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Respecting The Spectrum: Creating A Gender Inclusive Structured Diagnostic Intake Interview

Natalia Andino-Rivera
National Louis University

Respecting the Spectrum: Creating a Gender Inclusive Structured Diagnostic Intake Interview

by

Natalia Andino-Rivera

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Natalia Andino-Rivera, M.A.

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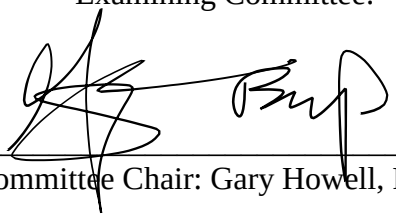

Committee Chair: Gary Howell, Psy.D.

Patricia S. Dixon, Psy.D

Member: Patricia Dixon, Psy.D.

Abstract

Transgender and nonbinary (TNB) people, more than ever, are in need of and actively seeking out services in order to cope with the reality of being transgender in the United States. This includes requiring assistance from local and federal governmental systems that do not provide protections for equal housing, workplace discrimination, and healthcare provisions, much less hate crime investigation and prosecution. In 2011, 75% of transgender people were or had been in therapy in the past, with a further 14% intending to participate in therapy in the future. Recently, the newly elected President Joseph Biden issued an executive order (EO) within his first 100 days in office. The EO was a directive for all federal agencies to review their practices to ensure that they are not discriminatory in nature toward gender-diverse individuals. . Additionally, the Biden administration empowered the Department of Defense to do a similar review of their practices and conclude that trans individuals should be allowed to serve in the military to create a stronger, inclusive service (Department of Defense, 2021). These, along with other policies, including the protections of Title IX protecting trans athletes and students, are some of the significant positive changes by the current administration. TNB people experience discrimination in many ways, which calls for a review of the instruments psychologists use to differentiate the proper treatment clients. Using the research of risk factors and specific information needed for treatment planning with TNB individuals, the intake interview created an inclusive and efficient experience for the transgender clients and the clinicians administering the intake.

RESPECTING THE SPECTRUM: CREATING A GENDER INCLUSIVE STRUCTURED DIAGNOSTIC INTAKE INTERVIEW

DEDICATION

I owe everything to the wonderful woman I am proud to call my mother. From the very beginning, she encouraged me and was a model for the driven, compassionate and loving person I wanted to be. As my interests and passions grew, she was right there beside me—cheering me on even when I doubted myself. Many sleepless nights, notecards and pep talks have led to this moment and she was there every step of the way. I dedicate this dissertation and very pivotal moment to my mom.

I also dedicate this dissertation to the rest of my incredible family. My father who showed me the value and dedication in serving others. I am grateful to have a strong role model who always knew when I needed him and a sister who supports me in all of my ventures with unwavering love. I am so proud of you and cannot wait to see you change the world. To my wife, who is my rock and my heart, thank you for always inspiring me to be confident in myself and motivating me to pursue a project in an area that I am most passionate about.

Lastly, I wish to dedicate this dissertation to the TNB people who I call my family and friends, and others who have lost their lives simply for who they are. I am constantly in awe of your creativity, strength and beauty. I hope this dissertation along with my future projects and endeavors help to bridge the divide by elevating mental health and promoting inclusivity across all disciplines of medicine.

ACKNOWLEDGEMENTS

Throughout my training, Dr. Gary Howell was my mentor who inspired me to continue working with the LGBTQ+ community through nonprofit and clinical work. From events and presentations within the program to fundraising efforts, I was enthralled with his dedication to the community and am working to follow in those footsteps. My other mentor, Dr. Patricia Dixon, not only taught inclusivity but modeled it as well. Through her guidance I learned to broaden my definition of diversity and to advocate and continue to challenge my own biases to be a multiculturally competent psychologist. I am honored that they followed me until the end by serving on my dissertation committee. Lastly, I would like to thank Dr. Melina Scally, who supervised me through my last practicum and not only showed me the richness of clinical work but also the reality of the many limitations in our field pertaining to working with TNB individuals. Your mentorship made such an impact on me as a clinician and for that I am grateful.

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CHAPTER I

Introduction

Transgender people have been active, if not hidden members of society, since the beginning of recorded history (Massachusetts Transgender Political Coalition, 2021). Even though the reason for their hiding was largely due to safety concerns, transgender people have made significant contributions to the rights and privileges of folks from multiple marginalized identities and even elevated cultures in the process (Allen, 2008). In the modern era, films and television shows such as *Paris is Burning* and *Pose* have expanded public recognition and understanding of transgender people. *Pose* garnered attention to various trans-related issues, including political representation, legal rights, medical/housing benefits, sex work, and victimization at both the hands of police and civilians alike. The focus on these issues has garnered the support of the sexual and gender minority community and allies. A new civil rights movement for equity in treatment for transgender people has been evolving, and the discipline of psychology is showing signs of needed reform. As psychologists, the ethics code clearly articulates that they are to protect the rights and welfare of the people they serve (Singh & dickey, 2015). With this mission in mind, the proposal to create an inclusive structured intake interview for TNB individuals was made. If psychologists can create an inclusive experience from the first contact, the profession may be able to foster a rewarding and safe therapeutic environment in which clients can grow.

First, it is important to define and operationalize the terms transgender—trans, nonbinary, genderqueer, and/or Two-Spirit—and transphobia, transmisogyny, cisgender, and cisgender privilege. Transgender or trans is an over-arching term that describes a person whose gender identity varies from that of the societal gender binary or what was assigned at birth (Human

Rights Campaign, 2020). Commonly, in popular culture, the terms cross-dresser and transgender are interchangeable; however, this is not the case. A person who cross-dresses is an individual who wears clothing, makeup, or accessories that are not traditionally associated with their gender. Cross-dressing is a form of gender expression and is not tied to a person's gender or sexual identity (HRC, 2020). In fact, gender identity and expression are a normal part of childhood development that occurs around the age of three (Mayo Clinic, 2017). While most research on gender development has been done on cisgender children, it is important to note that children between the ages of three and five understand their assigned gender and either accept it and move on to gender identity stability or experience confusion, as their assigned gender does not match their gender expression, which later develops into dysphoria (Rae, Gülgöz, Durwood, DeMeules, Lowe, Lindquist & Olson, 2019). Untreated dysphoria in a transgender person can lead to depression, anxiety, increased suicidality, and low impulse control later in life (Kosciw, Clark, Truong & Zongrone, 2020). Transphobia is defined by Merriam-Webster as the "fear of aversion to, or discrimination against transgender people" (Merriam-Webster, n.d.). Similarly, transmisogyny describes the conjoining of transphobia and misogyny (Serano, 2007). Transmisogyny is unique as it looks at the intersectional discrimination that transgender women face that often results in bodily harm.

As stated, the transgender umbrella includes genderqueer, nonbinary, and Two-Spirit identities. Genderqueer and nonbinary, as defined by National Center for Transgender Equality (2020), is a gender identity that is not representative of the gender binary and typically is associated with they/them/theirs pronouns. A Two-Spirit person is an identity represented in many Indigenous or Native American tribes and denotes an individual who possesses both a female and male spirit. These individuals are seen as a conduit to the divine and historically

revered as wise and sacred individuals (Fewster, 2010). Similarly, the Hijras or Kinnar of India are a community of transgender people who, due to social stigmatization, live in a community under the guidance of a guru (Mal, 2018). The commonality of all of these identities is the desire to be treated as a person respectfully and to be afforded the same rights and access as cisgender individuals. Cisgender describes a person whose gender identity aligns with their sex assigned at birth. When considering transgender people's access to resources, one cannot do so without examining the role of cisgender privilege, which is defined as "the privileges, advantages, and resources attributed to a cisgender person rather than a trans person" (HRC, 2020).

In an effort to continue to recognize and combat cisgender privilege in communities and systems of care, various disciplines in medicine have begun to review their practices with transgender and nonbinary (TNB) individuals. Recognizing and enhancing the therapy experience for transgender people is more important now than ever since trans people are actively seeking out services in record numbers in order to cope with the reality of being transgender in the United States (Grant, Mottet, Tanis, Harrison, Herman, & Keisling, 2011). In 2011, 75% of transgender people were or had been in therapy in the past, with a further 14% intending to participate in therapy in the future (Grant et al., 2011). This increase opposes the traditional belief that transgender people seek therapy primarily for the diagnosis of gender dysphoria. While some of these issues fall into common pitfalls that therapists encounter when working with trans clients, this does not take into account the other various factors that affect clients. The Human Rights Campaign (2018) identified eight areas in which TNB individuals suffer from anti-transgender violence. These include lack of family acceptance, hostile political climate, cultural marginalization, impediments in education, employment discrimination, barriers in healthcare, unequal policing, and drawbacks in legal identification.

The Family Acceptance Project (2009) found that familial rejection is closely tied to mental and medical health concerns. A familial bond, whether through blood or chosen, can be a protective factor for many TNB youth and adults in terms of engaging in risky behavior. However, some families choose to release their children from their familial bond in an attempt to force them to fit into the heterosexual/cisgender world around them. By abandoning their children, the belief is that out of concern for their lack of safety and basic needs, the children will renounce their trans identity. In response, many transgender children and youth tend to attempt to hide themselves for fear of rejection; however, hiding has a cost. Hiding their true selves exposes them to self-doubt, intrusive negative thoughts, and stereotypes that inhibit their personal growth (Family Acceptance Project, 2009). Additionally, familial rejection and continued societal rejection through the lifespan of a transgender person can lead to being eight times more likely to commit suicide, six times more likely to develop depression, three times more likely to engage in the use of illegal drugs, and three times more likely to be at risk for HIV or other sexually transmitted diseases in comparison with gay and transgender youth and young adults who were rejected in a minor fashion or not rejected at all (Vanderbilt Health, 2021). As such, it can be argued that parental interventions using gender identity change efforts and other debunked and harmful practices only serve to increase the likelihood that a transgender child or young adult will suffer from poor mental or medical health across their lifespan.

