender identity is more malleable. Of course, there may well be additional factors that might distinguish those children for whom gender identity issues persist into adolescence and, indeed, adulthood.

Treatment and Intervention

The terms *treatment* and *intervention* are often used together, but they denote somewhat different perspectives. Treatment typically refers to strategies involving an individual approach to distress and other symptoms. Intervention refers to a wider range of approaches, including individual treatment, but also encompassing, in the case of children with gender identity issues, approaches such as assisting a child's school to be aware of his or her situation and needs. Supervised peer support is another example of an intervention that might be appropriate for adolescents with gender identity issues. The preponderance of psychological research on interventions for children and adolescents, however, has focused on treatment, including symptom reduction or reduction of distress.

Treatment has generally focused on modifying the child's cross-gender behavior or assisting the

child to feel more satisfied or less distressed with his or her natal sex and associated gender role. In general, there seem to be five rationales for intervention with children with GID:

- Reduction in social ostracism
- Treatment of the underlying distress
- Prevention of transsexualism in adulthood, which is predicated on the assumption that this, too, will prevent social ostracism and distress, as well as the social and physical complexities of transitioning
- Treatment of any underlying psychopathology
- Prevention of same-sex attraction in adulthood

Clinicians have varied perspectives on what to treat and must thus be aware of the complex ideological, political, and theoretical perspectives that underlie the different positions.

It is apparent that the last rationale is the most dubious one for treatment of children with GID. Not only is it contentious and, in most quarters, an unacceptable rationale, but it is unsupportable from a scientific standpoint: Although there is some statistical linkage between gender identity and sexual orientation (Bailey & Zucker, 1995), they are distinct psychological constructs.

The treatment literature on GID in children and adolescents has many gaps. The literature for children consists of case reports from varying theoretical perspectives, with little in the way of comparative evaluation. Clinicians have varied perspectives on what to treat and must thus be aware of the complex ideological, political, and theoretical perspectives that underlie the different positions.

Early behavioral interventions

Behavioral interventions are described in 13 single-case reports of GID in children (citations in Zucker, 2003, 2007). These behavioral approaches assume that children learn sex-typed behaviors much as they learn any other behavior and that those sex-typed behaviors can be shaped, at least initially, by encouragement and discouragement. Accordingly, these behavioral interventions for GID systematically arrange to have rewards follow gender-typical behaviors and to have no rewards (or perhaps punishments) follow cross-gender behaviors.

Two main limitations in the use of reinforcement in the context of treating cross-gender behavior are that (a) some of the children studied reverted to cross-gender play patterns in the adult's absence or in other environments, such as the home (Rekers, 1975), and (b) there is little generalization to untreated cross-sex behaviors. This has led behavioral therapists to seek more effective strategies of promoting generalization, including self-regulation or self-monitoring, in which children reinforce themselves when engaging in a sex-typical behavior. Although self-monitoring also results in substantial decreases in cross-sex play, there is little evidence that generalization is better promoted by self-regulation than by social attention (Zucker, 1985).

Behavioral interventions appear to have some short-term effect on the sex-typed behavior of children with GID; however, formalized studies are needed to evaluate their effectiveness. While this approach, if shown to be effective in the long term, can serve to reduce ostracism (e.g., in modifying the behavior of a boy who wants to wear girls' clothing to school), there is a question as to whether the internal conflict regarding gender is resolved. Furthermore, this approach is viewed as reifying gender roles and prescriptive behavior for each gender.

Behavioral interventions with an emphasis on the child's cognitive structures regarding gender could be an interesting and novel approach to treatment. A cognitive approach to treatment might help children with GID to develop more flexible and realistic notions about gender-related traits (e.g., "boys can wear pretty cool clothes too" or "there are lots of boys who don't like to be

rough"), which may result in more positive gender feelings about being a boy or being a girl.

Psychotherapy

There is a large case report literature on the treatment of children with GID using psychoanalysis, psychoanalytic psychotherapy, or psychotherapy, some of which is quite detailed and rich in content (citations in Zucker, 2001, 2007). An overall examination suggests that psychotherapy, like behavior therapy, does have some influence on the sex-typed behavior of children with GID. However, the effectiveness of psychoanalytic psychotherapy, like that of behavior therapy, has never been demonstrated in a randomized, controlled outcome study. Moreover, in many cases, treatment does not consist solely of psychoanalysis. The parents were often also in therapy, and in some of the cases, the child was an inpatient and thus exposed to other interventions. It is impossible to disentangle these other potential therapeutic influences from the effect of the psychotherapy alone.

Psychoanalytic clinicians generally emphasize that cross-gender behavior emerges during the preoedipal years and, accordingly, focus on prior developmental interferences and conflicts. There is developmental evidence that the toddler years are critical in the development of gender identity formation (Martin, Ruble, & Szkrybalo, 2002) and even the suggestion that there may be a sensitive period for gender identity formation (Coates, 1990; Martin et al., 2002) and for the development of atypical gender identity (Coates & Wolfe, 1995). Some psychoanalytically oriented research with boys has identified difficulties in the parent–child relationship (Coates, 1985; Coates & Wolfe, 1995; Fischhoff, 1964; Gilpin, Raza, & Gilpin, 1979; R. Green, 1987; Owen-Anderson, Jenkins, Bradley, & Zucker, 2008; Pruett & Dahl, 1982; Stoller, 1979, 1985). With one exception (Owen-Anderson et al., 2006), however, these studies used no control or comparison groups.

Regardless of the validity of these studies, it is obvious that parents must be involved in any interventions with children with GID. First, individual therapy with the child will probably proceed more smoothly and quickly if the parents are able to gain some insight into their own contribution, if any, to their child's difficulties (Zucker, 2001, 2007). Second, parents will benefit from regular, formalized contact with the therapist to discuss day-to-day management issues that arise in carrying out the overall therapeutic plan (Newman, 1976).

Supportive Treatments

In the past few years, clinicians critical of conceptualizing marked cross-gender behavior in children as a disorder have provided a dissenting perspective to the traditional treatment approaches described thus far (Lev, 2005b; Menvielle & Tuerk, 2002; Menvielle, Tuerk, & Perrin, 2005). These clinicians are concerned that treatment focused on causing children to be more gender conforming is potentially harmful to children and may instill shame for their gender presentation. As an example of this perspective, Bockting and Ehrbar (2005) argued that "instead of attempts to change the child's gender identity or role, treatment should assist the family to accept the child's authentic gender identity and affirm a gender role expression that is most comfortable for that child" (p. 128). Along similar lines, Menvielle and Tuerk (2002) noted that although it might be helpful to set limits on pervasive cross-gender behaviors that may contribute to social ostracism, their primary treatment goal (offered in the context of a parent support group) was "not at changing the children's behavior, but at helping parents to be supportive and to maximize opportunities for the children's adjustment" (p. 1010). Menvielle et al. (2005) took a somewhat stronger position by arguing that "therapists who advocate changing gender variant behaviors should be avoided" (p. 45).

Because comparative treatment approaches have not been conducted, it is not possible to say whether this supportive or "cross-gender affirming" approach will result in more beneficial short-term and long-term outcomes in comparison to more traditional approaches to treatment. The supportive approach does, however, highlight a variety of theoretical and clinical disagreements, which will only be resolved by more systematic research on therapeutics.

Treatment of Adolescents

For adolescents, there is an emerging consensus that cross-sex hormone treatment may well be a

reasonable early therapeutic intervention once it becomes clear that psychosocial approaches have not resulted in a reduction of the gender dysphoria. In adolescents with GID, there are three broad clinical issues that require evaluation:

- Psychiatric comorbidity
- The phenomenology pertaining to the GID itself
- Sexual orientation

The psychotherapy treatment literature on adolescents with GID has been very poorly developed and is confined to a few case reports (Cohen-Kettenis & Pfäfflin, 2003; Zucker, 2001, 2007). In general, adolescents with GID are less likely than children with GID to develop a gender identity that is consistent with their natal sex. This state of affairs is similar to other child psychiatric disorders: The longer a disorder persists, the less likely it is to remit, with or without treatment. From a clinical management point of view, two key issues need to be considered. First, some adolescents with GID are not particularly good candidates for therapy because of coexisting disorders and general life circumstances (Cohen-Kettenis & van Goozen, 1997). Also, some adolescents with GID have little interest in psychologically oriented treatment and are quite adamant about proceeding with hormonal and surgical treatment related to physically transitioning, without psychotherapy. Zucker et al. (2002) found that, compared with children with GID, adolescents with GID had more general behavioral difficulties. However, this may be due to demographic issues, since they were also more likely to come from a lower socioeconomic background and from a single-parent home, factors which may have precluded seeking help at an earlier stage of development.

Prior to recommending hormonal and surgical interventions, many clinicians encourage adolescents with GID to consider alternatives to this invasive treatment. One area of inquiry can, therefore, explore the meaning behind the adolescent's desire to physically transition and explore viable alternatives. The most common area of exploration in this regard pertains to the patient's sexual orientation. Gender-dysphoric adolescents with a childhood onset of cross-gender behavior typically have a same-sex sexual attraction. Although they often recall feeling uncomfortable growing up as boys or as girls, often the idea of "sex change" does not occur until they become aware of same-sex attractions. For some, a sex change is preferable to being gay, lesbian, or bisexual, which they find abhorrent (Zucker & Bradley, 1995).

For such adolescents, psychoeducational work can explore attitudes and feelings about same-sex attraction. Group therapy, in which these youngsters have the opportunity to meet gay adolescents, can be a useful adjunct. In some cases, helping adolescents resolve internalized homophobia will resolve the gender dysphoria, and they are able to live comfortably as a gay or lesbian person. For other adolescents, however, a gay or lesbian identity is not possible, and the gender dysphoria does not abate (Zucker & Bradley, 1995).

For adolescents for whom gender dysphoria is persistent, there is considerable evidence that it interferes with general social adaptation, including general psychiatric impairment, conflicted family relations, and dropping out of school (Zucker et al., 2002), some of which can be attributed to stigma and marginalization. For these youngsters, therefore, the treating clinician can consider management until the adolescent turns 18 and can be referred to an adult gender identity clinic, although "early" institution of cross-sex hormonal treatment may be an option. Hormones suppress the development of secondary sex characteristics, such as breast development in females and facial hair growth and voice deepening in males, which facilitates the complex psychosexual and psychosocial transition to living as a member of the other sex and results in a lessening of the gender dysphoria (Cohen-Kettenis & van Goozen, 1997; Smith et al., 2001). Although such early hormonal treatment is controversial (Beh & Diamond, 2005), it may well be the treatment of choice once other options have been exhausted (Cohen-Kettenis, 2005).

