Curr Psychiatry Rep (2017) 19: 102
https://doi.org/10.1007/s11920-017-0845-z

Gender Dysphoria in the Military

Shannon Ford[1] · **Carla Schnitzlein**[2]

Published online: 7 November 2017

Abstract
Purpose of Review With the announcement that members of the military who identify as transgender are allowed to serve openly, the need for Department of Defense behavioral health providers to be comfortable in the assessment, diagnosis, and treatment of this population becomes quickly evident. This population has been seeking care in the community and standards have been developed to help guide decision-making, but a comparable document does not exist for the military population.
Recent Findings Previously published papers were written in anticipation of the policy allowing for open service. The civilian sector has treatment guidelines and evidence supporting the same for reference. There is no similar document for the military population, likely due to the recent change and ongoing development. This paper attempts to provide an overview of the recent Department of Defense policy and walks the reader through key considerations when providing care to a transgender member of the military as it relates to those who are currently serving in the military through the use of a case example.
Summary The military transgender population faces some unique challenges due to the need to balance readiness and deployability with medically necessary health care. Also complicating patient care is that policy development is ongoing—as of this publication, the decision has not yet been made regarding how people who identify as transgender will access into the military nor is there final approval regarding coverage for surgical procedures. Unique circumstances of this population are brought up to generate more discussion and encourage further evaluation and refinement of the process.

Keywords Transgender · Gender dysphoria · Military · Veteran · LGBT · Mental health · Open service

This article is part of the Topical Collection on *Military Mental Health*

✉ Shannon Ford
shannon.c.ford.mil@mail.mil

Carla Schnitzlein
carla.w.schnitzlein.mil@mail.mil

[1] Department of Behavioral Health, William Beaumont Army Medical Center, 5005 N. Piedras St, El Paso, TX 79920, USA

[2] Headquarters, 3rd Infantry Division, 942 Ben Hall Place, Fort Stewart, GA 31314, USA

Introduction

Prior to when Secretary Ash Carter signed the Transgender Service Directive in July 2015 [1] Transgender Service Members in all branches of Military Services were unable to serve openly. This ban did not affect service; estimates made prior to the policy change indicated there were between 12,800 and 15,500 transgender service members enlisted or commissioned in the US military [2, 3]. Compared to their cisgender peers, a disproportionate percentage of the transgender population serves—twofold, as an estimated 21.4% of transgender individuals are believed to have served in the military, compared to 10.4% of the general adult US population [4]. And with this policy change, the USA joined 18 countries already allowing open service of transgender individuals [5].

With the policy change came concerns regarding integration into the military and healthcare needs unique to the transgender patient. Healthcare is delivered based on a diagnosis of gender dysphoria. The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) defines gender dysphoria in adolescents and adults as "incongruence between

one's experienced/expressed gender and assigned gender, along with at least two other symptoms [as outlined in the DSM-5] for at least six months" [6]. Further, DSM-5 requires a degree of distress and dysfunction in areas such as social and occupational arenas. There is an additional specifier that takes into consideration post-transition state and is defined along with other common terms in Table 1.

Transgender people are subject to harassment and discrimination in all facets of their lives: unsupportive family members, homelessness, unemployment, lack of access to health care, harassment, concomitant behavioral health and medical diagnoses, and widespread discrimination [7]. While healthcare for the transgender population in the civilian sector is increasingly guided by published policy as more research is completed and there is an increased focus on this topic, access to healthcare is complicated due to the likelihood of lower socioeconomic status and lack of training within the medical community, among other issues. Fifty percent of respondents to the National Transgender Discrimination Survey said they taught their physicians about transgender-related health care [8]. And because open service was not allowed until 2016, military medical providers are unlikely to have had exposure to this population. Dr. Jamie Henry pointed out in an open letter to JAMA, many clinicians have received little training in the care of transgender patients [9] and Schvey's survey of military family physicians found 74.3% did not receive training in gender dysphoria during their medical education. 62.7% reported having no transgender patients since receiving their medical license. Of the 47.1% of respondents who would be willing to prescribe cross-sex hormone therapy (CSHT), 0.6% said they would independently (without additional education and/or assistance from someone more experienced) [10]. Even when the provider felt comfortable with and wanted to treat patients for all of their concerns, this patient population is hesitant to disclose identifying as transgender due to the threat of being "outed" and receiving an administrative separation (especially prior to 2016). Now, despite allowance of open service, there is sufficient controversy, ongoing study, and confusion about policy that leaves many transgender soldiers very concerned for their future careers in the military.

Multiple studies have shown that transition-related care is medically necessary and proven to relieve dysphoria related to incongruence between assigned and identified gender [11••]. Open service will allow for members of the military to transition, with the goal of alleviating their dysphoria. A member of the military who identifies as transgender faces similar stressors to the civilian sector, though the construct of military service alleviates some but adds other unique challenges. While on active duty, these individuals have employment, access to health care, and room and board covered as part of their service. Harassment and discrimination are not tolerated by regulation. But completing the mission takes precedence over freedoms not necessarily considered elsewhere: where you are stationed (and the city you are living in), when you are moved elsewhere, when vacations are taken, when you may be separated from your primary support system (deployments and remote assignments), and most important for this topic—when elective health care (that is otherwise covered by insurance) is provided—these are not decisions made unilaterally by the patient. The Department of Defense (DoD) has taken considerable efforts to support open service and ensure provision of appropriate medical care, all while balancing the needs of the military and having a capable force.