The Trump-Pence administration was responsible for more than 11 separate pieces of legislation, executive orders, and internal memos that stripped TNB individuals of their rights, including the ability to serve in the military and attempts at erasure from various census databases, both domestically and internationally (National Center for Transgender Equality, 2020). Oppressive bills intended to demean and demoralize, like the “bathroom bill,” have

served to not only marginalize transgender people more but also fed into dangerous stereotypes that infer transgender people are dangerous or engage in predatory behavior (Family Acceptance Project, 2009). Changes in the political environment were impactful to the transgender community that, in 2018, calls to the TransLifeline quadrupled in the week that the Trump-Pence administration attempted to erase TNB people from civil rights protections (Human Rights Campaign, 2018).

While the number of transgender individuals who experience violence is statistically greater than those who identify as cisgender, trans people of color are 2.5 times more likely to be assaulted or experience discrimination than their cisgender counterparts (National Coalition of Anti-Violence Programs, 2010). Individuals who identify with intersecting identities, such as being a trans person of color, have a more difficult experience than those who only hold one minority identity (Cole, 2009). Due to their intersectional identities, transgender people of color have considerably less access to familial bonds and financial and medical resources (Lefevor, Janis, Franklin, & Stone, 2019). Having multiple intersecting identities not only affects the person's familial attachments, but it also may have a detrimental effect on their community memberships, which means that a transgender person of color may be isolated both from their racial/ethnic group and the LGBT community for different reasons, including not performing femininity as expected or being rejected due to race/ethnicity from a predominantly White LGBT community (Sun et al., 2016). In the United States, transgender women of color (TWOC), more specifically Black TWOC, are disproportionately affected by violence and murder (HRC, 2017). Of the 27 known transgender people in 2019, 44 in 2020, and 12 thus far in 2021, who were murdered, the majority were Black transgender women, but nearly all were TWOC. The HRC (2017) reported that 8 out of 10 homicides were committed against TWOC. Transmisogyny has

been connected to some of the violence when parsing out the reasons for the continued violence; in fact, the HRC noted that it was a “toxic mix of misogyny, transphobia and racism” (“A National Epidemic,” 2019).

Academia can be an escape for many children and young adults who grow up in difficult situations. Schools and colleges have the ability to create a safe space for their students; however, this is not the reality for many TNB individuals. In 2019, the Gay, Lesbian and Straight Education Network, also known as *GLSEN*, (Kosciw, Clark, Truong & Zongrone, 2020) created a report as a result of a mass survey that asked 16,003 Lesbian, Gay, Transgender, and Queer (LGBTQ+) students across the country about their experience with harassing language and harmful policies in school. The survey showed that TNB students were unable to access safe bathrooms that aligned to their expressed gender (46.4%), were unable to use their name or pronouns in the classroom (46.5%), and were forced to use locker rooms based on their sex assigned at birth (43.5%). Of the students who completed the survey, only 10.6% of the sample had schools with inclusive policies and protections for TNB individuals. Unsupportive school practices and peers can lead to an increased amount of school absences by TNB students. Additionally, the Trump-Pence administration rolled back the protections the Obama administration put in place to protect TNB students (Gay and Lesbian Alliance Against Defamation, 2018). Left unprotected, these students remained vulnerable to discrimination at all levels of education. The difficulty faced by these students can affect all areas of their health and future employment endeavors (Kosciw, Clark, Truong & Zongrone, 2020).

For the working members of the TNB community, harassment and discrimination are commonplace. Brewster, Mennicke, Velez, and Tebbe (2014) found that 80% of their sample of 139 transgender individuals experienced direct harassment or forced isolation. In some cases,

supervisors or work peers would reject the transgender person's appearance, which led to the transgender individual feeling they must wear clothing that does not affirm their gender identity in order to keep their position (Brewster et al., 2014). Employment at "inclusive organizations" is not always an option for trans and nonbinary people; most are geographically tied to a location due to familial or monetary reasons. Additionally, numerous factors keeping transgender individuals in their unsupportive jobs, including disproportionate rates of homelessness, adds to the higher rate of mental health concerns in this population (Brewster et al., 2014).

Barriers to physical and mental healthcare are not new concepts for racial/ethnic, gender, or sexual minorities in the United States. There is not only a long history with an inability to access care but also a distrust of practitioners and the treatment they would provide. Shipherd, Green, and Abramovitz (2010) found that of their sample of 130 transgender adults, 52% of them had signs of psychological distress but had been unable to access care in over a year. Similarly, the National Transgender Survey (2018) found many disparities in not only access to medical but also discriminatory and harmful practices of the practitioners.

With the various barriers and complications in a TNB individual's life examined, it is important to look at the connection these factors have with mental health. On average, TNB individuals experience higher rates of depression, body dysmorphia, and anxiety and spectrum disorders than cisgender individuals (Bouman, Bauer, Richards & Coleman, 2016). Hendricks and Testa (2012) found that this increased minority stress is perpetuated by norms created by the dominant society that instills a sense of the transgender or nonbinary person as an outsider who does not adhere to the principles of the gender binary. As a result of living in a heteronormative and cisnormative society, TNB individuals tend to have greater distress, which results in heightened hypervigilance and internalized transphobia (Hendricks & Testa, 2012).

While there is a push to improve the experience of transgender and nonconforming clients in the therapeutic space by educating mental health professionals on inclusive language and interventions, many TNB people are hesitant to engage in therapy due to negative experiences with a mental health provider (Mizock & Lundquist, 2016). Applegarth and Nuttall (2016) found the initial search for a trans-affirming therapist to be anxiety-provoking. Once in therapy, these individuals felt that they had to educate the provider on transgender issues or practices and experienced discrimination.

In order to meet the needs of transgender clients, clinicians must call upon their role as advocates. Clinicians have a unique position to not only care for clients but also to advocate for laws and practices that promote a healthier and more ethical treatment of transgender people (Sigh & dickey, 2015). Advocacy can look different from one psychologist to another. It could be the facilitation of an LGBTQ+ non-profit that provides group and individual therapy for transgender clients on a sliding scale or presenting oneself at a city planning meeting to discuss the lack of housing and shelter options for transgender people. While advocacy may feel like boundary crossing for some, it has been noted in various studies that advocating for LGBTQ+ clients especially transgender people, helps to bridge the gap to accessible housing and healthcare and builds stronger rapport.

With the inclusion of gender dysphoria in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*), the American Psychiatric Association (2013) supported a way to give mental health access to transgender individuals while giving them the opportunity to use the covered assistance provided by insurance companies. The process of arriving at the current diagnostic criteria was not done so without controversy; many LGBT organizations across the United States provided public comment and urged the removal of the diagnosis

altogether, arguing that any diagnosis will continue to pathologize transgender people (Davy, 2015). While there is a diagnosis that allows clinicians to better advocate for their clients, the basic intake instruments, assessments, even the training psychologists and other mental health clinicians receive instills a cisnormative agenda, and assessments are rarely normed with transgender people in mind (Singh, 2016).

Statement of Problem

Transaffirmative care is already a significant problem for TNB clients since they have difficulty finding quality mental health care in addition to other medical and transition-related care (HRC, 2020). The number of transgender people in the United States continues to increase as individuals become more comfortable coming out; however, this leads to increased experiences of transphobia at the hands of unqualified providers (Planned Parenthood, 2010). The problem is that there are limited tools to support more affirming practices with transgender clients, especially in reference to intake assessments.

Purpose of Literature Review

This critical review of the literature evaluated past and current literature in an effort to support the development of a trans-affirming intake tool. Given the lack of empirical research on this specific area of research, this project aimed to highlight the limitations of current research to provide more context for specific questions that will more safely assess the experience of TNB clients.

Research Questions

The following questions framed the context of this critical review in order to examine historical considerations in understanding the evolution of transgender people and their experiences with acceptance, rejection, and amplification over the years:

1. What are the unique risk factors impacting the mental and physical health of the transgender community?
2. How do barriers to care and detrimental clinical practices negatively impact the transgender community?
3. What are the limitations of current intake approaches and what improvements could be made to improve them?

Research Procedure

The research of this critical review of the literature included a comprehensive review of peer-reviewed articles and books accessed through the database of EBSCO, Google Scholar, and the original sources located within the articles. Key terms used in this search process included *transgender, transgender history, transgender terminology, transmisogyny, TGNC, trans, nonbinary, gender non-conforming.* The search parameters included articles from 2007-2021. Books and articles that include qualitative research were in abundance and are included in this review to provide a better picture of the transgender community from an authentic and first-hand perspective.

CHAPTER II

Contextual and Historical Background of Transgender People

Historically, transgender people have silently worked in the background of history's greatest moments (Allen, 2008). Mainstream television has created a platform for series like *Pose* and *Orange is the New Black* to generate a tremendous amount of public interest in the existence and plight of TNB people. The downside of this newfound publicity is the misunderstanding that transgender people are a recent phenomenon. Not only is this false narrative embedded in popular culture, but it is also apparent in the literature of many health disciplines that note transgender care is "popular," indicating that research was not previously performed as the population was deemed to be hidden (Bockting, 2014). The contextual research that has been produced since the so-called "popularization" of the transgender community is scant and has only begun to scratch the surface of the clinical considerations for the treatment of transgender individuals. Furthermore, this research only began to surface more so in the last five to seven years. For clinicians to understand where and how to use interventions unique to transgender clients, they must understand the vast history of trans people in the world (White Hughto, Reisner & Pachankis, 2015). From the Ancient Romans to the 1960s in the United States, trans people have made their mark in notable ways (Allen, 2008).

Ancient Romans

Contrary to popular belief, transgender people have been prevalent in history for thousands of years, with the earliest records hailing from the Ancient Roman Empire (Massachusetts Transgender Political Coalition, 2021). While it is important to note that ancient history often remembers the most notable and powerful figures, transgender people may have been had earlier origins. In fact, according to Anna Burns (2019), one of the first notable

accounts of transgender people in history is with Emperor Elagabalus (203-222AD). Emperor Elagabalus was born male; however, since gender identity has not been verified, this paper will refer to them using they/them pronouns. Emperor Elagabalus is believed to be one of the first accounts of a transgender person in history. Elagabalus was born into an elite culture, which was the case with most upper-class Romans, and their parents offered them to the priesthood of the solar deity El Gabal. While a young priestess in the temple, Elgabalus danced for tribute to El Gabal in long flowing robes, often reserved for the women of the time period. It was posited that they captivated the soldiers with their dancing and quickly found favor among their ranks (Burns, 2019).