In summary, a variety of interventions are available for treating a child with GID. However, it is important to bear in mind that there are no randomized controlled treatment trials. There have been some treatment-effectiveness studies, although there are methodological difficulties with these. In general, the practitioner must rely largely

on the "clinical wisdom" that has accumulated in the case report literature and the conceptual underpinnings that inform the various approaches to intervention.

Causal Processes

The etiology of GID has been examined from both a biological and a psychosocial perspective. Research on etiology, or causal processes, is controversial, as it is embedded in complex sociopolitical issues, and the contemporary clinician needs to be aware of this social context. Parents, for example, hold all kinds of beliefs regarding causality. Some parents adhere to a biological explanation for their child's cross-gender behavior ("He must have been born that way"), whereas others adhere to a psychosocial explanation ("His father was never around"). In many respects, parental perspectives mirror the general scientific debate on the relative roles of nature and nurture with regard to psychosexual differentiation. Regardless of their accuracy, parental perspectives on causal processes are important because they may correlate with their views on their child more generally, on what they want from the clinician, and their attitudes and goals about therapeutics.

Biological Mechanisms

Since the early 1990s, there has been a remarkable surge in research on possible biological mechanisms underlying human psychosexual differentiation: molecular genetics, behavior genetics, prenatal sex hormones, prenatal maternal stress, maternal immunization, neurodevelopmental processes, pheromones, anthropometrics, and neuroanatomic substrates. Some of these have been studied for both children and adults with GID, others have been investigated in relation to sexual orientation, and still others have been examined in nonclinical populations (e.g., twin studies) (Cohen-Kettenis & Gooren, 1999; Cohen-Kettenis & Pfäfflin, 2003; Rahman & Wilson, 2003; Zucker & Bradley, 1995).

Research has begun to identify some unrelated, possibly biologically based characteristics of children and adults with GID (Gooren, 2006), suggesting that GID may have a biological basis as well. There is little evidence to suggest that prenatal hormone levels play a role (Meyer-Bahlburg, 2005), since the vast majority of people with GID are biologically normal. This has led some researchers to consider alternative biological pathways that might affect psychosexual differentiation or to reconsider prenatal hormone theory in terms hormonal effects on the brain but not on the genitals.

Other lines of research have investigated a possible genetic basis for gender identity. Although there have been no molecular genetic studies of gender identity, several behavior genetic studies have suggested a strong heritable component for cross-gender behavior in general population studies (Bailey, Dunne, & Martin, 2000; Coolidge, Thede, & Young, 2002; Iervolino, Hines, Golombok, Rust, & Plomin, 2005; Knafo, Iervolino, & Plomin, 2005; van Beijsterveldt, Hudziak, & Boomsma, 2006). Left-handedness, which is known to be influenced by genetic factors, is significantly elevated in people with GID (R. Green & Young, 2001; Lalumière, Blanchard, & Zucker, 2000; Zucker, Beaulieu, Bradley, Grimshaw, & Wilcox, 2001). However, clinical case reports of identical twins discordant for GID have demonstrated that genetic factors do not account for all of the variance in the development of cross-gender behavior (Segal, 2006).

Studies of sibling sex ratio and birth order have also suggested biological processes that are different in people with GID in comparison to controls (Blanchard, Zucker, Bradley, & Hume, 1995; Blanchard, Zucker, Cohen-Kettenis, Gooren, & Bailey, 1996; R. Green, 2000; Zucker et al., 1997). Collectively, these studies suggest some genetic or other biological process may contribute to the development of GID.

Psychosocial Mechanisms

Several psychosocial mechanisms thought to be involved in the genesis and perpetuation of GID have been investigated. Some specific, relatively simple hypotheses have been shown to be incorrect. Others, such as parental response to cross-gender behavior when it first emerges, appear to have greater clinical and empirical support. The emphasis here, however, has also been to highlight the complex psychosocial chain and the difficulties in identifying direction-of-effect processes. On

this point, considerably more research attention is clearly warranted. Psychosocial factors, to truly merit causal status, must be shown to influence the emergence of marked cross-gender behavior in the first few years of life. Otherwise, such factors are better conceptualized as perpetuating rather than as predisposing.

The psychosocial variables that have been studied include parents' expressing a prenatal gender preference (Zucker & Bradley, 1995; Zucker, Bradley, & Ipp, 1993; Zucker et al., 1994) and the role of parental socialization (e.g., via reinforcement or modeling, consistent with the normative developmental literature on sex-dimorphic sex-typed behavior; Ruble et al., 2006). With regard to the former, results are inconclusive. With regard to the latter, what research there is suggests that parents' early responses to cross-gender behavior in children with GID are often tolerant or encouraging (R. Green, 1974, 1987; Mitchell, 1991; Zucker & Bradley, 1995). It should be noted, however, that some critics are quite skeptical of the role of parental socialization in inducing sex differences in sex-typed behavior among ordinary children or within-sex variations (Lytton & Romney, 1991). Many scholars adhere to a transactional model of gender differentiation (Ruble et al., 2006), in which a child's gender identity is constructed gradually over time.

Even if one concedes a biological predisposition that affects the likelihood of a child engaging in varying degrees of sex-typical versus sex-atypical behavior, it is likely the case that many other factors either accentuate or attenuate its expression. These include parental response to cross-gender behavior, the child's own phenomenology of gender (Martin et al., 2002), and peer responses to cross-gender behavior differentiation (Ruble et al., 2006). Identifying the causal sequence is certainly no easy task, and as a result, the direction-of-effect of the various processes has not been easy to establish.

Psychosocial Issues for Transgender Youth[7]

Within the past 10 years a number of researchers have started to investigate the range of concerns experienced by transgender youth, above and beyond the issues outlined previously. It is interesting to note that many of the researchers who are cited in the following discussion have a considerable track record in research with LGB youth. It is not surprising that their work expanded to include transgender youth, since marginalization and stigmatization of LGB youth are shared by transgender youth. Furthermore, as transgender youth have come out and sought community and support, they have gravitated toward existing LGB communities and, in particular, services for their LGB counterparts. This has led to the expansion of youth-oriented services in order to be inclusive of transgender youth.

Transgender youth report lack of access to health care in two particular areas: prevention and treatment of sexually transmitted infections and ongoing health care services related to transitioning (Grossman & D'Augelli, 2006). They attribute lack of access to health care, both physical and mental, to discrimination by providers (Garofalo, Deleon, Osmer, Doll, & Harper, 2006; Grossman & D'Augelli, 2006). The participants in the Garofalo et al. (2006) study were ethnic minority youth and/or youth of color, raising the distinct possibility of double discrimination. In fact these authors identified ethnic minority transgender youth as being particularly vulnerable. Thirty-seven percent of their participants had experienced incarceration, 18% had experienced homelessness, 59% had engaged in sex work for resources, 52% had experienced forced sexual relations, and 63% had difficulty in obtaining employment.

In the absence of adequate support related to transitioning, a majority were also using hormones obtained from nonmedical providers and were injecting silicone unsupervised, which may have serious medical consequences. Unsupervised injections of silicone and street hormones were also discussed as having severe health consequences in transyouth by Mallon and DeCrescenzo (2006). HIV prevention is a particular concern reflected in the research. However, transgender youth represent a heterogeneous group with risk levels depending on variables such as ethnicity (Bockting & Avery, 2005; Garofalo et al., 2006),

[7] We would like to thank Professor Stephen T. Russell, University of Arizona, Tucson, for providing the materials on which this section is based.

socioeconomic status (Bockting & Avery, 2005), and whether an individual is a male-to-female or female-to-male transgender person (Kenagy & Hsieh, 2005).

Suicidal ideation is a common occurrence among transgender youth. Grossman and D'Augelli (2007) found that approximately 50% of the participants in their study had seriously thought about suicide, and of those, half of suicidal ideations were related to being transgender. Twenty-five percent of the transgender youth in their sample had attempted suicide, with 75% of those attempts related to being transgender. Other experts suggest that the pressure to conform to conventional gender roles results in low self-esteem and self-hatred, especially when the pressure is combined with aversion therapy (Mallon & DeCrescenzo (2006). Lev (2004) raised the issue of the impact of behavioral therapies, especially when the child or adolescent is treated involuntarily. Mallon and DeCrescenzo, who are long-time youth advocates, refer to this therapy as "brutal" and provide some anecdotal evidence to support their perspective, which is espoused by many front-line workers, both psychologists and professionals in other fields. Polemics aside, there have been long-standing questions about the use and misuse of behavioral techniques to encourage gender role conformity and their impact on children and adolescents; such questions merit systematic investigation.

It is not surprising that the family has been found to be a significant factor affecting the well-being of transgender youth. Parental support can be a buffer against psychological distress (Goldfried & Bell, 2003). However, most parents react negatively to their child's transgender status (Grossman, D'Augelli, Howell, & Hubbard, 2005), although mothers tend to be more supportive than fathers (Garofalo et al, 2006: Grossman at al., 2005). Some parents are abusive, and studies have found that suicidality is associated with more parental verbal and physical abuse (Grossman & D'Augelli, 2007). Without parental support, transgender youth are at greater risk for dropping out of school, running away, and homelessness, which also raises the risk of substance abuse and sexual abuse (Ryan, 2003). Many transgender people report moving away from home during adolescence or young adulthood (Sugano, Nemoto, & Operario, 2006).

School-related issues are particularly significant for transgender youth, especially because they are required to spend so much time there. In Sausa's (2005) research, 96% of participants reported being verbally harassed, 83% being physically harassed, and 75% not feeling safe in schools and eventually dropping out. These youth reported problems associated with teachers not stepping in to stop gender-nonconformity-related harassment, as well as teachers actually harassing them. Often this harassment is related to the use of gendered facilities such as bathrooms or locker rooms. Other studies confirm that routine verbal harassment and assault often result in serious academic difficulties for transgender youth, some of whom drop out of school as a result (Grossman & D'Augelli, 2006; Rosenberg, 2003).

As this brief review demonstrates, there are a number of areas in which applied research will enhance the capability of psychologists to work effectively with transgender youth. HIV prevention is one priority, with a focus on demographic and social factors related to risk (Bockting et al., 2005; Kengay & Hsieh, 2005). Clearly there is a need to develop effective interventions and evaluate them, particularly with a focus on educating health and mental health service providers (Grossman et al., 2006) who, in turn, are in a position to facilitate parental knowledge surrounding a child's gender identity (Grossman et al., 2005) and to work with youth themselves.

