Literature Review on The Therapeutic Needs, Insights, and Considerations of Transgender Individuals in a Clinical Setting in the United States

What follows is a draft, brief literature review written by the author in partial completion of a doctoral class in Diversity Issues in Psychology, in May, 2024. The author has made every effort to use sources believed to be reliable to provide information that is accurate and compatible with the standards generally accepted at the time of composition. The author shall not be liable for any special, consequential, or exemplary damages resulting, in whole or in part, from the readers' use of, or reliance on, the information contained herein. The author has no responsibility for the persistence or accuracy of URLs for external or third-party Internet websites referred to in this paper and does not guarantee that any content on such websites is, or will remain, accurate or appropriate. The author does assert and claim a general copyright over this work, at the same time as recognizing the debt this work owes to the published academic work upon which it rests. Further, the author wishes to extend his grateful appreciation for the scholars, researchers, writers, editors, and publishers of so many peer reviewed resources for their efforts, ingenuity, and generosity.

Abstract

The transgender community is global, diverse, and emerging. Despite their small number, they experience disproportionate adverse health indicators and inequities. While academic and medical attention has been increasing in recent decades, a dearth of information and well-informed clinicians remain a barrier to mental health and medical care. This literature review canvases research in the past 30 years and touches on recent developments in research, nomenclature, and recommendations for clinicians and current standards of care. First, this paper will attempt some description and understanding of the transgender community and experience. Then, we will report findings on the particular needs of transgender individuals, focusing on the arena of mental health. Finally, this literature review will explore recommendations for clinicians in working with transgender and gender diverse (TGD) persons in clinical settings.

Literature Review on The Therapeutic Needs, Insights, and Considerations of Transgender Individuals in a Clinical Setting in the United States

The transgender community is global, diverse, and emerging. Studies estimate a global prevalence at 0.3-0.5% of the population identifies as transgender (Institute of Medicine, 2011; Winter et al., 2016), while a US presence is slightly higher at 0.6% (Safer & Tangpricha, 2019), though the difference may also represent increased diagnosis resulting from growing acceptance in the US since 2011. Despite their small number, they experience disproportionate adverse health indicators and inequities. While academic and medical attention has increased in recent decades, a dearth of information and well-informed clinicians remain a barrier to mental health and medical care (Walker & Prince, 2010; Wylie et al., 2016).

> There are several barriers to access to care that vary between countries and cultures, including the fear of being seen as different (with associated stigma and violence), lack of access to caring and competent professionals, difficulty in identifying sources of information about gender dysphoria and hormone therapies, and inadequate access to safe prescribing and monitoring of hormone therapy." (Wylie et al., 2016, p. 401).

Walker and Prince (2010) acknowledge that factors such as religious and political affiliation, alongside institutional heterosexism, can create obstacles to transgender-affirmative counseling.

It is important to recognize that the pathologization of gender minorities in the Western medical model (Munro, 2007; Winter et al., 2019) has historically labeled transgender or gender diverse (TGD) individuals as deviant and requiring medical and legal intervention (Meier & Labuski, 2013) (see Human Rights Campaign, 2023, for more). In 2010 and again in 2015, and updated in 2017, the World Professional Association for Transgender Health (WPATH) strongly urged the de-psychopathologization of gender variance worldwide (Knudsen et al., 2018). A 2022 declaration observed de-pathologization at international and institutional levels, however much culture- and

political-specific groups may vary (Coleman et al., 2022). The mental health community must be prepared to respond to this growing need.

In a broad canvas of primary resources, secondary resources, and meta-analyses on transgender care, findings and recommendations fall into two broad categories significant for this study: (1) the needs and dynamics of TGD individuals, and (2) recommended competencies of mental health professionals desiring to work with members of the TGD population. This bifocal consideration aims at balancing the weight of analysis, putting both ends of the therapeutic relationship under examination, fairly representing the particular demands on TGD individuals, and raising the expectation that clinicians are also attended to in the assessment of their preparedness to meet those demands (an equity/justice issue raised by Haldeman [2012]). This study will embrace this two-handed approach in the review of literature and recommendations for working with transgender clientele.