During a moment of political unrest, Elgabalus' mother claimed that they were the illegitimate child of the previous emperor who treated the Roman soldiers with great generosity. This claim was accepted by the Roman soldiers, who helped to overthrow the emperor in power to secure Elgabalus' throne. Elgabalus was crowned Emperor of Rome at the age of 14, was famously extravagant, and often appeared in court in the latest feminine fashions, wearing the very best makeup from Rome's conquered lands. Often the young emperor made politically irresponsible or absurd appointments, including assigning friends or lovers into positions of authority. In a move that confounded conservative ancient Romans but would have satisfied modern sensibilities, Elgalblus created a Woman's Senate that wielded equal power to the senate which was already populated with men. In private, they struggled immensely with their gender identity and famously offered a doctor half of the empire to perform corrective surgery on their genitalia. Their reign ended as quickly as it began as more traditional Greco-Roman legions worked together to murder Emperor Elagabalus and restore traditional values back into the empire (Cronn-Mills, 2015).

King Ashurbanipal was the last of the Assyrian monarchs. In the seventh century, the King was often seen in the finest feminine apparel and matching jewelry. They were not successful in their military conquests and lost several important military battles that greatly weakened the Assyrian empire and reduced its size to only include the city limits of the capital city. King Ashurbanipal, however, was more deeply concerned with trying to fit in as a female person. Ashurbanipal often spoke in a high-pitched, soft voice in conversation with others and wore immense amounts of makeup (Allen, 2016). As a result, his routines and actions in court angered many generals. One such general entered his chambers and witnessed Ashurbanipal filling in his eyebrows with makeup and became enraged. The general immediately drew his weapon and murdered the King, who represented the last of the Assyrian kings (Allen, 2016).

Middle Ages

In the Middle Ages, the first recorded court case attempted to identify a person who lived as a woman and called herself Eleanor against records that show a male who resembles Eleanor with the name John. The charge that brought her into the London court was for a sex work arrest, which was tolerated broadly during that time (Henningsen, 2019). The sex work charge was not the sole reason for bringing Eleanor before the court; it was to understand whether sodomy was a punishable offense. After interrogation, Eleanor was forced to confess that she was previously John. She described her transition as well as her job as a seamstress and sex worker. While the outcome of the trial has not been recorded, the implication was obvious. Transgender individuals were gaining visibility legally, and this is the first documented example of a person with gender dysphoria (Henningsen, 2019).

Trans people continued to be visible during the Middle Ages. Notably, this time period produced some of the most famous historical transgender figures of all time, including Joan of

Arc and the Cevalier d'Eon (Stryker & Whittle, 2013). Joan of Arc preceded the Chevalier by 100 years but impacted the French sensibilities surrounding transgender people. Moreover, Joan of Arc was born impoverished to peasants in the French countryside but had a great history for such a short life. Joan was always connected to spirituality (Stryker & Whittle, 2013).

At the age of 17, after many years of experiencing dreams that showed her leading the French army to victory against the invading English, Joan went to seek an audience with the French King Charles. When Charles refused to see her, she dressed in men's attire and again requested an audience which was then granted. After discussing her visions with the King, he granted Joan an army of 5,000 soldiers, suited with full armor, as well as personal aides (Stryker & Whittle, 2013). Joan led their army to victory at 18 years old and was subsequently captured and put on trial by the English. While the assumption could be made that the English charged Joan of Arc with defeating the English army, in essence, the charge was for heresy as Joan presented as male (Crane, 1996). While there are recorded documents of the trial, there is still contention among historians as to whether Joan identified as a lesbian or transgender. It is important to note that there is no evidence Joan had an attraction to women. Joan paved the way for the Chevalier to gain popularity and remain a fixture in the court of France for her whole life (Hoy-Ellis, 2017).

Chevalier d'Éon (1728-1810) was a French diplomat, spy, freemason, and soldier who fought in the Seven Years' War. She was a popular figure in France and later English society that the term "Eon" was used in the late 1700s to describe a person who would now be considered a transgender person (Encyclopedia Britannica, 2020). Chevalier d'Eon was born and raised in a poor yet noble family in the wine-bearing countryside of France. Assigned male at birth, she was intelligent and excelled in school and soon found her passion in the military. Chevalier d'Éon

eventually joined the le Secret du Roi, or “the King’s Secret,” which was the 18th-century spy syndicate that reported directly to the King of France. Due to her success in the syndicate, d’Eon found herself in a temporary position at the French court. Although she enjoyed a position, it did not last long; in fact, she was replaced by another soldier, and d’Eon did not take kindly to this change and threatened to release damning documents from her time as the King’s most trusted spy. The documents were released except a few for her to use as leverage. The release of the documents led her to be banned from France, and she journeyed to England, where she was warmly embraced into high society. (Encyclopedia Britannica, 2020).

d’Eon later wrote several books and made public appearances showcasing her fencing and fighting prowess. Despite rumors that ’she had been born a woman but hid her identity in order to join the military and become a spy, many historians believe that these rumors were started by d’Eon but were most certainly encouraged by her, as evidenced in her unfinished autobiography, The Maiden of Tonnerre. (Ryan, 2018) She was eventually declared as a woman publicly in the English courts and soon was followed with a similar declaration in the French courts. As a result, she was invited back to France, where she spent many years as a French dressmaker to Marie Antoinette. Eventually, she moved back to England as she grew tired of the life of a French woman in court. (Ryan, 2018)

In England, d’Eon spent the remainder of her life writing books and holding shows showing off her fencing skills. When she passed in 1810, her roommate discovered her biological sex and announced it in her obituary. The announcement was too late, as d’Eon had lived as a woman for 33 years, comfortably. Regardless of her sex assigned at birth, d’Eon was celebrated for her military and espionage excellence as well as style (Ryan, 2018).

The United States in the Early 1900s and Beyond

Some of the more notable transgender legends in history have been discovered after the artist's death. A prime example is Wilmer "Little Ax" Broadnax (1916-1994), who was a popular gospel singer and member of groups such as the Five Trumpets, the Golden Echoes, the Spirit of Memphis Quartet, and most famously, the Five Blind Boys of Mississippi. Willmer was born and raised in Texas to a religious family that brought him into the gospel lifestyle early. Willmer quickly became a fixture in the gospel music scene and became a top touring act for over 40 years. In the mid to late 1990s, Willmer retired from touring and was living with his live-in girlfriend in Philadelphia. Willmer and his girlfriend got into an argument, and his girlfriend murdered him. It was only during his autopsy that his sex assigned at birth was revealed. The revelation shocked the gospel community (Price, 2011).

During the 1950s, Christine Jorgensen became a focal point in American history with regard to transgender people. Christine was coined "the first transgender celebrity" for telling the story of her gender affirmation surgery and transition. She was born in 1926 in the Bronx, New York. From a young age, she rejected boys' clothes and wanted to wear the beautiful dresses her older sister Dorothy wore. In school, Christine discussed being more envious of girls than interested in them and was often in an internal battle about her conflicting feelings regarding her gender. She was drafted into the military in 1945 and discharged a year later. While her service gave her a distraction momentarily, it prompted her to decide whether or not to transition (A&E Networks Television, 2020). Deciding to follow her heart, Christine traveled to Denmark in 1950 to begin hormone therapy and gender confirmation surgeries. While recovering from her procedures in Denmark, she sent a letter home in 1952 that was intercepted by the media, in which Christine explained to her family that while she was still the same person, they had now gained a daughter. Becoming an overnight sensation, Christine had difficulty with

her newfound fame and was mobbed by the media the moment she returned to the United States in 1953. Christine famously gave an interview with *American Weekly* magazine, in which she detailed her life and her persistent confusion as a child and her comfort with her decision to take steps to be authentically her. She stated that she was "correcting a birth defect." Christine lived and performed in stage shows until her death in 1989 from cancer (Lipsky, 2014).

The Fight for Equality and Acceptance

Transgender equality has a long and arduous history. It begins with a grassroots movement spearheaded by the Modern Transgender Movement led by Sylvia Rivera and Marsha P. Johnson (New York Historical Society Museum & Library, 2019). Following the Stonewall Riots of 1969, Sylvia and Marsha created the Street Transvestite Action Revolutionaries (STAR) group. Their organization was responsible for gathering transgender people who were living on the streets in New York City in an effort to provide housing and was the first organization to provide organized social support groups to the transgender community (New York Historical Society Museum & Library, 2019). This movement led many to seek psychological help, and psychologists started to notice the growing need for guidelines to assist their newfound clientele (Pak, 2019). This organization remains an active organization in the fight for housing rights, social justice issues related to unfair imprisonment of trans people, and general trans advocacy in New York.

The work of STAR, along with other grassroots organizations, led to many of the modern transgender celebrities today and has signaled changes in their disciplines and society at large. One of these people is Laverne Cox, who was born in 1972 along with her twin brother in Mobile, Alabama. From an early age, she felt more like a female and struggled to understand why she was not allowed to play certain games or wear more feminine clothing. She had an

affinity for the arts early on and begged her mother to put her in dance classes. Cox was an accomplished dancer and excelled in school but was bullied often for being feminine. She cultivated her love of the arts by attending a fine arts high school and eventually earned a BFA in dance. Cox quickly found her footing in entertainment, and after in roles in reality and network cable shows; she became a series regular in *Orange is the New Black* (Haynes, 2020).

While on the show, Cox became the first openly transgender person to be ever nominated for an Emmy. In the next year, she made history again by winning the Emmy for executive producing *The T Word,* a documentary that follows the lives of trans youth. Since then, Cox has continued to be a vocal advocate for LGBTQ+ rights and has broken barriers to ensure transgender women of color representation in movies and TV (Haynes, 2020).

Unlike some famous personalities today, some celebrities were unable to come out until later in life. For example, Caitlyn Jenner was an Olympic gold-medal winning track star who is best known for her world record in the decathlon during the summer Olympics in 1976. Jenner was born in 1949 in New York and struggled in school much of her life. She found solace in sports and was athletic, excelling in water skiing, football, basketball, and track. Jenner earned a spot in college on a football scholarship and but had to change her preferred sport after suffering a knee injury. Her college track coach convinced her to train for the Olympic decathlon (Bissinger, 2015).

After winning the gold in 1976, Jenner remained in the public eye through endorsements, TV appearances, and series guest spots. In the mid-1980s, she began transitioning and took hormones that resulted in breast growth, as well as extensive electrolysis. However, during this time, Jenner's story of Olympic success likened her and her family to the "All American Family" (Bissinger, 2015). They were icons and represented American ideals to many people around the

world. Jenner's transition caused rumors to start; she worried about the reaction and how it would impact her children at the time, so she stopped her transition.