Conclusion

Psychological research among transgender/gender-variant children and adults has traditionally been clinical in nature and focused on the treatment of gender dysphoria. While extensive, the existing studies are hampered by methodological limitations due to inherent ethical dilemmas (i.e., a randomized controlled trial would involve withholding treatment from some clients), concerns about feasibility (e.g., sampling and compliance), and the many potential confounds (e.g., medical interventions occur within the context of a social gender role change, minority stress, socioeconomic status, ethnicity—itself possibility related to socio-

economic status—employment and employability, etc.). In particular, rigorous evaluations of the *Standards of Care* have not been conducted. There are a few life span studies and virtually none that focus on the aging transgender population.

More recently, the focus of empirical research on adults has broadened to address transgender health more generally, with an emphasis on health disparities. In addition, scholarship examining the implications of transgenderism for an understanding of sex, gender, and sexuality has greatly expanded. Some of this increase in research and scholarship activity can be attributed to more transgender individuals coming out, thereby making gender variance much more visible, and to the involvement of transgender and gender-variant individuals themselves in conducting research and scholarship.


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Conclusions and Recommendations

Addressing the Needs of Transgender Psychologists and Students

The task force was charged with identifying how APA can best meet the needs of psychologists and students who identify as transgender, transsexual, or gender variant. This section addresses this aspect of our charge. Our conclusions in this section reflect the results of the survey we conducted, our examination of professional and community-generated literature, consultations with community-based organizations, and our own knowledge and experience. This section is divided into three parts:

- An overview of the needs of transgender psychologists and students and a general framework for addressing these needs, emphasizing the ways in which they are similar to the needs of other people who do not hold dominant-group status for important dimensions of diversity.
- An examination of several specific needs that transgender psychologists and students may experience in educational and workplace settings.
- A focus on the specific needs of transgender psychologists and students within APA itself.

Overview and General Needs of Transgender Psychologists and Students

As noted in the Consultation and Fact Finding section, the transgender psychologists and students we surveyed identified several broad categories of needs related to their status as transgender persons. These included more education, training, and research devoted to transgender issues; greater protection from discrimination; more acceptance, mentoring, advocacy, and demonstration of ally status by colleagues; and greater recognition that transgender persons are experts regarding their own issues.

Many of these concerns will seem familiar to anyone who has considered the needs of people who do not hold dominant-group status for other dimensions of diversity (e.g., people who are members of ethnic minorities, people with disabilities, and LGB people). Most people who do not hold dominant-group status, for whatever reason, want other people to have some knowledge of their issues and some emotional understanding of their particular challenges and concerns. They

want to be accepted by other people and to be protected from prejudice and discrimination based on their minority status. They want to be able to identify role models, mentors, advocates, and allies within the institutions in which they work and study. They want their issues to be considered legitimate topics for scholarly research, and they want others to recognize that their status as members of a nondominant group carries with it special expertise regarding their particular dimensions of diversity. As a corollary, they want to have a voice in how their concerns are addressed.

The intent of the foregoing discussion is not to suggest that the issues of transgender people are isomorphic to those of people of color, people with disabilities, and LGB people. It is simply to suggest that much of what psychologists have learned about the respectful and appropriate treatment of people who do not hold dominant-group status with regard to other dimensions of diversity will be broadly applicable to people whose dimensions of diversity involve gender-variant identity and gender expression. We believe that applying these lessons will be an important first step in addressing the needs of transgender psychologists and students.

Specific Needs in Educational and Workplace Settings

Transgender psychologists and students also have specific needs that are likely to be especially relevant in educational and workplace settings. Some of these needs go considerably beyond the general issues discussed previously and may be seen as quite challenging. Although APA usually has little direct influence on workplace and academic policies, we believe it can exert substantial indirect influence in a number of ways:

- Providing educational and training resources to doctoral and internship training programs and to the Commission on Accreditation
- Promulgating ethical standards
- Emphasizing acceptance and nondiscrimination
- Providing a model of an institutional culture that welcomes, values, and supports transgender and gender-variant people.

Access to Facilities Typically Segregated by Sex and Gender

Transgender people often encounter difficulties when using or attempting to use workplace or campus facilities typically segregated by sex and gender, including restrooms, locker rooms, health and athletic facilities, and dormitories and other housing facilities. Transgender employees and students commonly report that they are unable to use either men's or women's restrooms without making themselves or others feel uncomfortable. Some individuals may appear "too feminine" to use men's restrooms but "too masculine" to use women's restrooms; others may have birth genitals or gender expression that are inconsistent with the restroom they would choose based on their gender identity. The "restroom dilemma" can create safety concerns as well emotional discomfort, because people perceived to be entering the "wrong" restroom may be harassed or assaulted.

In the case of restrooms, one partial solution is to provide at least some gender-neutral facilities (i.e., single-stall restrooms with locking doors). Requiring transgender people to use separate bathrooms is not a complete solution because it reinforces cultural stigma of transgender people as fundamentally different from and dangerous to other people and creates a "separate and unequal" situation. This stigma needs to be addressed directly—for example, through training on transgender issues for coworkers of a transitioning employee (see, e.g., the video *Toilet Training*; Mateik & the Sylvia Rivera Legal Project, 2003). Providing appropriate access to other sex-segregated facilities for transgender people is substantially more complicated and typically requires creative or individualized solutions. However, there are consultants who specialize in workplace issues concerning gender identity and expression, and APA could maintain a list of these resources.

Documentation and Record Keeping

Transgender psychologists and students who have transitioned or legally changed their name and/or gender through a court order or who have otherwise changed their identity documents need institutional cooperation in changing their employment or academic documents and records. This may need to be done retroactively. They also need

help in keeping these changes confidential, unless they request otherwise. Conversely, providing opportunities for transgender people to openly identify themselves as such on workplace or academic documents that request demographic information (e.g., by including a question about transgender identity) may help meet transgender psychologists' and students' needs for institutional acceptance and visibility. These data can also be used to inform policy and allocate resources.

Medical Care and Insurance Plans

Some transgender people, especially those who undergo sex reassignment, will require transgender-specific health services. Their needs will best be met by health insurance plans that do not exclude transgender-related health care. Students often receive care at campus health clinics and counseling centers; it is important that staff at these facilities be familiar with the medical and mental health issues of transgender students. It would be ideal for at least one staff member at campus clinics and counseling centers to have had training, including a practicum, in service delivery to this population.

Specific Needs Within APA

Creation of Homes for Transgender Issues Within APA

The task force believes that in order to most effectively address the needs of transgender psychologists and students—indeed, to address most of the issues raised in this report—it is imperative to have one or more designated homes for transgender issues within APA. This is important for meeting the specific needs of APA's transgender members directly and also for providing the impetus and oversight to implement other recommendations contained in this report that might have an impact on transgender members indirectly.

As noted earlier, we considered a number of different models for establishing a home for transgender issues. In our discussions, we took into account several factors. We recognized that a number of divisions and committees exist that have some interest in transgender issues. We felt, however, that some kind of cooperative subcommittee that spanned these entities would be unwieldy and would likely be unworkable in terms of personnel and financial resources.

Ultimately, we recognized that the most appropriate entities to house transgender issues would be the (former) CLGBC and Division 44 (Society for the Psychological Study of Lesbian, Gay and Bisexual Issues) and that both CLGBC and Division 44 could work together—as they have done around LGB issues—to pursue the recommendations in this report. Historically, transgender and LGB issues have been coupled by convenience and political expediency. We want to be clear, however, that this conclusion was not arrived at by default but through a legitimate scientific position—namely, that gender variance is the commonality among and the foundation for discrimination against transgender and LGB people.

It is imperative to have one or more designated homes for transgender issues within APA.

CLGBC proposed the addition of *transgender* to its name and mission in 2006, and the addition was approved by the Council of Representatives in February 2007. The Lesbian, Gay, Bisexual, and Transgender Concerns Office, which provides staff support to the committee, has also added transgender to its name and mission.

As noted in the Consultation and Fact-Finding section of this report, Division 44 has a long history with transgender issues and has been identified by many as the logical home for transgender issues. Although there is considerable enthusiasm within the division, some members require more information on the issue and/or a sound theoretical and scientific foundation for linking LGB and transgender issues. We believe, as we have set forth in this report, that gender variance is the linking foundation between LGB and transgender issues. Our consultation with Division 44 has encouraged the executive committee and membership to begin a dialogue

about the place of transgender issues in the division. Opinions vary, but regardless of whether Division 44 broadens its mandate to include transgender issues, it will continue to be one of the strong advocates for these issues in terms of research, education, and training.

We cannot emphasize enough how important it is for specific entities within APA to take responsibility for leadership in promoting awareness of and action around transgender issues within APA. We anticipate that once homes are established for these issues, APA will become a more welcoming and relevant organization for transgender psychologists, students, and those who work with this client population.

Meeting Other Specific Transgender Needs Within APA

There are other specific recommendations of the task force that pertain to equity within APA. Most of these are addressed later in this report, but we will briefly mention them here:

- Include collection of demographic information regarding transgender status in relevant surveys of APA members.
- Review existing APA employment policies to ensure that they support equal employment opportunities for transgender people.
- Review health insurance programs offered to APA members to ensure that they cover transgender-related health care.

Additionally, we noted that in 2006, the Office of Accreditation added *gender identity* to the *Accreditation Guidelines* in the section on diversity training. We appreciate the timely action of the office in making this addition. We believe, however, that for this to be meaningful, site visitors must be provided with resources in order to be able to evaluate whether a program is inclusive of transgender issues. Moreover, accredited programs and those seeking accreditation also need resources in order to integrate these issues in their curricula. These resources must constitute a balanced and comprehensive survey of the area, with a critical analysis of the state of knowledge and an avoidance of material that reflects a prejudicial view of transgender people.

Research

To advance knowledge of transgender issues and to improve the lives of transgender people, the task force recommends that researchers, research-funding organizations, and other stakeholders work together to strengthen the evidence base for transgender issues. Accordingly, we recommend that APA prioritize transgender health in its ongoing research and training initiatives and that it advocate for funding in this area (e.g., through existing awards, such as the Wayne F. Placek award and through ongoing efforts to protect peer-reviewed federal research funding).

Additional recommendations related to research are outlined in the Research Recommendations section (see p. 69).

Education and Training

Putting Education and Training Needs in Perspective

APA engages in a variety of education and training activities and services for members. These include sponsoring conventions, providing continuing education opportunities, publishing books and journals, accrediting training sites, and so on. To meet APA's public education mandate, the association publishes materials, including brochures, reports, Internet materials, the *Monitor*, and so forth, that meet the needs of laypersons.