First, this paper will attempt to describe and understand the transgender community and its experience. Then, we will report findings on the particular needs of transgender individuals, particularly in the realm of mental health. Finally, this literature review will explore recommendations for clinicians in working with TGD persons clinical settings. Naturally, these three areas are not entirely distinct: understanding transgender experience naturally includes awareness of their particular needs, and beginning to enumerate their needs points to much of the advice for clinicians wishing to work with trans clients. Additionally, while the worlds of medical care and mental health may overlap, we are focusing on mental health concerns in this review.

Defining, Identifying, and Understanding the Transgender Population

There is a difficulty at the outset that demonstrates the profound need for clarity, research, and training around TGD issues, namely:

> the task of representing the transsexual and transgender population is nothing if not daunting. The difficulties, as we see them, stem from two main sources: (1) though a general “trans”

> sensibility exists in both the United States and worldwide, there are currently few measurable and/or standardized criteria (e.g., physical, social, political, etc.) regarding what might or *should* constitute a transgender person; and (2) problems with locating and accounting for this population are compounded by the relative invisibility through which many transgender individuals exist in their daily lives. Marginalized by political, religious, legal, medical, and other cultural institutions, transgender persons encounter levels of discrimination that range from simple misapprehension and/or exclusion by an uneducated public, to explicit acts of sexual and physical violence. Indeed, many in what is often referred to as the mainstream, including transgender individuals, are first exposed to the idea of "transgender" through media that often sensationalize and misrepresent the issues most salient for this population. (Meier & Labuski, 2013, p. 289)

Transgender people are those whose assigned sex at birth differs from their current gender identity or expression (Reisner et al., 2016), though more specific and differing definitions vary among cultures and jurisdictions. More broadly, transgender people (often called trans people) experience a degree of gender incongruence (Drescher et al., 2012); that is, a discordance between their personal sense of their own gender (their gender identity) and the sex assigned to them at birth (Coleman et al., 2012). The term transgender can also refer to any gender identity or presentation that either violates conventional conceptualizations of "male" or "female" or mixes different aspects of male and female roles and identities (Diamond, 2011).

The term "gender minority" was introduced in 2011 as part of the landmark Institute of Medicine report entitled "The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding" (Institute of Medicine, 2011). Gender minority is intended to serve as an umbrella term for people who are transgender or who have other genders and distinguishes between transgender identity and intersex or DSD (disorders of sex development, or the term of the

intersex community, diverse sexual development) (Liao & Simmonds, 2014), who are sometimes confused or conflated with the transgender community or label. Being transgender is not the same or equivalent to being intersex (Winter et al., 2016).

Understanding the frequency or numerical scope of the transgender population is also challenged by the difference between those who seek gender-affirming healthcare at specialty clinics versus polls of the general population, the latter of which place the frequency much higher. In studies seeking those who question their gender identity, estimates range from 0.5% to 1.3% for birth-assigned males and from 0.4% to 1.2% for birth-assigned females (Winter et al., 2016). Other studies have called these figures into question, based generally on the definitions utilized, lack of consideration of factors influencing reporting rates, and data-gathering techniques (Meier & Labuski, 2013). The research for this paper found no evidence or claim for a prevalence of transgender identity above 1.5%, but Meier and Labuski (2013) report academically rigorous estimates as low as 0.009% for male-to-female and 0.0032% for female-to-male transgender identity.

While prevalence is a nuanced question that requires more focused coverage than is appropriate in this paper, one consistent fact is notable. Far more individuals assigned male at birth transition to another gender than do individuals assigned female at birth, worldwide (with the curious exceptions of Poland, Japan, Sweden, and Iran) (Meier & Labuski, 2013). This might be a biological phenomenon or socially influenced by culture (for instance, the broadly restrictive nature and oppressive stance of patriarchy toward *men* that is rarely given voice or an articulate avenue for understanding or resistance).