In 2007, Jenner became a well-known household name with the debut of the popular reality show *Keeping up with the Kardashians*. While the show kept rumors to a minimum, Jenner still felt incomplete and would often wear a bra under her suit in order to feel connected with her gender identity. Following her divorce from Kris Kardashian in 2014, she began to consider starting the process over in order to live authentically. Transitioning behind closed doors, she debuted herself to the world in the bombshell interview and photoshoot in which she asked the public to "call [her] Caitlyn" (Bissinger, 2015). Jenner was awarded the Arthur Ashe Award for Courage, which recognizes individuals who "transcend sports." In her acceptance speech, Caitlyn called for people to recognize and respect Transgender people as well as protect transgender children and young adults who are discovering themselves similarly to how others go through periods of exploration (A&E Networks Television, 2020).

One such child is Jazz Jennings. After her birth in 2000, it was only two years before she began referring to and dressing herself as a girl. In 2007, Jennings appeared on *20/20* with Barbara Walters and discussed how she felt about being a transgender child; she was six years old. Jennings and her family were brought into the mainstream at a time when transgender issues were largely unheard of at this scale (Diaz, 2020). A few years later, she and her family debuted their reality show that centered around the various ups and downs in her life, including different milestones. In 2012, Jennings became the youngest person to be on the *Top 40 under 40* list, and in 2013 she was honored at the GLAAD Awards. Jazz continues to be a beacon of support and an inspiration to many trans children and their parents alike in her role as a Human Rights Campaign youth ambassador (Bever, 2019).

Although these historical examples are only a small representation of many more equally important stories of trans people, it illustrates that trans people have been just as present as other diverse communities throughout history but are often silenced or invisible. These stories highlight the prejudice and blatant judgment which led to the institutionalized transphobia seen around the world today. Overall, transphobia and violence toward trans people is an international crisis of epidemic proportions (Human Rights Campaign, 2018).

From Acceptance to Pathologization

As with many marginalized identities, colonization has had a direct impact on trans people embedded in numerous cultures, including hijras in the Indian culture and Two-Spirit people in the Native American culture. Colonization refers to the process of settling a native area and establishing control over the indigenous people that reside there (Kohn & Reddy, 2017). Control does not only mean through legal force but also involves changes in culture. An example is during the 18th and 19th centuries when North America saw a dramatic change in culturally acceptable activity from the indigenous population (Zoccole, Ristock & Potskin, 2017). Native Americans were discouraged and often forced from practicing their belief system, speaking their native language, and engaging in long-held customs, as they were seen to be "barbaric." One such custom was that of Two-Spirit individuals. Often, these individuals held high statuses in their tribes or nations and were seen as vessels to the divine and advisors to the leadership; however, during the period of colonization, Two-Spirit people had their statuses removed, and a propaganda campaign was waged by the colonizers, insinuating that Two-Spirit people were unnatural and not the wise advisors that they were perceived to be. Consequently, many Two-Spirit people were ostracized and largely stayed quiet to avoid further torment (Bull, 2018).

In India, the British Empire did the quick work to dominate and adopt new colonies under their flag. Notorious for their cultural subjugation, it was not uncommon for many native cultural rites and rituals to be outlawed in favor of Western ideals and practices (Biswas, 2019). One such practice was that of the hijras in India. Hijras, similarly to Two-Spirit individuals, were seen as wise advisors and soothsayers with a special connection to the divine. The British found the Hijras to be an affront to their Western ideologies and were vocal about their disdain for the practice. In fact, in 1852, a Hijrah named Bhoorah was brutally murdered. During the trial of the accused, British magistrates commented on Hijras being "ungovernable" and insinuated that they were likened to descriptions of filth, disease, contagion, and contamination. After the murder, a new trial played out in public, which was of the Hijras themselves. British officials declared them a danger to public morals and spread many stereotypes about them. They suffered ridicule and became outcasts until 2014 when India recognized a third gender in which to properly document all their citizens. This was a win for transgender Indians who, for so many years, were stripped of their culture and made to feel "less than" due to the prevailing power and their leftover influence (Biswas, 2019).

Creation of Treatment Guidelines

The APA endeavors to dismantle the years of neglect and pathology that further isolated the transgender community. Accordingly, the organization established clinical treatment guidelines for practitioners. In order to comprehend the importance of creating a structured intake interview that is transgender/nonbinary-specific, it is important to evaluate how modern psychology continues to create difficulties between clinicians and trans clients. The *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* were officially adopted and published in 2015 to put things into context. Moreover, a new task force has

officially been slated to begin the work on revising the original guidelines. (Singh & disckey, 2015)

Psychologists and mental health professionals tried to understand the clients they were seeing; however, there was a lack of research and a prevalence of cisnormative thinking. In 1980, the *DSM-III* debuted the term "transsexualism" and made distinctions for "Gender Identity Disorder (GID)/Children transsexualism," "GID/adolescent and adult, non-transsexual type," and "GID/not otherwise specified." In 1987, the *DSM III-R* moved the GID diagnosis and its affiliated distinctions into the "Disorders Usually First Evident in Infancy, Childhood or Adolescence" (American Psychiatric Association, 2017)

Over the subsequent seven years, the terminology evolved from "transexual" to "Gender Identity Disorder," and the change was recognized formally in the *DSM-IV* in 1994. Although the terminology changed, the emphasis on the diagnosis pathologized the identity of the individual. Furthering the preconception of transgender as a medical disorder, the *DSM IV-TR* in 2000 placed the diagnosis on the category of "Sexual Disorders," with the subcategory of "Gender Identity Disorders." After 15 years, the American Psychiatric Association held a conference to discuss the evolving research that showed that gender identity was not the diagnosable issue; however, the distress that trans people may experience when their sex, assigned at birth, does not align with their gender identity was the main issue. This was the basis of the diagnosis of "Gender Dysphoria" in the *DSM-5* (Davy, 2015).

An inherent problem in the field still centers around the basic intake instruments, assessments, and even the clinical training for psychologists and other mental health clinicians. Cisgender privilege is not just seen interpersonally but is apparent in the assessment instruments and intake measures that psychologists administer (Singh, 2016). The latter is the main crux of

this paper, as intake documentation or structured interviews that are not inclusive and sensitive to the idiosyncratic needs of the trans community can lead to premature termination or issues in creating a rewarding, therapeutic alliance (Singh & dickey, 2015).

CHAPTER III

Understanding Risk Factors Unique to Transgender People

The most influential driving force behind the research to continue creating inclusive practices in psychology is the TNB community, as they represent those most at risk in the LGBTQ+ community. As mentioned, transgender individuals are eight times more likely to commit suicide than their cisgender counterparts. Over 40% of trans individuals have attempted suicide at least once in their life, and 62% have persistent active and passive suicidal ideation (National Center for Transgender Equality, 2020). Additionally, trans people are three times more likely to engage in the use of illegal substances and have HIV or other sexually transmitted diseases (Family Acceptance Project, 2009). Transgender people will often feel they must stay in situations that are harmful to them in order to reduce the chance of another outcome, such as homelessness or unemployment. The fear of unemployment which is three times higher in TNB people than their cisgender counterparts can keep many TNB people in unsupportive and discriminatory work environments. With limited housing options due to systemic discrimination and an unsupportive local and federal government, many trans people are left feeling boxed in at work. This can lead to depression, anxiety, and higher levels of suicidal ideation (Human Rights Campaign, 2018). A review of the statistics shows that the rate of transgender individuals who complete suicide is exceedingly high and is often preventable. To discuss the changes that need to be made to the intake to capture such clients, clinicians must first understand the risk factors that TNB people have that are unique to their lived experiences.

Risk Factors

According to James et al. (2016), the top risk factors include (1) engagement in non-suicidal self-injury, (2) distress related to gender dysphoria, (3) stress related to fear, (4) process

or backlash related to transitioning, (5) the experience of transphobia and harassment or physical/sexual assault, (6) lack of support from biological family members and parents/guardians, (7) institutional prejudice in the form of laws and policies that promote inequity, (8) predisposition to severe mental illness or family history of mental illness, (9) excessive alcohol and drug use, (10) stigma, (11) isolation from others, and (12) access to lethal means are among the top risk factors.

Non-suicidal self-injury. Non-suicidal self-injury (NSSI) refers to the direct and deliberate destruction of one's tissue without suicidal intent (Brent, 2011). This behavior can include but is not limited to cutting, rubbing, snapping bands, or whipping the skin. Over the last several decades, there has been an increase in this behavior, especially in sexual and gender minorities. Liu et al. (2019) reported that transgender people were found to have a much higher prevalence of NSSI than those of their LGB and heterosexual and cisgender peers at 46.65%. NSSI is a risk factor, as it is associated with poor physical health and negative mental health functioning (Pakula, Shoveller, Ratner, & Carpiano, 2016).

Distress and stress-related fear. The World Professional Association for Transgender Health (2011) discussed the role distress plays in gender dysphoria. Distress is often seen as inherently being integral to experience gender dysphoria and the product of social stigma. The integral distress is focused on the continued experience of non-anatomical physiology such as hormones and the adverse sensation of exhibiting the wrong genitalia. In a social context, distress is experienced through imposed cultural stigma through prejudices from others, as well as discrimination experienced through housing, employment, and social services (Bauer et al., 2009).

Transgender individuals often experience fear that adds to the stress they experience daily. This stress can include the social stigma previously discussed and familial and interpersonal stress (Eyssel, Koehler, Dekker, Sehner & Nieder, 2017). Similarly, stress relating to transition is also a common risk factor. This can be further broken down into two categories: (1) risk of harm to self and (2) time period. Often, TNB people have successfully explored their gender mentally but have difficulty beginning to transition socially. Social transitioning refers to the "[individual] presenting to other people as a member of the "opposite" gender in all contexts, e.g., wearing clothes and using pronouns of that gender" (Durwood, McLaughlin & Olson, 2017, p. 28). Social transition presents many challenges; however, the most notable are safety concerns for the individual as they may fear not "passing," which could be met with harassment or even violence. Passing refers to a transgender person being able to "pass" for a cisgender individual (Bockting, Miner, Swinburn, Romine & Coleman, 2013). The lack of safety is a significant risk factor.