Although transgender people constitute only a small percentage of the general population, many, if not most, psychologists and students of psychology can expect to encounter transgender people among their clients, colleagues, and trainees. As shown in the results of the task force's survey (see Appendix A), over one third of APA and/or APAGS members have worked with transgender clients, colleagues, or students. Only one quarter of the survey respondents, however, felt that they were "sufficiently familiar" with transgender issues. Based on the likely greater than average interest in these issues by survey respondents, these figures may overestimate familiarity with transgender issues among many APA and APAGS members generally.

It appears that many psychologists and students of psychology currently receive little or no exposure to transgender issues in their education and training. In the task force's survey, only half of APA and APAGS members reported that they had had an opportunity to learn about transgender issues in graduate or undergraduate school or in subsequent professional development or educational settings. Consequently, we believe that it is especially important to address transgender issues in psychology programs and at practicum, internship, and postdoctoral training sites. We note that the *Guidelines and Principles for Accreditation of Programs in Professional Psychology* effective January 1, 2008 (see APA Committee on Accreditation, 2006) emphasize that gender identity is an aspect of human diversity that should be reflected in the curricula of accredited psychology training programs. Consequently, we believe that the directors of training programs in psychology and members of the Committee on Accreditation will be crucial participants in educational initiatives concerning transgender issues.

Categories of Information Resources

The task force delineated three levels of information that would meet the needs of psychologists, students, and interested members of the public. We identified specific products that should be available to meet needs at all three levels.

Resources Providing Basic Information

Basic information on transgender issues should be readily available to all psychologists and students of psychology as an element of cultural competence and to interested members of the public as well. To that end, the task force developed a brochure, *Answers to Your Questions About Transgender Individuals and Gender Identity* (M. Schneider et al., 2006), published by APA's Office of Public and Member Communications, to introduce transgender issues and answer frequently asked questions (see Appendix C).[8] The task force also developed proposed language that addresses transgender issues for inclusion in APA's *Publication Manual* (see Appendix D).

Basic information on transgender issues includes definitions of terms, guidelines for culturally sensitive language, answers to frequently asked questions, and suggested sources of additional information. Many of the psychologists and students that we surveyed were uncertain how to refer to transgender people appropriately and how to address transgender issues in a respectful and sensitive manner. For example, survey participants mentioned wanting to learn more about "definitions and social norms regarding how such people would like to be addressed," "appropriate language and how to sensitively express acceptance," "how to start the conversation regarding theses topics," "how to be respectful in interactions by using appropriate language and pronouns," and so forth. The documents mentioned previously address these issues.

Resources Providing Intermediate-Level Information

Intermediate-level information concerning transgender issues is aimed at psychologists who work with transgender clients and at interested members of the public. Such information would address clinical presentations, prevalence, etiology, life span development, assessment and treatment, comorbidity, and aspects of cultural competency. Examples of intermediate-level resources would include review articles in refereed journals, book chapters, and video presentations. Intermediate-level resources would be especially relevant to clinicians with little or no prior experience in working with transgender clients and to students of psychology studying the assessment and treatment of diverse populations. As previously noted, only a minority of APA and APAGS members we surveyed reported that they were "sufficiently familiar" with transgender issues, suggesting that most psychologists do not possess intermediate-level knowledge concerning these issues.

APA could facilitate access to this information by listing intermediate-level information resources on APA or divisional Web sites, inviting review articles for APA journals, including relevant chapters in books published by APA, publishing or sponsoring DVDs and videotapes, and soliciting presentations for its annual convention.

[8] The task force also developed a brochure on intersex conditions that can be accessed on the APA Web site at www.apa.org/topics/intersx.html.

Resources Providing Advanced or Specialized Information

Advanced or specialized information concerning transgender issues includes a more in-depth consideration of the topics listed under intermediate-level resources. This information would be most relevant to clinicians working intensively with transgender clients and to students with particular interests in transgender issues. We believe that very few psychologists and students currently possess high-level or specialized information on transgender issues.

APA could facilitate access to this information by publishing special issues of relevant APA journals and books, providing continuing education opportunities at APA's convention, listing specialized training sites on APA or division Internet sites, and providing referrals to consultation and supervision resources for clinicians through APA and/or its divisions.

Policy Issues

Policy recommendations are outlined in the Recommendations section.

Practice Issues

Practice Guidelines

APA has a history of developing practice guidelines for populations with unique needs, such as ethnic minorities, the elderly, and lesbian, gay, and bisexual people. Transgender people constitute a population with unique psychosocial needs, and practice guidelines for working with transgender people would be a valuable resource that could be developed by APA. Psychologists are likely to encounter clients with gender identity issues from time to time, and given that many psychologists are unfamiliar with working with this population, this is a necessary resource.

The task force considered the possibility of developing guidelines that could be integrated into the existing *Guidelines for Psychotherapy With Lesbian, Gay, and Bisexual Clients* (APA Division 44/CLGBC Joint Task Force on Guidelines With Lesbian, Gay, and Bisexual Clients, 2000), particularly because they are being revised for 2010. However, we did not view this as a viable solution for several reasons. First, the unique needs of transgender clients justify the development of a separate document. Second, the development of new guidelines, even if they are integrated in an existing document, is a time-consuming project, requiring far more time than will be required to revise the existing LGB guidelines, which are founded upon research that began in the 1980s. Therefore the task force strongly supports the development of separate practice guidelines for transgender clients.

In making this proposal, we were forced to ask whether there are still too many unanswered questions about working with this population to permit the development of guidelines that are evidence based. However, we noted that the *Guidelines for PsychotherapyWith Lesbian, Gay, and Bisexual Clients* (APA, 2000) is not prescriptive but rather assists professionals in understanding the social context, the role of discrimination, and how to practice in a nondiscriminatory manner; indeed that was the perspective of the early research that was the foundation for the LGB guidelines (Garnets, Hancock, Cochran, Goodchilds, & Peplau, 1991). From that perspective, we believe that there is sufficient knowledge and expertise to develop parallel guidelines for working with transgender populations.

Diagnostic Issues

The inclusion of GID as a diagnostic category in the *DSM* has been a major point of contention both within transgender communities and between some transgender activists and some mental health professionals, including psychologists. The depth of conviction of some activists concerning this issue is evident in the number of letters we received, asking us to work toward the removal of GID from the *DSM*.

Psychologists who work with clients with gender identity issues are not of one mind on this issue. It is also important to note that the *DSM* is a publication created by the psychiatric profes-

sion, not by psychology, and thus revision is their responsibility. Psychologists, however, may be required to use or consider using relevant *DSM* diagnoses, including GID, in their work with transgender clients regardless of how they feel about the diagnosis. In addition, psychologists can and do have input into the contents of the *DSM* through their work on various subcommittees and by conducting empirical research that informs this issue. Lastly, psychologists who treat or otherwise work with transgender clients may be required to render a diagnosis in order to provide care for their clients, regardless of how they feel about the diagnosis per se.

The task force notes that in the past, APA has adopted resolutions discouraging psychologists from using specific diagnoses that are potentially harmful to or discriminatory toward specific groups of people (Fox, 1988). Accordingly, if there were evidence showing the GID diagnosis to be similarly harmful and discriminatory against gender-variant, transgender, or transsexual people, there would be a precedent for a resolution discouraging psychologists from using this diagnosis. However, as discussed previously, there is a great deal of disagreement about the GID diagnosis and whether it is helpful or harmful; therefore we do not recommend that APA take a position on GID at this time.

Advocacy

Discrimination

Transgender people often experience discrimination in employment, housing, and other public accommodations (see Greenberg, 1999, and Minter, 2003, for a more detailed discussion of the case law and legislation). In many jurisdictions, transgender people lack protection from discrimination. Even in jurisdictions with laws banning gender-identity-based discrimination, these laws remain largely untested. For example, despite an antidiscrimination law in Minnesota, a transgender woman lost a suit seeking the right to use the women's restroom following her transition to the feminine gender role because she had not yet had genital surgery (Currah, 2006).

Access to Sex-Segregated Facilities

Equal access to resources is a social justice issue that is particularly salient for pre- and postoperative transgender people who need access to sex-segregated facilities, including public restrooms, emergency or homeless shelters, prisons, dormitories, and athletic facilities. Each setting poses some unique issues. For example, transgender people who are incarcerated are generally placed "according to their biological genitalia" (Giresi & Groscup, 2006, p. 43; see also Edney, 2004). A male-to-female transgender person who has not had genital surgery would likely be incarcerated in prison facilities for males, thereby placing her at greater risk for sexual abuse and other violence (Petersen et al., 1996), not to mention the psychological impact from the inmate's perspective that she is a woman in a men's facility.

Placing inmates in facilities consistent with their gender identity, however, may also not be safe. For example, female-to-male transgender men without, or even with, genital surgery are similarly at risk for sexual assault when placed in a male facility (Petersen et al., 1996). This is an example of a way in which the needs of male-to-female transgender people and female-to-male transgender people may differ, and not simply mirror, one another. Alternatively, sometimes transgender inmates are isolated or placed in special units, but this often means that they are excluded from recreational, educational, and occupational opportunities, and being kept in solitary confinement effectively increases the severity of their sentence (Edney, 2004; Minter, 2003). Additionally, transgender prisoners may receive inadequate or inappropriate medical care (Edney, 2004).

There are many variations on the dilemmas posed by sex-segregated facilities. In the case of shelters, consideration must be given to whether to allow abused transgender women to use shelters for abused biological women, given that many of the residents of the shelter will have been abused by biological males and may be upset by their presence. Solutions to this issue include providing individual placement in alternate facilities (such as hotels) and providing training to shelter personal on how to address these issues, such as directly addressing the concerns of other shelter clients and

establishing a norm that all women are welcome.

Access to facilities becomes a particularly challenging issue for persons transitioning on the job (e.g., at what point in the transition should individuals use the restrooms consistent with their gender identity?) or attending university (e.g., what is the appropriate housing situation, locker room, or sports team affiliation?)

These examples illustrate a number of dilemmas facing transgender people using gender-segregated facilities. While not every transgender individual will face the issue of prisons or shelters, most transgender people do face the issue of which restroom facilities to use. The situation is particularly difficult for those who have not fully transitioned or may never transition fully. Given the expense, risks, and technological limitations of genital surgery, many transgender men who fully transition may not have genital surgery. There are very real concerns about which restrooms transgender people should use, in which dormitories they should reside, and in which gender they should compete in sports. The list of difficult situations is daunting.

Many of these situations can be resolved with a combination of compassion, justice, accurate information, and common sense—ingredients that are sometimes lacking in decision-making processes. While these usually are not situations that APA can affect directly, APA can adopt resolutions—publicly supporting the rights of transgender people to appropriately gendered treatment—and can file amicus briefs in relevant court cases on behalf of transgender people. APA can also provide guidance to therapists who are working with transgender clients to advocate on their client's behalf and to help them navigate these situations.