The putative source or cause of gender dysphoria is also being informed by current research that points to biological factors (especially hormonal or genetic) instead of a prominent role for cultural or parental factors (Meier & Labuski, 2013; Winter et al., 2016), though no consensus has been reached on a biological basis for transgender identity (Meier & Labuski, 2013, p. 304). The presence of many

physical brain structure discrepancies in TGD individuals continues to confirmed and explored in varied and multiple studies. One study of dichotic listening (a test of selective attention and brain function lateralization) in transgender women showed that their lateralization resembles that of cisgender women rather than that of cisgender men (Diamond, 2009). Another study drawing on what is known about sex differences in sensitivity to specific odors shows sensitivity patterns in transgender women that reflect their gender identity, rather than their birth-assigned sex, suggesting that their physiological responses are sex-atypical in specific hypothalamic circuits (Berglund et al., 2008). Further developing this theme, limited post-mortem studies of transgender individuals suggest neural brain structure that does not correspond with their particular genital and gonadal characteristics at birth but is in actuality similar to that of cisgender individuals of the same gender identity (Garcia-Falgueras & Swaab, 2008; Kruijver et al., 2000; Luders et al., 2009; Zhou et al., 1995). These phenomena are not the result of hormone treatment, as is demonstrated by two studies: one of the white matter in the brains of transgender men who had not yet undergone hormone treatment demonstrated that their neural patterns were masculinized and closer to those of birth-assigned males than to those of birth-assigned females (Rametti et al., 2011a), and another of scans in untreated transgender women showing neural patterns to be feminized and substantially different from those of birth-assigned males (Rametti et al., 2011b). Even the process of attempting to separate sexual orientation from gender identity as well as from physical sex highlights many ways each of these notions is socially constructed, or at least informed (Bornstein, 1994; Denny & Green, 1996; Diamond, 2001), which unsettles any conclusions such research aims to reach.

Regardless of the origin, consensus is gathering around the validity of healthy individual experience of gender incongruence and recognizing such incongruence as a natural, “normal” potential quality of human experience. The presence or absence of any of the above phenomena cannot serve as a diagnostic criterion (Meier & Labuski, 2013). “The only valid route to understanding a person’s

gender identity is to listen to them" (Winter et al., 2016, p. 393). Awareness of gender has been shown to present as early as four months old, and awareness of one's own gender may begin to be prominent by 18 months (Martin & Ruble, 2010).

Diamond et al. (2011) raise a good summary point that contrasts with the growing field of scientific data on transgender experience listed above:

> Despite increasing social scientific acknowledgment and investigation of transgender experience, most contemporary perspectives presume that the primary identity dilemma for transgender individuals is a conflict between one's psychological gender and one's biological sex, such that the normative and healthy endpoint of transgender identity development is the achievement of a stable, integrated, unambiguous identification as 100% male or 100% female, often achieved via some form of physical transformation aimed at bringing one's psychological gender and one's physical gender presentation into alignment. Yet there is increasing evidence that such dichotomous models of gender fail to accommodate the true complexity and diversity of transgender experience. (p. 629)

This is echoed in subsequent research (Meier & Labuski, 2013, p. 294). Rather, Diamond et al. (2011) argue for broader, more flexible models of gender identity development among transgender individuals, which can accommodate the fact that, for some trans people, identity development feels like a linear trajectory leading to a singular outcome, whereas for others that development may be a recursive process that accommodates multiple and shifting identity states over time. In the latter case, transgender would not be a static, solid, or consistent identity but nevertheless accepted as just as valid as a "singular" gender identity. One's gender identity need not fit easily into a binary nor be consistent over one's lifetime and may vary broadly in scope and significance for an individual, at which point, identifying who "is" and "is not" transgender becomes more fluid, nuanced, and difficult to pin down (Meier & Labuski, 2013). Regardless, however, individuals should be allowed to self-identify (even

beyond or outside a gender binary) and have that identity fully recognized in their lives (Knudsen et al., 2018).

The line between identity and experience is somewhat arbitrary – one identifies as trans or cis because one experiences oneself that way. However, in addition to questions of how one feels about oneself, it should be noted that transgender identity brings with it social consequences, many of which are difficult and negative (Meier & Labuski, 2013). TGD populations across the globe face many stressors. While the United States may have an established tradition of human rights and an increasing openness to gender-diverse expression, trans people in the US are not at all immune to nor free from discrimination, prejudice, and violence. Most TGD individuals bear stigma on a nearly daily basis, being seen as sexually deviant, morally corrupt, unnatural, or mentally disordered (Winter et al., 2009). Trans people often experience "minority stress," contributing to poor health and less well-being (Bockting et al., 2013). Because of social and familial stress, trans youth are more likely to drop out of school (Winter et al., 2016), compounding the social limitations already in place for occupations and employment, leading to a higher prevalence in sex work and the attendant dangers to health, security, and well-being (Nadal et al., 2014).