Transition backlash. Depending on the cultural or religious background of the trans persons, certain kinds of abuse, including gender identity change efforts or arranged marriages, can be forced on the trans individual by coercive methods (Mallory, Brown, & Corron, 2019). This lack of support from family and friends can serve as a deep rejection and feel like a denial of the person themselves. Family rejection is closely associated with worsening depression, suicidal ideation, and continued attempts. Similarly, parental closeness can either be a protective factor or risk factor, depending on the familial makeup. Wilson, Chen, Arayasirikul, Raymond & McFarland (2016) found that a close relationship with the trans person's parents/guardians can significantly lower the risk for post-traumatic stress disorder and suicidal ideation. Gender identity change efforts (GICE) have been facing increased justified criticism regarding the

harmful techniques they use to “rehabilitate” transgender individuals, which instead increases mental health issues. Recently, the American Psychological Association (APA) released a resolution opposing efforts to change people’s gender identity, citing scientific research showing that such actions may be harmful (APA, 2021). The resolution cited research confirming that variations in gender identity is a normal part of the human experience, and change efforts are detrimental to a trans person’s mental health and feeling of self-worth (APA, 2021).

For the working members of the TNB community, harassment and discrimination are commonplace. Brewster et al. (2014) found that 80% of their sample of 139 transgender individuals experienced direct harassment or forced isolation. In some cases, supervisors or work peers rejected the transgender person’s appearance, which leads to the transgender individual feeling they must wear clothing that does not affirm their gender identity in order to keep their position. Also, in the school environment, it is important to understand whether an individual engages in behaviors that indicate discomfort by skipping school or engaging in non-suicidal self-injury (NSSI). In addition, some clients may have engaged in gay-straight alliances (GSAs) or clubs that are LGBTQ+ friendly, which mitigates risk (Vanderbilt, 2021).

Transphobia and bigotry. Transphobia is not only limited to verbal affronts but is seen in various examples of violence, including the high prevalence of sexual assault and the murder of TWOC, which ties into the constant presence of transmisogyny both socially and institutionally. The Human Rights Campaign (2019) identified an epidemic of violence against transgender people, notably TWOC. In 2019, 91% of all victims of anti-transgender violence were TWOC. Sexual assault is often perpetrated by individuals close to the trans person. This includes intimate partner violence (IPV), which along with sexual abuse, can include intimidation and emotional harm (James et al., 2016). Sexual violence is found at a higher rate

in trans individuals. In the 2011 National Transgender Discrimination Survey (2011), 12% of transgender youth reported being sexually assaulted in K-12 settings by a peer or educational staff. In the workplace, 13% of African American transgender people were sexually assaulted in the workplace. For homeless transgender individuals, violence is present even in areas meant to serve as a safe space, showing 22% being sexually assaulted while staying in shelters (Grant et al., 2011).

Murder in the transgender population has also shown a trend in heightened hate crimes among minority populations. In 2009, 50% of the victims were transgender women, and 82% were women of color (National Coalition of Anti-Violence Programs, 2013). In 2020, there was a record number of violent fatalities (44), making 2020 the most violent year since HRC began tracking fatalities. As of April 2021, 13 transgender individuals have been killed in violent means (HRC, 2021). Anti-transgender stigma, social vulnerability, including housing, financial or work needs, and other risk factors can continue to enable a culture of violence that has little to no repercussions due to the low rate of being solved or convicted. (HRC, 2018)

Transmisogyny is often pointed to as a major factor in threats to TWOC. Kussin-Shoptaw, Fletcher and Reback (2017) found that heterosexual, cisgender men who engage in sexual encounters with transgender women attempt to maintain an illusion that includes misgendering their partner in order to make sense of the attraction they feel. While this is offensive, it also shows a clear issue, as once the “illusion” is broken, the reaction often results in violent retribution for their partner (Kussin-Shoptaw, Fletcher & Reback, 2017). This is typically reinforced by the LGBT Panic defense, which has been successful in reducing the culpability of the perpetrator. To date, 12 states have banned the LGBT panic defense tactic, with another 13 having introduced bills and are awaiting their passage (The National LGBT Bar

Association, 2021). Various studies indicate that aversive experiences increase the likelihood of suicidal behaviors or ideations (Felitti et al., 1998; Hendricks & Testa, 2012; Meyers, 2003). Harassment and assault are not only perpetrated by strangers or acquaintances, but family members are commonly associated with transphobic verbal or physical abuse.

Institutional oppression. Systemic and institutional discrimination is seen in various facets of society, including housing, employment, military service, and healthcare. While some access is dependent on state laws, certain rights have been manipulated at the federal level from one White House administration to another. The best example of blatant institutional bias can be seen in the transgender military ban put in place by the Trump administration. On a federal level, trans individuals serving in the military were banned in 2018 after the Trump administration falsely claimed that the cost of troops transitioning and the distraction of them openly serving would negatively impact the mission of the armed forces to operate at the highest level of efficiency to protect the country (United States Department of Defense, 2018). The administration supported their claims by insisting that persons diagnosed with or have a history of gender dysphoria may be unable to properly serve in the military, as gender dysphoria may lead to severe depression or anxiety.

Schaefer, Plumb, Kadiyala, Kavanagh, Engel, Williams, and Kress (2016) discovered, in their overview of the research pertaining to trans military costs of benefits and activity in the military, several erroneous conclusions that do not support the claims that uphold the military ban. In fact, as of 2016, there were 2,450 active transgender military members of the 1.3 million total troops. Of these trans military members, between 29 and 129 of the members received transition-related medical care that could impact the members' ability to serve. As a result, Schaefer, Plumb, Kadiyala, Kavanagh, Engel, Williams and Kress (2016) reported that "the

readiness impact of transition-related treatment would lead to a loss of less than 0.0015 percent of total available labor-years in the active component" (p. 12). The last finding suggests that trans-related treatment would be a minor cost to the military represented by "0.04 to 0.13 percent increase in active-component health care expenditures" (Schaefer et al., 2016, p. 3).

General mental health vulnerabilities. Hendricks and Testa's (2012) model of gender minority stress illustrates how consistent social stress increases psychological distress. Trans individuals internalize the stress and develop a defensive stance when stigmatized. The defensive stance can manifest as becoming oppositionally defiant in children and developing generalized anxiety and depression (Barrow & Apostle, 2018). Researchers have found a significant difference between psychopathology in trans populations in comparison to non-trans persons. Reisner, Katz-Wise, Gordon, Corliss, and Austin (2016) found that depressive and anxiety symptoms that met clinical significance were 52% and 38%, respectively, compared to 27% and 30% in cisgender females and 25% and 14% in cisgender males. Roberts, Rosario, Corliss, Koenen, and Austin (2012) found that a transgender child's exposure to childhood physical, psychological, and sexual abuse resulted in a higher indication of post-traumatic stress disorder across the lifespan. Heylens et al. (2014) corroborated the previous studies and found that substance abuse disorder also occurred at higher rates than in cisgender populations. Additionally, Heylens et al. discovered that 70% of their trans participants had current or lifetime mental health diagnoses that worsened during the transition process (Heylens et al., 2014).

Alcohol and drug use. Substance use is a strong indication of client distress, and research shows there is a high prevalence of abuse within the LGBTQ community (Vanderbilt Health, 2021). Specifically, in the transgender community, substance abuse is often used as a coping mechanism for previously discussed risk factors, including lack of access to care, mental

illness, discrimination, and stigma. Drugs such as crystal meth, marijuana, ecstasy, and cocaine have been found to increase the level of HIV transmission in the trans population through impaired judgment, leading to sexual contact or intravenous drug use (Vanderbilt, 2021). Prolonged drug use in conjunction with mental health decline can lead to an increase in suicide attempts by use of drugs and alcohol. Additionally, trans people that have been currently or previously diagnosed with a substance use disorder are 40% more likely to have chronic passive suicidal ideation (Family Acceptance Project, 2009).

Stigma. As mentioned, the stigma perpetuates not only the cycle of violence against transgender individuals but also continues to allow the internalization of negative stereotypes for transgender individuals. Regarding transgender individuals, constant internalization can lead to increased instances of generalized anxiety and depression and aggravate cycling in individuals with bipolar disorders (Stanton et al., 2021). Gender dysphoria, as defined in the *DSM-5*, in adolescents and adults is a marked incongruence between one's experienced/expressed gender and their assigned gender, lasting at least six months (American Psychiatric Association, 2013). According to Bonfacio, Maser, Stadelman and Palmert (2019), gender dysphoria is a unique phenomenon because it can have an early onset for some individuals, starting in childhood and progress through the lifespan, or can have a late onset. Often the differences pertain to the societal values of the time, support of the family, and openness of peer relationships and media. Gender dysphoria can be tempered in treatment when paired with a therapeutic environment that allows the client to grow in their identity; however, left untreated, it can lead to negative symptoms, which include negative intrusive thoughts regarding the incongruence the person feels, anxiety, body dysmorphia, depression, agoraphobia, and passive suicidal ideation (Bonfacio, Maser, Stadelman and Palmert, 2019).

Minority Stress Model

The Minority Stress Model, developed by Meyers (2003), aims to capture how stigma, prejudice, and discrimination create a stressful social environment that can lead to mental health problems in people who belong to stigmatized minority groups. Also, Meyers found that minority stress can contribute to overall stress in different ways. These include being an extra layer of stress than generalized stress; it is pervasive, as it is related to social and cultural structures and is socially based on institutions and customs (Meyers, 2003).

Meyers (2003) discussed the minority stress experience as "all encompassing" and emphasized that minority individuals are often placed in a position of playing teacher to majority or privileged audiences. In the case of gender minorities, this can be seen in interpersonal relationships, work environments, and medical visits. The stress that is consistently placed upon gender-diverse individuals can lead to increased levels of anxiety, panic attacks, depression, and substance abuse (Meyers, 2003). Often, this is not an experience only felt by the gender diverse but also by sexual and racial minorities. As a result, gender-diverse clients tend to look for therapists and clinics with similar diverse demographics, which depending on the geographical area, may prove difficult to accommodate. It is the mission of psychologists to adapt to the needs of their clients, especially when the needs pertain to the comfort they can provide and the accessibility of care. (Singh, 2016)

Hendricks and Testa (2012) provided a framework for understanding key clinical issues that psychologists who work with transgender and gender-nonconforming individuals will likely encounter in their clinical work. The researchers found that increased minority stress is perpetuated by norms created by the dominant society that instills a sense of the transgender or nonbinary person as an outsider who does not adhere to the principles of the gender binary. As a

result of living in a cisnormative and heteronormative society, transgender and nonbinary individuals tend to have greater distress which results in heightened hypervigilance and internalized transphobia (Hendricks & Testa, 2012).