Health Care

Transgender people often require specialized health care services, which may range from psychological services aimed at managing the various psychosocial sequelae of being transgender as well as the medical care involved in the physical transition from one gender to the other. Individuals without health insurance will usually incur significant medical expenses if they decide to physically transition. However, even those individuals with health insurance often find that services related to gender identity issues are not covered. Male-to-female surgery may cost up to $50,000, while female-to-male surgery can cost $75,000 or more. Additionally, hormone therapy can cost more than $500 a year (Jost, 2006, p. 393).

Health care insurance providers and other third-party payers in the United States have frequently refused to cover transgender-related services, such as psychotherapy, hormone therapy, and surgeries. Transgender people are viewed as making trivial "lifestyle choices," while interventions are dismissed as "experimental" or "elective cosmetic" in spite of the medical and psychological literature which confirms that they are both effective and medically necessary. Individuals who experience psychological distress due to gender identity issues are at psychological risk and may also be at physical risk due to the increased likelihood of using silicone injections or unregulated hormones purchased on the street or via the Internet. Exclusionary statements in health insurance policies often work to deny basic and even emergency medical care to transgender and transsexual people based on their transgender status. This is gradually changing, with more providers offering plans that include coverage of transgender-specific health care, including surgical interventions. Over 60 Fortune 500 companies currently offer such coverage for their employees (Gorton, 2007).

The task force noted that APA has supported actions against third-party payers and believes that it can play a role in supporting transgender individuals seeking coverage for their treatment from third-party payers. Further, APA can advocate for increased access to transgender-specific health care in general.

Recommendations

Policy Recommendations

The task force recommends that APA adopt the following resolution promoting the civil rights and

physical and psychological well-being of transgender and gender-variant people.[9]

Resolution on Transgender, Gender Identity, and Gender Expression Nondiscrimination

WHEREAS transgender and gender-variant people frequently experience prejudice and discrimination and psychologists can, through their professional actions, address these problems at both an individual and a societal level;

WHEREAS the American Psychological Association [APA] opposes prejudice and discrimination based on demographic characteristics including gender identity, as reflected in policies including the Hate Crimes Resolution (in Paige, 2005), the Resolution on Prejudice, Stereotypes, and Discrimination (Paige, 2007), the APA Bylaws (Article III, Section 2), and the *Ethical Principles of Psychologists and Code of Conduct* (APA, 2002, Standard 3.01 and Principle E);

WHEREAS transgender and other gender-variant people benefit from treatment with therapists with specialized knowledge of their issues (Lurie, 2005; Rachlin, 2002), and that the *Ethical Principles of Psychologists and Code of Conduct* state that when "scientific or professional knowledge . . . is essential for the effective implementation of their services or research, psychologists have or obtain the training. . . necessary to ensure the competence of their services" (APA, 2002, Standard 2.01b);

WHEREAS discrimination and prejudice against people based on their actual or perceived gender identity or expression detrimentally affects psychological, physical, social, and economic well-being (Bockting, Huang, Ding, Robinson, & Risser, 2005; Clements-Nolle, 2006; Coan, Schranger, & Packer, 2005; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto, Operario, & Keatley, 2005; Paige, 2007; Risser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Sperber, Landers, & Lawrence, 2005; Xavier, Bobbin, Singer, & Budd, 2005);

WHEREAS transgender people may be denied basic nongender transition-related health care (Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; GLBT Health Access Project, 2000; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Risser et al., 2005; Rodriguez-Madera & Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005);

WHEREAS gender-variant and transgender people may be denied appropriate gender-transition-related medical and mental health care despite evidence that appropriately evaluated individuals benefit from gender-transition treatments (De Cuypere et al., 2005; Kuiper & Cohen-Kettenis, 1988; Lundstrom, Pauly, & Walinder, 1984; Newfield, Hart, Dibble, & Kohler, 2006; Pfäfflin & Junge, 1998; Rehman, Lazer, Benet, Schaefer, & Melman, 1999; Ross & Need, 1989; Smith, van Goozen, Kuiper, & Cohen-Kettenis, 2005);

WHEREAS gender-variant and transgender people may be denied basic civil rights and protections (Minter, 2003; Spade, 2003), including the right to civil marriage, which confers a social status and important legal benefits, rights, and privileges (Paige, 2005); the right to obtain appropriate identity documents that are consistent with a posttransition identity; and the right to fair and safe and harassment-free institutional environments such as care facilities, treatment centers, shelters, housing, schools, prisons, and juvenile justice programs;

WHEREAS transgender and gender-variant people experience a disproportionate rate of homelessness (Kammerer, Mason, Connors, & Durkee, 2001), unemployment (APA, 2007) and job discrimination (Herbst et al., 2008), disproportionately report income below the poverty line (APA, 2007), and experience other financial disadvantages (Lev, 2004);

WHEREAS transgender and gender-variant people may be at increased risk in institutional environments and facilities for harassment, physical and sexual assault (Edney, 2004; Minter, 2003;

[9] This resolution was adopted by the American Psychological Association Council of Representatives in August 2008 (see http://www.apa.org/pi/lgbc/policy/transgender.html)

Petersen, Stephens, Dickey, & Lewis, 1996; Witten & Eyler, 2007), and inadequate medical care including denial of gender-transition treatments such as hormone therapy (Bockting et al., 2005; Coan et al., 2005; Clements-Nolle, 2006; Edney, 2004; Kenagy, 2005; Kenagy & Bostwick, 2005; Nemoto et al., 2005; Newfield et al., 2006; Petersen et al., 1996; Risser et al., 2005; Rodriguez-Madera &Toro-Alfonso, 2005; Sperber et al., 2005; Xavier et al., 2005);

WHEREAS many gender-variant and transgender children and youth face harassment and violence in school environments, foster care, residential treatment centers, homeless centers, and juvenile justice programs (D'Augelli, Grossman, & Starks, 2006; Gay, Lesbian and Straight Education Network, 2003; Grossman, D'Augelli, & Salter, 2006);

WHEREAS psychologists are in a position to influence policies and practices in institutional settings, particularly regarding the implementation of the *Standards of Care* published by the World Professional Association of Transgender Health (WPATH, formerly known as the Harry Benjamin International Gender Dysphoria Association), which recommends the continuation of gender transition treatments and especially hormone therapy during incarceration (Meyer et al., 2001);

WHEREAS psychological research has the potential to inform treatment, service provision, civil rights, and approaches to promoting the well-being of transgender and gender-variant people;

WHEREAS APA has a history of successful collaboration with other organizations to meet the needs of particular populations, and organizations outside of APA have useful resources for addressing the needs of transgender and gender-variant people;

THEREFORE BE IT RESOLVED THAT APA opposes all public and private discrimination on the basis of actual or perceived gender identity and expression and urges the repeal of discriminatory laws and policies;

THEREFORE BE IT FURTHER RESOLVED THAT APA supports the passage of laws and policies protecting the rights, legal benefits, and privileges of people of all gender identities and expressions;

THEREFORE BE IT FURTHER RESOLVED THAT APA supports full access to employment, housing, and education regardless of gender identity and expression;

THEREFORE BE IT FURTHER RESOLVED THAT APA calls upon psychologists in their professional roles to provide appropriate, nondiscriminatory treatment to transgender and gender-variant individuals and encourages psychologists to take a leadership role in working against discrimination toward transgender and gender-variant individuals;

THEREFORE, BE IT FURTHER RESOLVED THAT APA encourages legal and social recognition of transgender individuals consistent with their gender identity and expression, including access to identity documents consistent with their gender identity and expression that do not involuntarily disclose their status as transgender for transgender people who permanently socially transition to another gender role;

THEREFORE BE IT FURTHER RESOLVED THAT APA supports access to civil marriage and all its attendant benefits, rights, privileges and responsibilities, regardless of gender identity or expression;

THEREFORE BE IT FURTHER RESOLVED THAT APA supports efforts to provide fair and safe environments for gender-variant and transgender people in institutional settings such as supportive living environments, long-term care facilities, nursing homes, treatment facilities, and shelters, as well as custodial settings such as prisons and jails;

THEREFORE BE IT FURTHER RESOLVED THAT APA supports efforts to provide safe and secure educational environments,

at all levels of education, as well as foster care environments and juvenile justice programs, that promote an understanding and acceptance of self and in which all youths, including youth of all gender identities and expressions, may be free from discrimination, harassment, violence, and abuse;

THEREFORE BE IT FURTHER RESOLVED THAT APA supports the provision of adequate and necessary mental and medical health care treatment for transgender and gender-variant individuals;

THEREFORE, BE IT FURTHER RESOLVED THAT APA recognizes the efficacy, benefit, and medical necessity of gender-transition treatments for appropriately evaluated individuals and calls upon public and private insurers to cover these medically necessary treatments;

THEREFORE BE IT FURTHER RESOLVED THAT APA supports access to appropriate treatment in institutional settings for people of all gender identities and expressions; including access to appropriate health care services including gender transition therapies;

THEREFORE BE IT FURTHER RESOLVED THAT APA supports the creation of educational resources for all psychologists in working with individuals who are gender variant and transgender;

THEREFORE BE IT FURTHER RESOLVED THAT APA supports the funding of basic and applied research concerning gender expression and gender identity;

THEREFORE BE IT FURTHER RESOLVED THAT APA supports the creation of scientific and educational resources that inform public discussion about gender identity and gender expression to promote public policy development and societal and familial attitudes and behaviors that affirm the dignity and rights of all individuals regardless of gender identity or gender expression;

THEREFORE BE IT FURTHER RESOLVED THAT APA supports cooperation with other organizations in efforts to accomplish these ends.

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Additional Policy Recommendations

With further regard to policy, the task force also recommends that APA undertake the following internal policy initiatives:

- Remove "intersex" from the name of the task force and the title of the report to reflect the decision of the task force not to address intersex issues.
- Include transgender issues in the next revision of the APA *Publication Manual* in the section titled "Guidelines to Reduce Bias in Language." The *Publication Manual* is a highly influential reference source widely used by psychologists and students of psychology, as well as by writers in other academic disciplines. Consequently, the potential educational value of language addressing transgender issues in the *Publication Manual* is substantial (see Appendix D for suggested language changes). We also recommend that these additions be posted on the APA Web site (e.g., http://apastyle.apa.org/previous tips.html) and that other interested APA divisions and offices, including the Public Interest Directorate and Division 44, post this document on their Web sites as well.
- Amend the Equal Employment Opportunity and Anti-Harassment sections in the APA *Policies and Procedures Manual* to include gender identity and gender expression.
- Ensure that all APA policies that make reference to *gender identity* be amended to include *gender expression* as well.