Trans people also live under a greater threat of violence (Meier & Labuski, 2013, p. 304). A 2011 survey (Grant, Mottet et al.) on discrimination done by the US National Center for Transgender Equality revealed that 35% of individuals who expressed gender non-conforming identity at any time between kindergarten and grade 12 (about ages 5 to 18) were victims of physical violence, with 12% of them becoming victims of sexual violence. They found further that 7% of trans adults had been physically assaulted at work and that 6% had been sexually assaulted. In 1999, an expert affiliated with the Harvey Milk Institute in San Francisco estimated that "transgender individuals living in America today have a 1 in 12 chance of being murdered." (Brown, as cited in Meier & Labuski, 2013, p. 304)

(For comparison, the FBI [n.d.] estimated that individuals in the general population at that time had a 1 in 20,000 chance of being murdered.)

Segueing into the needs of transgender individuals, the stressors of discrimination, prejudice, and violence (in addition to the "interior" or intrapsychic stressors of variant self-awareness, body dysmorphia, and gender dysphoria, among others) contribute to a heightened strain on the mental and physical health of trans people. 41% of respondents to the US study (Grant, Mottet et al., 2011) mentioned above reported having attempted suicide, compared with 1.6% of the general population. While gender-affirming mental and physical health care correlates with improvements in social, emotional, and physical well-being, gender-affirming health care is not consistently available in the United States and has, in recent years, come under focused political attack (Human Rights Campaign, 2023). A 2014 study in Australia, a society not dissimilar to the United States in many ways, found that 56% of transgender people had been diagnosed with depression at some point in their lives, four times the rate for the general population, and 38% had been diagnosed with anxiety, around 50% higher than the background rate (Hyde et al.). A more recent study (Bretherton, 2021) saw those numbers increase: lifetime diagnosis of depression was reported by 73% and anxiety by 67% of respondents, with 63% percent reporting previous self-harm and 43% had attempted suicide. A UK study (McNeil et al., 2012) of transgender individuals found similar results as the contemporaneous Australian study, but with the added measurement of marked improvement after affirming mental and health care. The 2021 Trevor Project Study found that 52% of LGBTQ youth in the US had seriously considered attempting suicide in the past year. Building on the international scope of Winter et al. (2016), we see the risk factors for suicidal behavior in the transgender population include discrimination (Clements-Knolle, 2006), verbal and physical abuse (Nutbrock et al., 2010), being recognized as transgender (Haas et al., 2014), internalized transphobia (Perez-Brumer et al., 2015), poor educational qualifications, unemployment and poverty (Haas et al., 2014), and absence of social support (Bauer et al., 2015; Bockting et al., 2013;

Yadegarfard et al., 2014). Moreover, citing Balzer and Hutta (2012) and Byrne (2013 & 2014), Winter et al. (2016) observe that:

> Many of the challenges faced by transgender people are exacerbated by laws and policies that deny them gender recognition. Identity documents undermine privacy when they reveal a transgender person's birth-assigned sex, and can worsen the risk of discrimination in education, the workplace, housing, health care, and elsewhere. Laws and policies that impose onerous preconditions for gender recognition commonly violate a range of rights. The effect of difficulties related to gender recognition on the lives of transgender people is extensively documented. (p. 395)

Meier and Labuski (2013) point out that:

> Marginalized by political, religious, legal, medical, and other cultural institutions, transgender persons encounter levels of discrimination that range from simple misapprehension and exclusion by an uneducated public, to explicit acts of sexual and physical violence (Mizock & Lewis, 2008; Richmond et al., 2012). (p. 289)

Many of these factors continue to be prevalent in the experience of transgender individuals in the US and shape the nature and urgency of appropriate, informed, competent mental and medical care.

Crucially, however, extensive research has shown that, despite such high risk factors, with access to gender-affirming mental and medical care, trans people exhibit consistently high levels of mental/psychological health (Meier et al., 2011; Rachlin, 1999; Ross & Need, 1989).