As clinicians, it is important to recognize these risk factors and be conscious not to over pathologize the trans person. There can be an initial inclination to conceptualize a trans person's distress as pertaining to their gender identity. However, it is more likely that the client is appearing for difficulties in a relationship, self-esteem, difficulty in their careers, or self-consciousness—similar topics to those seen in the average session with a cisgender individual. Similarly, clinicians should also be aware that transgender clients may have fluctuations in their gender identity and expression. Fluctuations do not necessarily indicate an underlying psychiatric illness; they are common and are a healthy part of the self-exploration component of the transition (National LGBT Task Force, 2011). Over time, as the trans person becomes more confident in their identity, they will settle into a consistent gender identity and expression. By using the assistance of an inclusive therapist, transgender clients are more likely to move through transition and life stressors with less distress and have a higher rate of clinical success (Gerken, McGahee, Keuroghlian & Freudenreich, 2016). Analyzing the aforementioned data on risk factors, historical and current hardships, and unique stressors will further support an appropriate and clinically useful structured intake that will prioritize inclusivity and effectiveness in a concise format to maximize the amount of pertinent risk information from transgender clients in the first visit. Included in these items will be information on gender identity and expression, information on risk behaviors, aversive experiences on a micro and macro level, and significant mental health diagnoses that are predictors of lifelong distress.

CHAPTER IV

Detrimental Practices and Barriers to Care For Transgender People

Cisgender privilege can compromise the integrity of the treatment provided to TNB clients. Even in cases where the clinician is a cisgender sexual minority (lesbian, gay, bisexual), cisgender privilege can be a blind spot in offering competent care (Singh, 2016). Various studies have found that an environment that is devoid of inclusivity at all levels of the visit can lead to client avoidance of appointments and lead to self-harm and suicidal concerns. As evidenced by the Adverse Childhood Experiences (ACE) study (Felitti et al., 1998), mental health institutions, as well as community-based care clinics, can become a protective factor for a trans child or adolescent. Regular attendance to mental health appointments reduces the likelihood of criminal activity, violence, drug use, and suicidality. Taking a critical look at the various stages of an initial appointment with a mental health professional will lend to understanding the elements that can lead a trans client to discontinue their care (Singh & dickey, 2015).

Barriers to Care

Access to trans-affirming healthcare can be difficult to come by, and disparities are complicated by geographic location, socioeconomic factors, and more. Medical and mental health coverages are often made possible by becoming an employee of specific inclusive employers such as Starbucks. The benefits included in the Starbucks Transgender Medical Benefits range from gender confirmation surgery, hair grafting, wigs, and voice therapy (Kane, 2018).

Gatekeeping role. The current system is set up to include mental health and medical gatekeepers in treatment. TNB clients must first muster the courage to come out, understand their own process or journey, and seek help in navigating a system riddled with barriers and

multiple hoops to jump through to be themselves, which is enough to lead clients to dark and suicidal moments in their process (Applegarth & Nuttall, 2016). Some clinicians without proper training extend the time need in the letter writing process to unethical lengths. Unless the client is experiencing significant mental health concerns that require more restrictive measures of care, they do not need extensive treatment to be "allowed" to start their hormone treatment. Some providers force TNB clients through unnecessary psychological assessments. TNB clients may feel when their experiences and truth-telling are met with invalidation and more roadblocks. Research shows that they often cycle through multiple clinicians until they find someone qualified or with some knowledge of the process (Nolan, 2018).

Bureaucracy. Starting from the first contact with a provider in more competent clinical settings, the TNB person can expect the initial process to begin their medical transition to take between two to six months (Planned Parenthood, 2020); however, this is not the case for many TNB clients. Some states make counseling mandatory before a referral letter can be produced to initiate the next step of the medical transition (e.g., hormones or surgical procedures). The social transition is also a time-consuming process related to the person's emotional readiness rather than specific access. The social transition is important, as it allows the TNB individual to explore their identity as well as increase their self-confidence by presenting themselves to the public gradually, by increasing clothing pieces, jewelry, hairstyles, and beauty products that align with their identity. The transition process can be slow-moving depending on state laws for hormone/gender-affirming procedures, age restrictions that involve parental permission, and a person's emotional and mental readiness for transition (Planned Parenthood, 2020).

Inclusive spaces. Peering deeper into the average initial therapy appointment experience, cisgender privilege is embedded in every aspect (Planned Parenthood of Southern

Finger Lakes, 2010). Initially, when walking into a therapist's office, the waiting area is the first point of contact that either provides comfort or discomfort to the TNB person. The surroundings of the office may further the client's lack of comfort, and the literature or decor can be non-inclusive, as it may exclude mention of gender diverse individuals (Fenway Health, 2017). Magazines that are distributed in the waiting room are more likely to promote cisnormative and heteronormative messages and pictures which can be off-putting for TNB clients, thus promoting a feeling of otherness for the TNB person (Paine, 2018).

Additionally, educational literature present in the waiting room may hold similarly biased messages about different topics, including sexual health, partner discord, or raising a family. Often, these educational materials are written from the perspective of heterosexual, cisgender individuals and do not take into account various nuances related to the gender or sexual minority experience. Perhaps the walls are devoid of markers, flags, or certificates that indicate training, allyship, or correspondence with a gender minority community. There is no visual representation of anything which communicates that the space centers on diversity; this continues the feelings of otherness (Singh & dickey, 2015).

Inclusive forms. Within a few moments of waiting, a member of the staff greets the client, and based upon their perception of the transgender client, they often address them using gendered language (Paine, 2018). TNB clients often report being misgendered by office staff (receptionists, techs) before even meeting the provider. This first interaction can set the tone for the rest of the visit and lead a client to decide to discontinue service before seeing the therapist or not returning after the first appointment. When the paperwork is provided to gather additional information from the client before seeing the therapist, TNB clients often notice the intake

paperwork is consistently cisnormative by asking for “legal name” and sex. In many cases, the only choices are those on the gender binary (male/female).

It is common for intake paperwork to omit an option for TNB clients to list or identify the pronouns they use or may prefer. Some providers make an effort but use invalidating or pathologizing descriptors like “preferred pronoun” or “preferred name” rather than “pronouns used” or “name used.” Other intake forms ask the client to self-identify their gender identity using the line "Other." The insinuation being that anything outside the binary is other or different, adding more to the coldness of the experience (Paine, 2018). Another problem is exclusion of the terms gender expression, gender identity, or option to self-identify, which would instead typically empower the client to describe themselves in their preferred terms, authentically, without any perceived judgment. Lastly, there may be demographic or medical questions that are deemed “female/male” or male only. These questions typically regarding pregnancy or sexual health are asked from a cisgender perspective only. Transgender men may experience concerns around pregnancy and menstruation, which causes dysphoria. The question as presented on the intake form would not properly capture the client or their concerns. In general, most options further marginalize nonbinary people.

Furthermore, questions regarding the transgender person's family history can be (biased) problematic as some trans people may be rejected by their families. The trans client may have a chosen family that serves in that capacity. Often, asking about the genetic history of mental and medical health concerns is typically overshadowed by the social aspect of a family. Discussing biological family can be a difficult subject because there can be multiple layers of trauma that can harm the therapeutic relationship before the session is initiated. Collecting medical and mental health and familial information is important for treatment planning; however, assessing

the support level a person has from their chosen family is equally important. Chosen families are quite common for many trans people, as shown by Soler, Caldwell, Córdova, Harper, and Bauermeister (2018), where 91% of transgender and gender-expansive participants indicated that they have a chosen family compared to 63% of gay and bisexual men. Moreover, chosen families are important as a therapy tool, as the minority stress theory presupposes that individuals processing events and stressors in a group dynamic reduces their likelihood of detrimental mental health effects due to minority stress (Meyers, 2003). Ultimately, emphasizing a chosen family in therapy along with therapeutic techniques shows a higher level of meeting therapeutic goals (Soler, Caldwell, Córdova, Harper & Bauermeister, 2018).

Major omissions within the intake include various risk and safety factors to include non-suicidal self-injury, passive suicidal thoughts including content and frequency, and perceived safety of self at work and home. Perceived safety is a nuanced category for trans people because they statistically have higher rates of hate crimes (Johns, Lowry, Andrzejewski et al., 2019). When the client returns the paperwork, the receptionist may ask for the client's "real name" or legal name as their legal documents may differ from the name and gender marked on the form (Reisner, 2013). Another complication for TNB clients involves the office restroom. For example, a TNB client may make it through a challenging first encounter with a staff member or clinician who may have invalidated their trans experiences in some way then find a restroom that is not gender-neutral and is located in an area that makes them feel uncomfortable to use; ultimately, this would negatively affect them overall (HRB, 2020).

Problems with Standard Intake Assessments

Standard intake forms can perpetuate the barriers to care transgender patients may face when attempting to access care in mental health. Intake forms are the first contact any medical

or mental health service has with their patients. These forms, however, can be representative of cisgender, heteronormative bias and be off-putting to potential new clients (University of Iowa Hospitals and Clinics, 2017). An important point is the initial selection of the client's gender identity. Forms that only have options such as "male" and "female" are harmful, as the item perpetuates the microaggression that reinforces the gender binary (Smith et al., 2012). Smith et al. (2012) found in a sample of 249 intake forms that 185 (74.3%) included questions about gender/sex. Of the 185 forms, 43.2% failed to use TNB inclusive language, and of the aforementioned forms, only 6% included a space for clients to list their pronouns.

Non-inclusive language, including heteronormative tropes regarding marriage, parenting, and family, can also be difficult for patients to work through because it can promote a feeling of otherness in the trans client (Spade, 2011). Additionally, standard intake interviews do not include specific risk factor areas that affect transgender clients. These areas include NSSI, risk factors for suicide, substance use, and violence (Singh & dickey, 2015).