With further regard to policy, we recommend that APA consider acting upon the following advocacy issues:

- Advocate for improved access to competent transgender-specific health care by promoting the training of psychologists and patient education and by lowering and removing barriers to care.
- Advocate for improved access to sex reassignment services and for these procedures to be covered by third-party payers such as health insurance, medical assistance, and Medicare.
- Advocate for antidiscrimination protection for transgender people in jurisdictions that currently lack such protection and issue a policy statement in this regard.
- Advocate on behalf of civil rights for transgender people by filing amicus briefs in appropriate cases.
- Support actions against third-party payers that withhold payment for treatment for transgender people by filing amicus briefs in court cases, as well as generally advocating for coverage of transgender-specific health care needs.

Practice Recommendations

- Establish a task force to develop practice guidelines for ethical and competent psychological work with transgender populations and actively recruit transgender members of this task force who are eligible to become APA members.
- Establish a task force to examine both the science and politics of the GID diagnosis and ask this group to monitor and, if possible, participate in the revision of the *DSM.*
- Evaluate critically the criteria outlined in the WPATH *Standards of Care* (Meyer et al., 2001).

Research Recommendations

The following are recommendations of the task force regarding research process and research areas.

Research Processes

- Encourage researchers to expand the category of sex/gender in epidemiological re-

search to include a transgender option and the opportunity to indicate male-to-female or female-to-male when applicable in order to more accurately determine the size of this population and to enumerate health parities and disparities found among this population.

- Include a transgender-specific category in the surveillance of HIV and other sexually transmitted infections to more accurately determine the impact of the epidemic on this sexual minority population and support corresponding prevention research and interventions.
- Promote community participatory research—specifically, partnerships between universities, community-based organizations, and transgender community representatives.
- Organize a vehicle (e.g., roundtable at APA's annual convention) for psychologists in various fields to explore the intersection between research on transgender issues and other areas of focus in psychology, such as gay, lesbian, and bisexual issues; stigma and discrimination; child development; feminist studies, and aging.
- Pursue a research consultation meeting to sensitize funding organizations, such as the National Institutes of Health, the National Science Foundation, and the Ford Foundation, to the priorities for research on transgender issues.

Research Topics

- Investigate the reliability and validity of the diagnostic criteria of gender identity disorders, transsexualism, and transvestism.
- Critically evaluate criteria for gender role dysphoria and gender role behavior.
- Support studies using factor analysis to establish the coherence of supposed indicators of gender dysphoria.
- Promote research on the following topics:
    - *Social stigma, stigma management, and its impact on the mental health of transgender people.* This includes studies on public attitudes (harassment, discrimination, and violence), multiple stigma (gender and race/ethnicity), internalized transphobia (a heightened vulnerability to developing mental health problems as a result of social stigma), mental health comorbidities, and factors associated with resilience in coping with stigma.
    - *Identity development, the processes of gender role transition or coming out of transgender people.* This includes prospective studies of children and adolescents; the relationship between gender identity and sexual orientation; the impact of childhood gender nonconformity and the associated stigma on sexual identity development; cross-cultural studies of gender variance; psychosocial issues for adolescents and the aging transgender population, which are two underresearched age groups.
    - *The process and outcome of transgender-specific health care.* This includes a rigorous evaluation of the WPATH (formerly the Harry Benjamin International Gender Dysphoria Association) *Standards of Care* and research on the psychological effects of hormone therapy; the impact of sex reassignment procedures on sexual functioning; transgender adaptations short of surgery; and health services research (e.g., effective mental health interventions, access, quality improvement, cost-effectiveness).
    - *Assessment of, and tracking access to, transgender-specific health care.*
    - *Investigation of the cost-effectiveness of sex reassignment services.*
    - *Prevention research with transgender populations who are especially vulnerable to HIV/STI infection and transmission* (e.g., those who have sex with men, are involved in sex work, or struggle with substance abuse). This includes a focus on the broader psychosocial and sexual context of HIV/STI risk behavior and should address all areas of prevention (primary, secondary, and tertiary prevention).

- *Family issues of transgender people.* This includes research on the impact on the family of having a transgender loved one, including the adjustment process; interventions that would assist families in dealing with the associated challenges (e.g., stigma, decisions regarding sex reassignment, gender role transitions); relationship issues; and parenting (having a parent or a child who is transgender); and exploring the important role the family can have in promoting the health and well-being of transgender people.
- *Civil and human rights of transgender people and their families.* This includes research relevant to marriage, parenting, and child custody issues; anti-discrimination legislation; rights of transgender military personnel; and placement and treatment in custodial settings for children, adolescents, and adults.
- *Evaluation of the efficacy of sex reassignment using more rigorous methodologies,* including prospective studies and the use of control or comparison groups.
- *Evaluation of the efficacy of treatment that supports transgender people in actualizing a distinct transgender identity,* including those who do not opt for both hormonal and surgical sex reassignment.
- *Quantitative studies testing models of transgender coming out,* focusing in particular on factors, including coping strategies, that are associated with the development of resilience in the face of stigma and discrimination.
- *Assessment of body image disturbance,* including sex-specific anatomic dysphoria in children with GID.
- *Identification of predictor variables* (e.g., with regard to persistent GID vs. resolved GID) to understand the variation in gender identity and sexual orientation outcomes within a population of children referred for gender identity problems.
- *Assessment of the risks and needs of transgender prisoners* in terms of their safety and health care and evaluating corresponding interventions.
- *Examination of the relationships of transgender people,* with a focus on intimacy and social support.
- *Determination of the actual incidence of mental disorders and its correlates* (e.g., minority stress) among the transgender population.
- *Studies of transgender and gender-variant communities and subcultures in order to understand systems of peer support and resiliency in these populations.*

Education

Professional Education

- Provide the APA Office of Accreditation with materials for distribution to assist accredited programs and programs seeking accreditation in addressing transgender issues and in complying with the accreditation guidelines addressing diversity.
- Encourage APA to support the production of DVDs and videotapes addressing psychotherapy with transgender people as part of the APA Psychotherapy Videotape Series. These would be similar to existing APA-produced DVDs and videotapes addressing gender issues in psychotherapy, as developed and hosted by Jon Carlson, PhD.
- Support collaboration between CLGBTC and Division 44 to encourage the presentation of workshops and symposia addressing transgender issues at the APA convention.
- Encourage APA in the creation and maintenance of a list of practicum, internship, and postdoctoral sites offering training in culturally competent psychological services to transgender people. Encourage Division 44 to post this list of training programs on their Web site.
- Encourage APA's Public Interest Directorate to create and maintain a list of organizations

that provide consultation and supervision to psychologists and trainees working with transgender clients.

Public Education

- Encourage APA's Department of Public and Member Communications to continue to make available the brochures developed on transgender issues, both in hard copy and electronically.
- Encourage APA to make available a list of regularly updated information resources (e.g., journal articles, book chapters, books, Internet documents, videos) concerning transgender issues to be posted on appropriate APA Internet sites. Encourage the CLGBTC, in collaboration with Division 44's Committee on Gender Identity and Gender Variance Issues, to develop these resource lists.
- Encourage the publication of articles addressing transgender issues in APA journals and encourage journal editors to create special issues devoted to these topics.
- Encourage APA to include chapters addressing transgender issues in APA-published books dealing with gender, sexuality, and assessment and treatment of diverse populations.
- Encourage APA to publish edited books providing a range of perspectives on transgender issues, similar to the *Handbook of Counseling and Psychotherapy With Lesbian, Gay, and Bisexual Clients* (Perez, Debord, & Bieschke, 1999) or *Sexual Orientation and Mental Health: Examining Identity and Development in Lesbian, Gay, and Bisexual People* (Omoto & Kurtzman, 2006).

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Appendixes

Appendix A: APA Survey on Gender Identity, Gender Variance, and Intersex Conditions

The APA Task Force on Gender Identity, Gender Variance, and Intersex Conditions was established in February 2005 with the charge to develop recommendations, based upon a review of current research on gender identity and intersexuality, relative to the following:

(1) How APA should address these issues, including recommendations for education, training, and further research.

(2) How APA can best meet the needs of psychologists and students who identify as transgender, transsexual, or intersex, including which entities have interest or expertise in these issues, and how to develop ongoing dialogue and sensitivity training in this area.

(3) Review extant APA policies with regard to these populations and make recommendations for changes.

(4) Make recommendations for collaboration with other professional organizations in this area.

In order to accomplish its charge, the task force plans to consult with those individuals and organizations for which gender identity, gender variance, and intersex conditions are relevant. This survey is one aspect of the planned consultations.

The purpose of this survey is to provide psychologists, students, and other APA members who identify as transgender, transsexual, or intersex, and those who do not but who have an interest in the issues, an opportunity to provide input into the task force's recommendations. The survey is anonymous; you will not be asked for your name and you may skip any questions that you don't want to answer. Individual data will not be released; data will be released in the aggregate only. The only people who will have access to the completed questionnaires will be the members of the task force. The survey has been reviewed by APA's Research Office.

Please return your completed survey in the attached business reply envelope. We thank you for your input. If you have any questions or further comments contact the APA Lesbian, Gay, Bisexual, and Transgender Concerns Office at lgbc@apa.org, (202) 336-6041, or 750 First Street NE, Washington, DC 20002.

APA Survey on Gender Identity, Gender Variance, and Intersex Conditions

SECTION A

For all respondents

1. Are you currently:
   ____ an undergraduate student in psychology
   ____ a graduate or postdoctoral student in psychology
   ____ a psychologist
   ____ other

2. What is your primary employment setting?
   ____ retired or unemployed
   ____ university/college/medical school/other academic setting
   ____ school/district office
   ____ independent practice (individual or group)
   ____ hospital
   ____ counseling center
   ____ other organized health care setting
   ____ business, government, or industry
   ____ other
   ____ N/A / Currently a student

3. Are you a member of APA or APAGS?
   ____ Yes ____ No

4. What is your highest earned degree? _____

5. What is your age?
   ____ 25 or under ____ 26–35 ____ 36-45 ____ 46-55 ____ over 55

6. Are you (check all that apply)
   ____ Asian/Pacific Islander
   ____ Black/African American
   ____ Hispanic/Latino(a)
   ____ Native American /Alaskan Native
   ____ White/Caucasian
   ____ Other

7. Which of the following best describes your biological status at birth?
   ____ female ____ male
   ____ intersex (if so, what was your sex assignment at birth?)
   ____ female ____ male

*If you do **NOT** identify as transgender, transsexual, or intersex, please skip to Section C. Otherwise, continue to Section B.*

SECTION B

*Please answer the questions in Section B **ONLY** if you identify as transgender, transsexual, or intersex.*

8. Which of the following best describes the gender role in which you now live?
   ____ female ____ male ____ other (please specify) _____

9. How do you describe yourself in terms of your gender status or gender identity?
   _____

10. How would you describe your current openness about your gender status or gender identity in your academic or work setting?
    ____ no one knows
    ____ I am out to a few people
    ____ I am out to most people
    ____ I am completely out

11. Please identify two or three things that were helpful to you as a transgender, transsexual, or intersex person during the time you were/have been a student (both undergrad and graduate).