Dynamics of Transgender Needs

The World Professional Association for Transgender Health (WPATH) first introduced Standards of Care in 1979 and has periodically updated it, with version 7 appearing in 2012 and version 8 in 2022. The SOC-8 provides "evidence-based standards for safe and effective gender-affirming health care and represent the most expert, in-depth, and evidence-based and consensus-based guidelines

internationally" (WPATH, 2022, p. 1). This represents the gold standard for transgender care and identifies many key considerations for addressing TGD needs. One outstanding need is access to care because it is not guaranteed, as basic gender-affirming care is currently under attack in much of the US (Human Rights Watch, 2023). In stark contrast to the political characterization of transgender care as aberrant, unnatural, or inherently unhealthy:

> Every major U.S. medical and mental health organization, including the American Medical Association, the American Academy of Pediatrics, and the American Psychological Association, plus global health organizations including the Endocrine Society, the Pediatric Endocrine Society, the Society for Adolescent Health and Medicine, and the World Medical Association, and the World Health Organization support access to age-appropriate, individualized gender-affirming care for youth and adults. (WPATH, 2022, p. 4)

As referenced above, TGD individuals endure exceptional quantities and persistence of stressors that threaten sound mental health (de Vries et al., 2020; McLachlan, 2019). Research shows that gender-affirming healthcare and mental health support dramatically improve the quality of life for TGD youth and adults (Dhejne, 2016; Jones et al., 2019). One prominent need of the TGD community, in general, is for mental health care providers to publicly advocate for broad access to mental health support and gender-affirming health care for all ages. As advocacy serves to increase validation, resilience, and purposeful well-being (Nettles & Balter, 2012), trans-affirming advocacy is vital for TGD individuals and important to see undertaken by their healthcare providers.

Mental health is an area of tremendous need among TGD individuals. Some studies have demonstrated a more frequent occurrence of depression (Witcomb et al., 2018), anxiety (Bouman et al., 2017), and suicidality (Arcelus et al., 2016; Bränström & Pachankis, 2021; Davey et al., 2016; Dhejne, 2011; Herman et al., 2019) among TGD people (Jones et al., 2019; Thorne et al., 2019) than in the general population. Importantly, researchers suggest that the risk factors that increase these negative

outcomes can be traced to circumstances such as being denied access to care (Meier et al., 2011), stigma (Bockting et al., 1998), as well as the loss of social support from loved ones (Meier et al., 2010). Therefore, transgender identity in itself is not the risk factor for these symptoms, but rather the social, cultural, political, and familial reactions, threats, and withdrawal of support (and other demographic factors compounding minority stress such as race and socioeconomic status) that lead to these symptoms (Meier & Labuski, 2013, pp. 313-314).

Children often internalize rejection experienced from peers and family and even latent transphobia in the culture around them (Amodeo et al., 2015). The impact of transphobic abuse can be lifelong but especially acute in the teen years (Nuttbrock et al., 2010). A strong social support network can be a buffer to these stresses and contribute to resilience (Barker, 2015; Başar & Öz, 2016; Bockting et al., 2013). In fact, a diverse social support network, particularly of LGBTQ+ peers and family, has been correlated with better mental health outcomes, well-being, and quality of life (Barker, 2015; Başar et al., 2016).

Many uses and benefits of gender-affirming psychotherapeutic approaches with transgender clientele have been researched and reported in the past two decades (Applegarth & Nuttal, 2016; Austin et al., 2017; Budge, 2013; Budge et al., 2021; Embaye, 2006; Fraser, 2009; Heck et al., 2015; Matsuno & Israel, 2018), though more data needs to be collected before any definitive conclusions can be ventured about the effectiveness of particular therapeutic modalities (Catelan et al., 2017).

It should be noted that so-called “reparative” or “conversion” therapy aimed at changing a TGD individual’s gender identity or expression to be more in line with their sex assigned at birth is expressly *not* respectful of the client’s autonomy and has been demonstrated to be *harmful* to clients (American Psychological Association, 2021; Meier & Labuski, 2013, pp. 314-315; Przeworski et al., 2021; Ryan et al, 2020). These interventions are:

> opposed by many major medical and mental health organizations across the world, including the World Psychiatric Association, Pan American Health Organization, American Psychiatric and American Psychological Associations, Royal College of Psychiatrists, and British Psychological Society. Many states in the US have instituted bans on practicing conversion therapy with minors. (Coleman et al., 2022, p. S176)

In fact, not mincing words, the APA in 2021 stated: "scientific evidence and clinical experience indicate that GICE [gender identity change efforts] put individuals at significant risk of harm" (p. 3).