Detrimental Effects

When the client is called to initiate the appointment, the therapist may reset the pronouns they use based on how the client presents rather than the name written on the paperwork. The client may look around the office and try to find something that will calm their nerves, perhaps an inclusive pin or flag, only to find that there is nothing (Singh & dickey, 2015). When the therapist introduces themselves, they may misgender the client several times and insinuate that their presenting problems are related to them being transgender rather than other issues. Hendrick and Testa (2012) reported that in some cases, the therapist may be noticeably uncomfortable, causing the client to feel compelled to comfort the therapist and discuss various

therapies that have been helpful for them or people they know who have been able to find inclusive therapists.

As mentioned in Chapter one, there is an influx of trans patients seeking therapy. Examining some of the typical therapy experiences thus far has highlighted why many trans clients discontinue after the initial session. Singh (2015) noted that therapists who identify as cisgender having limited contact with TNB patients depended on the client to educate them about the correct way to address them, the structure therapy, and to provide resources for the client. Instead of being the expert that the client seeks, the therapist loses the upper hand and instead becomes another person the trans client needs to educate.

Meyers (2003) discussed the minority stress experience as "all-encompassing" and emphasized that minority individuals are often placed in a position of playing teacher to majority or privileged audiences. In the case of gender minorities, this can be seen in interpersonal relationships, work environments, and medical visits. The stress that is consistently placed upon gender-diverse individuals can lead to increased levels of anxiety, panic attacks, depression, and substance abuse (Meyers, 2003). Often, this experience is not only felt by gender minorities but by sexual and racial minorities as well. As a result, TNB clients tend to look for therapists and clinics with similar diverse demographics, which may prove difficult to accommodate depending on the geographical area. It should be a mission of psychologists and mental health professionals to adapt to the needs of TNB clients, especially when the needs pertain to the comfort clinicians can provide and the accessibility of care.

By changing small elements of the therapeutic experience, some protective factors begin to develop. According to the ACE study (Felitti et al., 1998) and the minority stress model (Meyers, 2003), TNB individuals who have a support system outside the family, which can

include medical/mental health services, educational safe spaces, and community outreach programs, are less likely to be involved in gang activity, substance abuse, or in volatile or abusive relationships. However, due to the current educational and professional practices, there is a disconnect between popular practices and necessities that would improve the therapeutic spaces (University of Iowa Hospitals and Clinics, 2017).

Singh (2016) noted that psychologists are trained in a way that uses cisgender privilege to detract from the experience of trans individuals. Most detrimental of these practices are psychologists who are trained in a medical model or the diversity characteristics of transgender/non-conforming, also known as TGNC, that was not taught unless discussed in psychopathology courses. These two practices place the transgender individual in a conceptual position where they are seen as an abnormality or psychological disorder rather than an identity that should be respected (Singh, 2016).

CHAPTER V

Clinical Implications and Future Directions: A Proposed Intake Tool

The significant challenges TNB clients face when seeking mental health treatment are sometimes insurmountable for some. Showing up to therapy for the first time should not be traumatic for a TNB client; however, data suggest clinicians can create some unsafe spaces when they are ill-equipped to work with this very diverse population (Seelman, Colón-Diaz, LeCroix, Xavier-Brier & Kattari, 2017). TNB clients face adversity in all facets of their lives, and seeking help should not create another unnecessary barrier to treatment. Transgender people have faced multiple levels of discrimination throughout history, with the effects leading to an epidemic of unique risk factors that still plague the. This study analyzed the various unique risk factors faced by trans individuals, including family acceptance, hostile political climate, cultural marginalization, impediments in education, employment discrimination, barriers in healthcare, unequal policing, and drawbacks in legal identification. These risk factors perpetuate physical and psychological health concerns such as hypertension, cardiac and gastrointestinal issues, depression, anxiety, autism spectrum disorders, and eating disorders. (FAP, 2009)

With trans individuals facing multiple mental and physical health concerns due to the risk factors previously discussed, many are deciding to connect to services or are thinking about connecting to services (Mizock & Lundquist, 2016). However, the experiences of trans individuals who are or have been in mental/medical health services have not been conducive to a positive continuing relationship. Many trans people have noted that the way they are addressed by staff and mental health professionals, the inability to access the care, and the intake instruments used have had an alienating effect due to the non-inclusive language and terms (Spade, 2011).

An in depth examination of the intake instruments that serve as the first impression in the therapy environment showed a number of areas that have detrimental language and negatively formatted questions. The standard intake important sections, including identifying information, psychosocial history, substance use history, and risk factors were not expanded on enough. Additionally, some aspects were not previously explored, such as sex work, area of use for substance use, and the role of non-suicidal self-injury (Pakula, Shoveller, Ratner, & Carpiano, 2016).

The current intake also fails to assist the psychologist with the conceptualization of the clients. In order to have a full conceptualization, mental health professionals rely on a full scope of information of the client as well as the depth of risk factors that could be present, as discussed in the most recent literature, on risk factors in this population (James et al., 2016). These issues combined with the long history of discrimination and the lack of accountability regarding the treatment of trans people, calls for change. Change needs to start in the base of clinical care, the intake interviews. The proposed intake form will take these previous concerns and integrate various models and literature to create an inclusive intake form for transgender clients that promotes a positive therapeutic relationship.

Proposed Intake

The proposed intake assessment form has elevated several different areas that are typically more general questions on standard intake forms, including the risk assessment, psychosocial information, childhood experiences, and work/education difficulties. In each section, there are points from the aforementioned studies that are highlighted as items. In addition, there are items added to better allow the TNB client to feel that they are in control of their services.

Demographic section. In the demographic information, the typical item "gender" was expanded to include "sex assigned at birth and gender identity." These indicators are important, as they provide the clinician insight into the trans client's identity. Later in the intake, gender expression will be assessed to understand the client's relationship with their public presentation, which may differ significantly from the person's gender identity, or the person may feel that they are at risk for violence and choose to wear non-affirming clothing or other forms of gender expression (Gower, Rider, Coleman, Brown, McMorris & Eisenberg, 2018).

Chief complaint. While discussing the client's history of current symptoms, a question was added regarding the client's ability to access services that might have been a barrier to treatment in the past. This question correlates to many previous studies about the access to care or client's concern for discrimination, which leads to lapses in medical and mental health appointments. By understanding the clients' history of care, the clinician can structure sessions and provide resources to better address this issue.

Psychosocial history. Throughout the proposed assessment tool, it should be noted that there is a distinction between genetic family and chosen family. As discussed, family support is a protective factor against suicide. Because some birth families (family of origin) reject the TNB client, the chosen family can serve as a replacement of the family of origin and be equally as protective against suicide. This relationship can be difficult and marred by judgment, abuse, and neglect. An item was included to discuss whether a client was exposed to substance abuse or mental illness in the past or present with their birth family or their chosen family. (FAP, 2009)

Risk assessment. This assessment section is also expanded to include questions pertaining to non-suicidal self-injury, which is a unique risk factor for accidental suicide later in life. In the substance use section, there are specific items that address coercion, harmful

behavior resulting from substance abuse, and the initial reasons that led to the substance use. These items were derived from research showing that trans individuals abuse substances 30% more than their cisgender counterparts (Vanderbilt, 2021). Additionally, it is not uncommon for them to be coerced into using substances for the purpose of escaping their reality, whether from their family circumstance or the environment in which they participate.

Furthermore, internalized transphobia is often derived early on in a trans person's life, whether from adverse childhood experiences or bullying in school. In the intake, this is identified through items that ask the client about their self-image and confidence while in school as well as negative intrusive thoughts that the client may have had throughout childhood and adulthood. The negative thoughts that are internalized are often lifelong and can be difficult to manage in therapy. In the school environment, it is important to understand whether an individual engages in behaviors that indicate discomfort by skipping school or engaging in non-suicidal self-injury (NSSI).

Additionally, the client may have joined and participated in gay-straight alliances or clubs that are LGBTQ+ friendly, which mitigates risk (Vanderbilt, 2021). In adults, this manifests as isolating behavior, skipping work, or quitting workplaces often. Social support from genetic and chosen family as well as friends has been found to be a strong protective factor against suicidal behaviors (Moody & Smith, 2013).

Interpersonal and romantic history. Romantic relationships and friendships are significant indicators of the individual's social interaction and possible instances of isolation. Trans individuals are at a much higher rate of intimate partner violence and become victims of murder by their intimate partner (National Coalition of Anti-Violence Programs [NCAVP], 2012). In order to assess the presence of this risk, items were added that assessed feelings and

concerns about the person's intimate partner as well as feeling trapped either emotionally, physically, or financially (Goodmark, 2013). Additionally, clarifying friendships lets the therapist have a clear idea about the client's social support outside of biological family and chosen family. This support system can be vital while going through transition or processing situational stressors related to discrimination (Goodmark, 2013).

Work and education. The proposed intake tool assesses the work and educational environments that the trans person experiences. The questions seek to expand information not only on the overall experience but also on key aspects of discrimination the trans person may face, including items about the need to present themselves at work in their old gender expression, safe people in the department to confide in, and any unwelcome or uncomfortable interactions in prior positions. Additionally, the question of sex work is one that can provide useful information regarding risk, stress, abuse potential, and general concerns about safety (Vartabedian, 2019. In the trans community, the occupation of sex work can be the only means of income during difficult times, as finding gainful employment as a trans person can be very difficult (Vartabedian, 2019). In some cases, sex work can feel like the only option. Although sex work is a legitimate occupation, it has risk factors not found in other careers. These downsides are usually at the expense of the trans person's health or safety (Glynn, Gamarel, Kahler, Iwamoto, Operario & Nemoto, 2016). High numbers of violent interactions directed toward trans sex workers are reported yearly (Fitzgerald, Elspeth, Hickey & Biko, 2015). It is important to ensure the trans individual was not coerced or forced into sex work, as there are a record number of trans individuals who are trafficked (Fehrenbacher, Must, Hoefinger, Mai, Macioti, Giametto & Bennachie, 2020).