12. Please suggest two or three things that would help provide a more supportive experience for transgender, transsexual, and intersex students.

13. Please identify two or three things that were/have been helpful to you as a transgender, transsexual, or intersex person in your work setting (if applicable).

14. Please suggest two or three things that would provide a more supportive experience for you as a transgender, transsexual, or intersex person in your work setting (if applicable).

15. Please describe two or three outstanding experiences or challenges (either positive or negative) that you, as a transgender, transsexual, or intersex person, have had in your education or professional life as a psychologist.

16. Please suggest ways in which you could have been better supported in dealing with these experiences or challenges.

Please skip to Section D.

SECTION C

*Please answer the questions in Section C **ONLY** if you do not identify as transgender, intersex or gender variant.*

18. From the following statements, check all those that describe your experiences.
    ____ I knew at least one transgender or transsexual student when I was an undergraduate/graduate student.
    ____ I knew at least one intersex student when I was an undergraduate/graduate student.
    ____ I went to graduate/undergraduate school with someone who transitioned during their academic career.
    ____ I had some opportunity in graduate/undergraduate school to learn about transgender and transsexual issues.
    ____ I had some opportunity in graduate/undergraduate school to learn about intersex issues.
    ____ I had some professional development opportunity to learn about transgender and transsexual issues.
    ____ I had some professional development opportunity to learn about intersex issues.
    ____ I feel that I am sufficiently familiar with transgender and transsexual issues.
    ____ I feel that I am sufficiently familiar with intersex issues.

19. From the following statements, check all those that describe your experiences.
    ____ In the course of my career I have worked with at least one transgender or transsexual colleague.
    ____ In the course of my career I have worked with at least one intersex colleague.
    ____ I have worked with a colleague who transitioned on the job.
    ____ I have had a supervisor in my workplace who was a transgender or transsexual person.
    ____ I have had a supervisor in my workplace who was an intersex person.

20. Please identify two or three things (e.g., specific skills, information, resources) that would be helpful to you **in working with or supervising** transgender, transsexual, or intersex colleagues (if applicable)?

    Transgender or Transsexual Colleagues Intersex Colleagues

21. From the following statements, check all those that describe your experiences.
    ____ I have supervised at least one transgender or transsexual student in an academic setting.
    ____ I have supervised at least one intersex student in an academic setting.
    ____ I have supervised at least one transgender or transsexual student in a practicum or internship setting.
    ____ I have supervised at least one intersex student in a practicum or internship setting.

22. Please identify two or three things (e.g., specific skills, information, resources) that would be helpful to you in **supervising** transgender, transsexual, or intersex **students** in academic or practicum settings (if applicable)?

    Transgender or Transsexual Students Intersex Students

23. From the following statements, check all those that describe your experiences.
    ____ I have worked with at least one transgender or transsexual client.
    ____ I have worked with at least one intersex client.

24. Please identify two or three things (e.g., specific skills, information, resources) that would be helpful to you in **working with** transgender, transsexual or intersex **clients** (if applicable)?

    Transgender or Transsexual Clients Intersex Clients

Please continue to section D.

SECTION D

For all respondents

25. Please suggest two or three actions or strategies that APA should put in place to address transgender, transsexual, and intersex issues in psychological research.

26. Please suggest two or three actions or strategies that APA should put in place to address transgender, transsexual, and intersex issues in psychological education and training.

27. Please suggest two or three actions or strategies that APA should put in place to address transgender, transsexual, and intersex issues in psychological practice.

28. Please let us know which items on this questionnaire you found difficult to understand or answer, if any, and briefly state why.

Thank you for your time and input.

Please return your completed survey in the attached business reply envelope or send it to: APA Lesbian, Gay, Bisexual, and Transgender Concerns Office
750 First Street, NE, Washington, DC 20002

If you have any questions or further comments, contact the APA Lesbian, Gay, Bisexual, and Transgender Concerns Office at lgbc@apa.org, (202) 336-6041, or the address above.

Appendix B: Consultation List

APA Committees and Divisions

Committees

Committee on Children, Youth, and Families
Committee on Psychology and AIDS
Committee on Women in Psychology
Committee on Lesbian, Gay, Bisexual, and Transgender Concerns

Divisions Identified by Task Force

Division 35, Society for the Psychology of Women
Division 44, Society for the Psychological
Study of Lesbian, Gay, and Bisexual Issues
Division 51, Society for the Psychological Study of Men and Masculinity

Additional Divisions

Division 8, Society for Personality and Social Psychology
Division 12, Society of Clinical Psychology
Division 17, Society of Counseling Psychology
Division 37, Society for Child and Family Policy and Practice
Division 42, Psychologists in Independent Practice
Division 50, Addictions
Division 53, Society of Clinical Child and Adolescent Psychology

Outside Organizations

American Academy of Family Physicians
American Association of Sex Educators, Counselors, and Therapists
American Medical Association
American Nurses Association
American Psychiatric Association
American Public Health Association
Association for Women in Psychology
CARES Foundation
Council on Sexual Orientation and Gender Expression of the Council on Social Work Education
Gay and Lesbian Medical Association
Intersex Society of North America
National Association of Social Workers
Parents, Families and Friends of Lesbians and Gays
Sylvia Rivera Legal Project
Society for the Scientific Study of Sexuality
Transgender Law and Policy Association
World Professional Association for Transgender Health

Appendix C: Answers to Your Questions About Transgender Individuals and Gender Identity [C1]

What does transgender mean? *Transgender* is an umbrella term used to describe people whose gender identity (sense of themselves as male or female) or gender expression differs from that usually associated with their birth sex. Many transgender people live part-time or full-time as members of the other gender. Broadly speaking, anyone whose identity, appearance, or behavior falls outside of conventional gender norms can be described as transgender. However, not everyone whose appearance or behavior is gender-atypical will identify as a transgender person.

What is the difference between sex and gender? *Sex* refers to biological status as male or female. It includes physical attributes such as sex chromosomes, gonads, sex hormones, internal reproductive structures, and external genitalia. *Gender* is a term that is often used to refer to ways that people act, interact, or feel about themselves, which are associated with boys/men and girls/women. While aspects of biological sex are the same across different cultures, aspects of gender may not be.

What are some categories or types of transgender people? Transsexuals are transgender people who live or wish to live full-time as members of the gender opposite to their birth sex. Biological females who wish to live and be recognized as men are called female-to-male (FTM) transsexuals or transsexual men. Biological males who wish to live and be recognized as women are called male-to-female (MTF) transsexuals or transsexual women. Transsexuals usually seek medical interventions, such as hormones and surgery, to make their bodies as congruent as possible with their preferred gender. The process of transitioning from one gender to the other is called sex reassignment or gender reassignment.

Cross-dressers or transvestites constitute the most numerous transgender group. Cross-dressers wear the clothing of the other sex. They vary in how completely they dress (from one article of clothing to fully cross-dressing) as well as in their motives for doing so. Some cross-dress to express cross-gender feelings or identities; others cross-dress for fun, for emotional comfort, or for sexual arousal. The great majority of cross-dressers are biological males, most of whom are sexually attracted to women.

Drag queens and drag kings are, respectively, biological males and females who present part-time as members of the other sex primarily to perform or entertain. Their performances may include singing, lip-syncing, or dancing. Drag performers may or may not identify as transgender. Many drag queens and kings identify as gay, lesbian, or bisexual.

Other categories of transgender people include *androgynous, bigendered,* and *gender queer* people. Exact definitions of these terms vary from person to person, but often include a sense of blending or alternating genders. Some people who use these terms to describe themselves see traditional concepts of gender as restrictive.

Have transgender people always existed? Transgender persons have been documented in many Western and non-Western cultures and societies, from antiquity until the present day. However, the meaning of gender variance may vary from culture to culture.

Why are some people transgender? There is no one generally accepted explanation for why some people are transgender. The diversity of transgender expression argues against any simple or unitary explanation. Many experts believe that biological factors such as genetic influences and prenatal hormone levels, early experiences in a person's family of origin, and other social influences can all contribute to the development of transgender behaviors and identities.

How prevalent are transgender people? It is difficult to accurately estimate the prevalence of transgender people in Western countries. As many as 2–3% of biological males engage in cross-dressing, at least occasionally. Current estimates of the prevalence of transsexualism are about 1 in 10,000 for biological males and 1 in 30,000 for biological females. The number of people in other transgender categories is unknown.

What is the relationship between transgender and sexual orientation? People generally experience gender identity and sexual orientation as two different

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[C1] *Answers to Your Questions About Transgender Individuals and Gender Identity* was written by the APA Task Force on Gender Identity, Gender Variance, and Intersex Conditions: Margaret Schneider, PhD; Walter O. Bockting, PhD; Randall D. Ehrbar, PsyD; Anne A. Lawrence, MD, PhD; Katherine Louise Rachlin, PhD; Kenneth J. Zucker, PhD; Produced by the APA Office of Public and Member Communications.

things. Sexual orientation refers to one's sexual attraction to men, women, both, or neither, whereas gender identity refers to one's sense of oneself as male, female, or transgender. Usually people who are attracted to women prior to transition continue to be attracted to women after transition, and people who are attracted to men prior to transition continue to be attracted to men after transition. That means, for example, that a biologic male who is attracted to females will be attracted to females after transitioning, and she may regard herself as a lesbian.

How do transgender people experience their transgender feelings? Transgender people experience their transgender feelings in a variety of ways. Some can trace their transgender identities or gender-atypical attitudes and behaviors back to their earliest memories. Others become aware of their transgender identities or begin to experience gender-atypical attitudes and behaviors much later in life. Some transgender people accept or embrace their transgender feelings, while others struggle with feelings of shame or confusion. Some transgender people, transsexuals in particular, experience intense dissatisfaction with their birth sex or with the gender role associated with that sex. These individuals often seek sex reassignment.