Lifting up the possibilities of helpful and harmful practices in seeking to support trans clients begs the question: What are the desired competencies or recommendations for practitioners?

Competencies, Concerns, and Recommendations for Practitioners

First and foremost, mental health practitioners (MHPs) should work within practices and systems that recognize gender diversity and respect client autonomy (Coleman et al., 2022, p. S171; Meier & Labuski, 2013). As such, it is key for MHPs to address any symptoms or concerns that interfere with a person's capacity to give informed consent to gender-affirming care before any such care or procedures take place (Applebaum, 2007; Berg et al., 2001), recognizing that symptoms such as depression or anxiety do not present barriers to consent. While psychotherapy has an established history of beneficial use with TGD patients (Fraser, 2009; Hunt, 2014; Matsuno & Israel, 2018), it is not necessary nor always beneficial (Spanos et al., 2021) and should not be made a prerequisite to gender-affirming care (Coleman et al., 2022, p. S176). Quite to the contrary, when psychotherapy is deployed as a "gatekeeper" to trans-affirming medical procedures, the requirement of psychotherapy can challenge the therapeutic alliance (Budge, 2015). Unsurprisingly, therefore, Applegarth and Nuttall (2016) have found that psychotherapy can be experienced as both fearful and beneficial for TGD clients.

It is also important to remember that trans clients may seek mental health support for reasons unrelated or not directly attached to their gender identity, such as depression, anxiety, grief over the death of a loved one, sexual assault, or any number of concerns. Regardless, clients always have the choice of whether or not to disclose their trans history. "Clinicians working with someone they perceive to be trans need to determine if it is clinically relevant…." (Meier & Labuski, 2013, p. 314) Meier and Labuski go on to caution, however:

> it is important for providers to consider their reasons for asking the question. If the answer is curiosity, it is likely that it is not clinically relevant and asking prematurely could damage rapport with the patient (though making assumptions about someone's trans status can be equally damaging). … the therapist may inadvertently behave in a manner that pressures the client to [for example] pursue surgery or to end therapy as she may not feel understood. … Due to lack of education, training, and exposure to trans people, many therapists unknowingly assume that there is a single or "correct" trans history and identity.... While that might be a common narrative, there is no single or correct trans history or identity, as the population is more diverse than most imagine. (2013, p. 314)

Importantly, therapists, doctors, and other health care (mental, medical, and occupational) professionals are not immune to or exempt from ignorance, prejudice, or misunderstanding, even while their profession, credentials, and social standing carry added cultural authority regarding the ways gender and other categories are understood (Karkazis, 2008). At the same time, many clinicians are hesitant to work with transgender clients because they feel uninformed about TGD needs (Meier & St. Amand, 2010). So, ideally, all students and clinicians should receive some training and orientation around transgender issues (Bradford et al., 2013). Meier and Labuski (2013, pp. 307-311) recommend four areas for trans-specific training for clinicians: body parts, hormones, gender identity does not equal sexual orientation, and gender affirmation treatment. The authors repeatedly note the importance

of clinicians undoing the assumptions they have about the expected behaviors, beliefs, and partners transgender individuals may have: “treating a transgender patient requires a reorientation in clinical and personal assumptions about sex and gender; it is vital that clinicians unseat as many of their own as they can in order to best care for this population.” (Meier & Labuski, 2013, p. 310)

Under the theme of respect for TGD client autonomy, it must be a firm expectation of clinicians and clinical staff that they use the correct name and pronouns (as supplied by the client) and any other considerations in line with the client’s gender identity (Grant et al., 2011; Karasic, 2011; Knudsen et al., 2018; Russel et al., 2018).