Personal expression. The expression section of the proposed tool provides a unique insight into the self-concept of the trans person by examining their satisfaction with their current gender expression. As discussed, gender is on a spectrum (HRC, 2020); people may express themselves in different ways and fashions before finding comfort and peace with how their gender expression aligns with their gender identity. By inquiring about their level of satisfaction, the therapist can also decipher whether there are barriers related to further levels of expression that they were hoping to explore. The disruption that internalized transphobia can cause is all-encompassing for the client's mental health and limits the efficacy of coping skills a trans person may attempt to use (Bockting, Miner, Swinburn, Romine & Coleman, 2013). Allowing the trans person the space to discuss their thought processes that have potentially led them to knowingly or unknowingly isolating from others or society at large is the first step in solidifying a positive therapeutic relationship and guiding treatment goals. Also, understanding the various stressors that the trans person has in their life, whether they are in the middle of their transition, thinking about beginning the process, or many years later during post-transition, can immediately isolate any common risk factors that need to be addressed or prioritized (Hendricks & Testa, 2012).

Resources. The resources—last section—of the proposed assessment allows the therapist to use the last few minutes of the intake to tailor the therapeutic experience and resources to the needs of the client. Asking about specific resources that the client needs and specific rules for the therapeutic space allows the client to participate in therapy and stimulates the therapeutic relationship to be mutually respectful and objective. Following APA guidelines, psychologists assume their advocate roles to ensure that the client is provided resources for a whole health experience. (APA, 2013). Providing a corrective experience is important to

counteract the client's previous experiences with mental and medical staff as a precaution against early termination of services.

Every day, the world changes and moves in directions that call for the ever-flexible field to move with it. Providing services, advocating for resources, and finding solutions are all things in which psychologists excel. By creating inclusive resources, psychologists can keep that tradition alive, ever-changing, and improve upon the previous idea. This proposed intake tool continues the work of LGBT psychologists and allies who place the risk and protective factors of trans individuals at the forefront to efficiently work out treatment goals and modes of treatment. By creating this instrument, it is expected that other clinicians will add, refine, and transform this intake for different settings and geographical areas. In addition, continuing to refine the spaces will ensure that psychologists are taking the necessary steps to create inclusive experiences beyond the intake session to make therapy accessible for everyone. In this way, they will all truly respect the spectrum.

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APPENDIX A

Affirming Transgender & Nonbinary Structured Intake

Demographic Information

Name:
Age:
Pronouns you use:
Sex assigned at birth (insurance only):
Gender Identity:
Sexual Orientation:
Race:
Ethnicity:
Relationship Status:

Chief Complaint

1. History of Current Symptoms:
    a. Current symptoms
    b. Duration of symptoms
    c. Have you had difficulty accessing services to work on these concerns due to financial reasons or concern about discrimination?
2. Psychiatric History:
    a. Have you ever been voluntarily or involuntarily hospitalized?
        i. If yes, what was the reason?
    b. Have you ever been in psychotherapy before?
        i. What was your experience?
        ii. If you discontinued early, what were the reason?
        iii. What worked?
        iv. What didn't work?
    c. Are you current prescribed any psychiatric medication? What medication(s)?
        i. Are you compliant?
        ii. If not currently prescribed medications, have you been prescribed any psychiatric medication in the past?
    d. Does anyone in your chosen/birth family (family of origin) have a history of mental illness and substance abuse?
        i. Which members and what has been your exposure to this behavior?

SI/HI

1. Have you ever felt that you wished you were dead or wished you could go to sleep and not wake up?
2. Has there ever been a time where you created a plan to kill yourself?
3. Did you ever cut, scratch, burn, rub or claw at yourself when you were upset?
4. When sad, have you ever felt concerned to reach out, in fear that you would not be helped for any reason connected to your identity?
5. Do you have any access to large quantities of medications, firearms, drugs, or rope?
6. Do you have a plan in case you feel unsafe and need to rely on someone else?

    a. What are some warning signs that you may not be feeling emotionally well that day?
7. On a down day, what are your reasons to continue living?
8. Have you ever made an attempt on your life?
9. Do you ever feel angry and want to physically harm another person?
    a. If yes, what stops you from engaging?

Substance Use/ Gambling History

1. *I am going to list a number of different substances and I would like you to tell me if you currently/have used them before.*
    a. Nicotine
    b. Alcohol
    c. Marijuana
    d. Methamphetamine
    e. Ecstasy/MDMA/Molly
    f. GHB
    g. Ketamine
    h. Heroin
    i. Cocaine
        i. In what form?
    j. Any intravenous drug?
    k. Non-prescribed prescription drugs?
2. If yes to any substances ask, *"Did you engage in the use of these substances consensually?"*
3. *What was the reason(s) that led to using the drug(s) you mentioned before?*
    a. Probe for signs of childhood abuse, instances of discrimination and coercion for sexual gain.
4. *Were you able to access to resources that assisted you in quitting?*
5. *Did you ever engage in harmful behavior as a result of drugs (e.g., unprotected sex, contraction of STI or exposure to abuse)?*
6. *The reasons that were present when trying the drug(s) for the first time, do you still have those thoughts or feelings presently?*

Psychosocial History

1. As far as you know, did you meet all of your developmental milestones?
2. Tell me about your childhood?
    a. *How was your relationship with your birth family/guardians*?
        i. *Extended relatives*?
3. *How was did you feel about yourself growing up?*
4. *Were you ever diagnosed with a psychiatric disorder or had any indication you had a disorder?*
    a. If so, which?
5. How was elementary, middle and high school for you?
6. What were your safe spaces in school?
    a. What made that space safe?
7. Did you have a tendency to "skip school" or leave early?
    a. What was the reason for this?
8. Did you ever belong to a Gay-Straight alliance or other clubs that were LGBTQ+ friendly?
9. While in school did you ever have physical, verbal or emotional abuse perpetrated by students, teachers or staff?
    a. What was the outcome of the events?
    b. Did you feel that these events have had an impact on you?

10. Did you have friends or acquaintances in school?
11. Did you ever engage in NSSI or experience suicidal ideation?
    a. If so, how long did it last and how sever were the symptoms?
12. In school, did you ever come in contact with or use drugs that were not prescribed to you?
    a. If so which and for how long?
    b. Do you still utilize these substances today?
13. Were you able to complete school?
    a. If not, for what reason?

Prior Mental/ Medical Health History?

1. Are you currently connected with medical care?
    1. If not, why?
2. Do you have concerns about prospective medical care due to negative past experiences?
3. Do you feel anxious about the way you will be treated when entering clinical care?
4. Have you had negative experience in prior mental health care?
    1. What about this experience made it negative?
5. What would you like to see in clinical practice that would make the experience more comfortable for you?

Interpersonal and Romantic History

1. Are you currently in a romantic relationship(s)?
    a. If so, for how long?
2. How do you feel your relationship(s) is(are) progressing?
3. Are there any concerns that you have or instances in which you feel unsafe with your partner(s)?
    a. Do you feel trapped either emotionally, physically or financially?
4. Is(are) your partner(s) supportive of you and your identity?
5. Are you currently sexually active?
    a. Are there any issues that you are experiencing with your sexual health?
6. Have there been any relationships in the past that have made you uncomfortable or you tend to avoid thinking about?
7. Do you currently have a trusted friend or friend group?
    a. What makes your relationship work?
    b. Do you have any concern regarding your friends?
8. Do you have a concern that any of the relationships you are in could be toxic or coercive in some way?
9. Have you been in contact with friends in the last month?
    a. If not, what kept you from doing so?

Living Situations

1. Do you currently live in a home, apartment, or group home?
    a. Do you feel safe at home emotionally and physically?
2. Over the past year, has there been an instance that you have experienced homelessness? (Ex. "Couch surfing" or living in your car for a period of time"
    a. Are you concerned about your housing situation in the next 3 months?
3. Do you live alone or live with someone?
    a. **If so, do you feel safe with the person(s) you are cohabitating with?**

Financial History

4. Are you currently feeling upset, anxious or frustrated regarding your finances?
    a. Are you concerned about your financial stability in the next 3 months?

i. If so, would you be interested in community resources for rent instability or food insecurity?

Work History

5. Are you currently employed or in school?
    a. If employed or employed and in school, start at question 14
    b. If in school and has no work history, start at question 24
6. Where are you currently employed?
    a. If mention of sex work, complete subsection of questions starting at question 19
7. Do you feel that this is a good place to work for you?
    a. How is the work environment?
    b. Do you get along with your coworkers?
8. Has anyone in your workplace ever made you feel that you needed to change who you are or how you express yourself?
    a. If so, what was the outcome?
9. Is there a safe person or department that you trust in case of negative interactions at work?
10. Since your first job, was there ever a job that made you feel unwelcome or make your time with them uncomfortable for any reason?

Sex Work subsection (Complete only if yes to question 19)

11. Have you ever been employed in the sex industry?
    a. Such as: escorting, OnlyFans, cam work, dungeon master, etc.
12. If so, were you coerced into the work?
    a. Did you engage in the work as a necessity for living arrangements or food?
13. When engaged in your work do you disclose that you are Trans?
    a. If not, why?
14. Have you ever been physically or sexually assaulted as a result or your work?
15. If currently engaged in sex work and thinking about discontinuing, are you having difficulty due to financial reasons?

School History

16. What are you going to school for?
17. Has the experience lived up to your expectations?
    a. What is the school environment like?
18. Is there a club(s) that are LGBTQ+ friendly?
    a. Do you feel your school is supportive of its Transgender students?
19. Have you ever experienced any instance of discrimination from faculty, staff or peers?

Legal

1. Have you ever been arrested?
2. If so for what charges?
3. What was your motive in these instances?
4. Are you currently in litigation for a charge?
5. Have you ever been the victim of a crime that was related to being a gender minority?

Pre-transition

10. Are you satisfied with current level of gender expression?
    a. If yes, move to resources section
    b. If no, continue to question 2 of this section

11. How has your transition or thoughts about your upcoming transition effected your thoughts and feelings?
12. Have you experienced any difficulties or hardships resulting from your transition?
13. Do you have access to the resources you need to continue or complete your transition?
    a. If not, what are the barriers?

Post-transition

1. Since your transition, were you ever made to feel inferior or inadequate due to your identity?
2. How would you characterize your mood since transitioning?
    a. If discussing symptoms of anxiety and depression, how long have you been exhibiting these feelings and thoughts for?
3. What has been the positive things that have come out of your transition?
4. What are areas that have had difficulties since transitioning?
5. Would you be interested in community resources?

Resources

1. Are there any resources that you are seeking but have been unable to find?
2. Do you have any transition goals that you have yet to complete?
3. How can I best make this space comfortable to you?