What should parents do if their child appears to be transgender or gender-atypical? Parents may be concerned about a child who appears to be gender-atypical for a variety of reasons. Some children express a great deal of distress about their assigned gender roles or the sex of their bodies. Some children experience difficult social interactions with peers and adults because of their gender expression. Parents may become concerned when what they believed to be a "phase" does not seem to pass. Parents of gender-atypical children may need to work with schools and other institutions to address their children's particular needs and to ensure their children's safety. It is often helpful to consult with a mental health professional familiar with gender issues in children to decide how to best address these concerns. In most cases it is not helpful to simply force the child to act in a more gender-typical way. Peer support from other parents of gender variant children may also be helpful.

How do transsexuals transition from one gender to the other? Transitioning from one gender to another is a complex process. People who transition often start by expressing their preferred gender in situations where they feel safe. They typically work up to living full-time as members of their preferred gender, by making many changes a little at a time.

Gender transition typically involves adopting the appearance of the desired sex through changes in clothing and grooming, adoption of name typical of the desired sex, change of sex designation on identity documents, treatment with cross-sex hormones, surgical alteration of secondary sex characteristics to approximate those of the desired sex, and in biological males, removal of facial hair with electrolysis or laser treatments. Finding a qualified mental health professional to provide guidance and referrals to other helping professionals is often an important first step in gender transition. Connecting with other transgender people through peer support groups and transgender community organizations is also very helpful.

The World Professional Association for Transgender Health (WPATH) (formerly the Harry Benjamin International Gender Dysphoria Association), a professional organization devoted to the treatment of transgender people, publishes the *Standards of Care for Gender Identity Disorders*, which offers recommendations for the provision of sex reassignment procedures and services.

Is being transgender a mental disorder? A psychological condition is considered a mental disorder only if it causes distress or disability. Many transgender people do not experience their transgender feelings and traits to be distressing or disabling, which implies that being transgender does not constitute a mental disorder per se. For these people, the significant problem is finding the resources, such as hormone treatment, surgery, and social support they need in order to express their gender identity and minimizing discrimination. However, some transgender people do find their transgender feelings to be distressing or disabling. This is particularly true of transsexuals, who experience their gender identity as incongruent with their birth sex or with the gender role associated with that sex. This distressing feeling of incongruity is called gender dysphoria.

According to the diagnostic standards of American psychiatry, as set forth in the *Diagnostic and Statistical Manual of Mental Disorders*, people who experience intense, persistent gender dysphoria can be given the diagnosis of gender identity disorder. This diagnosis is highly controversial among some mental health professionals and transgender people. Some contend that the diagnosis inappropriately pathologizes gender variance and should be eliminated. Others argue that, because the health care system in the United States requires a diagnosis to justify medical or psychological treatment, it is essential to retain the diagnosis to ensure access to care.

What kinds of mental health problems do transgender people face? Transgender people experience the same kinds of mental health problems that nontransgender people do. However, the stigma, discrimination, and internal conflict that many transgender people experience may place them at increased risk for certain mental health problems. Discrimination, lack of social support, and inadequate access to care can exacerbate mental health problems in transgender people, while support from peers, family, and helping professionals may act as protective factors.

What kinds of discrimination do transgender people face? Antidiscrimination laws in most U.S. cities and states do not protect transgender people from discrimination based on gender identity or gender expression. Consequently, transgender people in most cities and states can be denied housing or employment, lose custody of their children, or have difficulty achieving legal recognition of their marriages, solely because they are transgender. Many transgender people are the targets of hate crimes. The widespread nature of discrimination based on gender identity and gender expression can cause transgender people to feel unsafe or ashamed, even when they are not directly victimized.

How can I be supportive of transgender family members, friends, or significant others?

- Educate yourself about transgender issues.
- Be aware of your attitudes concerning people with gender-atypical appearance or behavior.
- Use names and pronouns that are appropriate to the person's gender presentation and identity; if in doubt, ask their preference.
- Don't make assumptions about transgender people's sexual orientation, desire for surgical or hormonal treatment, or other aspects of their identity or transition plans. If you have reason to need to know, ask.
- Don't confuse gender dysphoria with gender expression: Gender-dysphoric males may not always appear stereotypically feminine, and not all gender-variant men are gender-dysphoric; gender-dysphoric females may not always appear stereotypically masculine, and not all gender-variant women are gender-dysphoric.
- Keep the lines of communication open with the transgender person in your life.
- Get support in processing your own reactions. It can take some time to adjust to seeing someone who is transitioning in a new way. Having someone close to you transition will be an adjustment and can be challenging, especially for partners, parents, and children.
- Seek support in dealing with your feelings. You are not alone. Mental health professionals and support groups for family, friends, and significant others of transgender people can be useful resources.

Where can I find more information about transgender issues?

American Psychological Association
750 First Street, NE
Washington DC, 20002
p: 202.336.5500
lgbc@apa.org
www.apa.org/pi/lgbc/transgender

FTMInternational (FTM means Female-to-Male)
740A 14th St. #216
San Francisco, CA 94114
p: 877.267.1440
www.ftmi.org
info@ftmi.org

Gender Public Advocacy Coalition
1743 Connecticut Ave NW
Fourth Floor
Washington DC 20009
p: 202.462.6610
www.gpac.org
gpac@gpac.org

National Center for Transgender Equality
1325 Massachusetts Ave., Suite 700
Washington, DC 20005
p: 202.903.0112 | f: 202.393.2241
www.nctequality.org

Parents, Families and Friends of Lesbians and Gays (PFLAG) Transgender Network (TNET)
1726 M Street, NW
Suite 400
Washington, DC 20036
p: 202.467.8180
www.pflag.org/TNET.tnet.0.html
info@pflag.org

Sylvia Rivera Law Project
322 8th Avenue
3rd Floor
New York, NY 10001
p: 212.337.8550 | p: 212.337.1972
www.srlp.org

Transgender Law Center
870 Market Street, Room 823
San Francisco, CA 94102
p: 415.865.0176
www.transgenderlawcenter.org
info@transgenderlawcenter.org

World Professional Association
for Transgender Health (WPATH)
(Formerly the Harry Benjamin International Gender
Dysphoria Association)
1300 South Second Street, Suite 180
Minneapolis, MN 55454
p: 612.624.9541
www.wpath.org
wpath@wpath.org

Appendix D: Proposed Language to Address Issues in the *Publication Manual of the American Psychological Association*

Transgender Conditions and Disorders of Sex Development

Preferences for terms related to transgender conditions and disorders of sex development (also called intersex conditions) change frequently. Authors are encouraged to ask participants about preferred designations and are expected to avoid terms perceived as negative.

The adjective *transgender* refers to persons whose gender identity or gender expression differs from the sex to which they were assigned at birth; *transgender* should not be used as a noun. The word *transsexual* refers to transgender persons who live or desire to live full time as members of the gender opposite to the sex to which they were assigned at birth and who usually wish to make their bodies as congruent as possible with their preferred gender through surgery and hormonal treatment. Transsexual can be used as a noun or as an adjective. The terms *female-to-male transgender person, male-to-female transgender person, female-to-male transsexual,* and *male-to-female transsexual* represent accepted usage. Transsexual people undergo *sex reassignment* or *gender reassignment,* terms that are preferable to *sex change*, which may be perceived as negative. Transgender persons who present part-time as members of the gender opposite to the sex to which they were assigned at birth may identify as one or more of a number of identifiers, including *drag kings* (female-to-male persons), *drag queens* (male-to-female persons), or *cross-dressers* (persons of either birth sex). *Cross-dresser* is preferable to *transvestite*, which may be perceived as negative.

Refer to transgender persons using words (proper nouns, pronouns, etc.) appropriate to the person's gender identity or gender expression, regardless of their birth sex. For example, use the pronouns *he, him,* and *his* in reference to female-to-male transgender persons. If gender identity or gender expression is ambiguous or variable, it may be best to avoid pronouns (see Section 2.13).

The adjectives *female* and *male* can be used to refer to the birth sex of transgender persons, but the nouns *woman* and *man* refer to gender identity or gender expression (e.g., a male-to-female transsexual can be referred to as a *biologic male* but should be called a *transsexual woman*, not a *transsexual man*). Do not use quotation marks for ironic comment on words that have been assigned based on gender identity or gender expression rather than birth sex (see Section 3.06); this is regarded as pejorative.

When writing about the sexual orientation of transgender persons, authors should clearly specify whether they are referencing sexual orientation to biologic sex or to gender identity or gender expression. For example, a male-to-female transsexual who is sexually oriented toward men would be described as having *homosexual* orientation with reference to biologic sex but a *heterosexual* orientation with reference to gender presentation. In scientific literature, sexual orientation is commonly referenced to biologic sex, but many transgender persons feel strongly that their sexual orientation should be referenced only to their gender identity or gender expression and consider the alternative usage disrespectful.

Disorders of sex development (*DSD*) are congenital conditions in which the development of a person's chromosomal, gonadal, or anatomical sex is atypical. DSD is increasingly preferred to *intersex conditions*, which is sometimes considered pejorative (Hughes, Houk, Ahmed, Lee, & LWPES/ESPE Consensus Group, 2006). Some persons with DSD may, however, identify as intersex persons. The terms *person with a DSD, person with an intersex condition,* and *intersex person* represent accepted usage. Do not use *hermaphrodite* and *pseudohermaphrodite*, which are considered pejorative and confusing.

Reference

Hughes, I. A., Houk, C., Ahmed, S. F., Lee, P. A., & LWPES/ESPE Consensus Group. (2006). Consensus statement on management of intersex disorders. *Archives of Diseases in Childhood, 91,* 554-563.

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Table D1. Proposed Guidelines for Addressing Transgender and Intersex Conditions in Table 2.1 (Guidelines for Unbiased Language) of the APA Publication Manual.

Problematic	*Preferred*
Transgender and intersex conditions	
1. We studied male-to-female transgenders.	We studied male-to-female transgender persons.
Comment: Use *transgender* as an adjective, not as a noun.	
2. The sample included 14 male transvestites.	The sample included 14 male cross-dressers.
Comment: Cross-dresser is preferred to *transvestite*, which is considered pejorative.	
3. After changing her name, "Mark" began living full-time as a "man."	After changing his name, Mark began living full-time as a man.
Comment: Use pronouns that are consistent with a person's gender presentation. Do not use quotation marks for ironic comment on transgender persons' past or current names or pronouns.	
4. The focus group included six hermaphrodites.	The focus group included six persons with disorders of sex development.
*Comment: Person with a disorder of sex development (*or *person with an intersex condition)* is preferred to *hermaphrodite*, which is considered pejorative.	