Self-determination, autonomy, and empowerment are key needs for many trans clients (Knudsen et al., 2018) who may have encountered resistance to their identity and expression at key developmental points in their lives. Mental health professionals working with TGD clients should use active listening to encourage exploration in individuals uncertain about their gender identity; rather than imposing their own preconceptions, mental health workers should help clients determine their own direction (Coleman et al., 2022, p. S171). In a related example of the importance of nonjudgmental listening,

> many trans people take hormones without a prescription (Gooren, 2005; Moore et al., 2003), usually because it is either more affordable or is more geographically accessible. Clinicians must take care not to pass judgment on these individuals but rather inquire about the patient’s reasoning and seek to establish a system of monitoring if the patient cannot participate in a more clinically supervised regimen. (Meier & Labuski, 2013, p. 308)

Another aspect of self-empowerment should be clinical encouragement for TGD clients to establish more supportive relationships and communities (peers, friends, and families), recognizing that strong social support helps offset the minority stress experienced due to discrimination and stigma (Barker, 2015; Başar & Öz, 2016; Bockting et al., 2013; Trujillo et al., 2017).

Winters and Conway (2011) argue that minorities do not count until they are counted. Difficulties in research and policy exist in part because of poor definition or lack of clarity or specificity. While this is complex and nuanced under the oft-fluid transgender umbrella, there is a present need for clinicians and researchers to do more to identify the transgender community specifically (Meier & Labuski, 2013).

Another recommendation for cisgender clinicians seeking to work with transgender clientele is to consult resources within the TGD community for education, training, and practice. Advise from outside the trans community, even by well-meaning individuals or organizations, "can sacrifice sound clinical information for a focus on the exotic and curious aspects of the population" (Meier & Labuski, 2013, p. 306). Several reliable and helpful resources exist that offer specific suggestions about training staff, office logistics (e.g., forms, bathrooms), basic trans-specific medicine (types of surgery, risks of hormone therapy), and acceptable standards of care, and are listed in Table 1.

Conclusion

There are many more recommendations and considerations for mental health professionals considering working with transgender clientele. We quickly run the risk of exceeding the page count and attention capacity of a limited literature review. Suffice it to say the transgender community is in need of support, and the mental health community is in need of more education and training about transgender issues. We are making strides as a civilization, but we still have far to go for gender justice, equity, and expansiveness.

Appendix A: Tables

Table 1: Transgender and Gender Diverse Health Care Resources (reproduced from Meier & Labuski, 2013, p. 305)

Organization/Author	Resource/Title	Website/Publisher
World Professional Association for Transgender Health (WPATH)	Standards of care	http://www.wpath.org
Vancouver Coastal Health	Guidelines for transgender care	http://transhealth.vch.ca/resources/careguidelines.html
Vancouver Coastal Health	Clinical protocol guidelines for transgender care	http://transhealth.vch.ca/resources/careguidelines.html
The Endocrine Society	Clinical practice guideline	http://jcem.endojournals.org/cgi/content/full/94/9/3132
Fenway Health	Bibliography and resources	http://www.fenwayhealth.org/site/PageServer?pagename+FCHC_srv_services_trans_bibliography
Tom Waddell Health Center (San Francisco Department of Public Health)	Protocols for hormonal reassignment of gender	http://www.sfdph.org/dph/files/reports/default.asp
University of California at San Francisco (UCSF), Center of Excellence for Transgender Health	Primary Care Protocol	http://transhealth.ucsf.edu/trans?page=protocol-00-00
American Medical Students Association (AMSA)	Transgender health resources (includes guidelines from: WPATH, The Tom Waddell Center, The Endocrine Society, Vancouver Coastal Health, UCSF, Fenway Health)	http://www.amsa.org/AMSA/Homepage/About/Committees/GenderandSexuality?TransHlth.aspx
W.O. Bockting and J.M. Goldberg	Guidelines for transgender care	The Haworth Press, 2006
H.J. Makadon, K.H. Mayer, J. Potter, Hilary Goldhammer	Fenway guide to lesbian, gay, bisexual, and transgender health	American College of Physicians Press, 2007
G.E. Israel and D.E. Tarver II	Transgender care: recommended guidelines, practical information, and personal accounts	Temple University Press, 1998
J. Olson, C. Forbes, and M. Belzer	Management of the transgender adolescent	http://archpedi.jamanetwork.com/article.aspx?articleid=384321

Appendix B: Works Cited

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