It is anticipated that approximately 200 individuals in the DoD will seek medical care related to gender dysphoria annually as a result of this policy change [4]. For consistency and simplicity in this article, we will to refer to this population as patients. Consistent with the general population, these patients will seek transition-related medical care to the extent they feel is appropriate for them as an individual. Approximately, 76% of transgender individuals received CSHT and a small percentage will undergo gender-confirming surgery. From a readiness perspective, estimates regarding impact indicate the patient will be unavailable for worldwide missions during the

Table 1 Common terms and definitions

Sex: Classification, typically assigned at birth, as male or female based on anatomy and function.
Gender: Behavioral, cultural, or psychological traits that are traditionally assigned to a sex within a society or culture.
Gender identity: An internal sense of self as it relates to gender.
Cisgender: Having a gender identity or expression that is the same as assigned or birth sex.
Transgender: Having a gender identity or expression that differs from assigned or birth sex.
Transgender female: A person with a female gender identity and was assigned male sex at birth.
Transgender male: A person with a male gender identity and was assigned female sex at birth.
Transition: A complex, individualized process of developing and expressing oneself consistent with one's gender identity that occurs over a period of time.
Cross-sex hormone therapy (*CSHT*): The hormone treatment used to feminize or masculinize an individual as they transition to their expressed gender.
Gender affirming/confirming surgery (*GAS/GCS*) or *sex reassignment surgery* (*SRS*): Surgical procedures that further masculinize or feminize an individual to be more reflective of their gender identity, sometimes separated as "top" and "bottom" surgery.
Top surgery: Colloquial for breast augmentation or mastectomy/creation of a male chest.
Bottom surgery: Colloquial for phalloplasty, metoidioplasty, or vaginoplasty genital surgeries.
Post-transition: A specifier for the diagnosis of gender dysphoria, indicating the person is living full-time in their identified gender and has undergone/is undergoing at least one procedure or treatment (such as hormonal therapy). This was developed to allow for ongoing necessary medical care (such as the continuation of hormones).

first 1–6 months of transitioning (initiation and stabilization of CSHT). Gender-confirming surgeries such as mastectomies/breast augmentation and gonadectomies are being completed on a case-by-case basis. If supported, it becomes part of the transition plan, and the surgery and recovery time would be scheduled around unit mission requirements, and possibly obtain additional evaluations from behavioral health providers (all of which is currently in committee and not yet codified).

Gender confirming surgeries typically require 1–2 years of treatment and transitioning before occurring (with mastectomy being an exception), so the patient's unavailability to the unit and mission will be split between two periods: initial presentation (evaluation, development of a treatment plan, initiation of CSHT if desired, changing their gender assignment in the personnel system) and then surgery and recovery after 1–2 years of stability in the identified gender. At publication, the support for surgeries is also still being discussed and is not yet approved. However if gender-confirming surgeries are authorized, the impact to overall readiness is small as an estimated ten male to female transgender patients and six female to male transgender patients would be medically unfit for service annually [5]. It should be noted that many of the surgical options are already being electively completed within the DoD medical system for other diagnoses.

With these policy changes, published guidance and trainings have come from the DoD and are then further developed more specifically by each of the service branches (Army, Air Force, Navy, Marine Corps, US Coast Guard, and US Public Health Service). This is because each service branch has aspects that are either more common to or completely different from the other services. Being Army psychiatrists, the authors wish to note that some of the process details described herein may be specific to the Department of the Army and are only as current as the publication. Policies are still actively being debated and developed at the highest levels of government.

Policy and procedure specifics as it relates to the administrative side of military medicine should not be confused with the medical treatment plan that is developed with the patient by a multi-disciplinary treatment team (typically behavioral health, endocrinology, and internal medicine/primary care). Themes of formulating a case, patient concerns, and provision of care are applicable to all patients currently serving and those who are interested in serving. The administrative policies have been left vague in places to ensure that each patient receives an individualized plan as it relates to them as a person and their need for meeting the military mission. This has also though contributed to delays in initiating care and inconsistencies in evaluation and treatment. For example, one duty station may require neuropsychological testing as their "gold standard" for ensuring that a patient does not have any concomitant psychiatric problems that would prevent successful treatment, while another relies on clinical-based encounters alone.

To help demonstrate the process of both the administrative and clinical aspects of caring for a military patient with gender dysphoria, we will use the transition of soldier W, a 21-year-old transgender female, whose case was created using common themes the authors have seen in their care of this population.

Diagnostic Considerations and Military Process

Self-identifying and deciding to "come out" is the very first aspect of seeking care for gender dysphoria. At least four individuals are involved just to initiate care. A "military medical provider" (hired by the DoD to provide medical care to this population) must make the diagnosis, regardless of previous or current civilian care, a military behavioral health provider confirms the diagnosis and "medical necessity" for transitioning, and both the soldier's commander and a senior medical provider must approve the transition plan before it can be initiated.

After soldier W decided she was ready to initiate the process, she went to her first line supervisor, who appropriately advised her to go to her unit's behavioral health team. There, she was introduced to the local transgender care team (TGCT), which is comprised of three specialties: behavioral health, primary care, and case management. Consistent with other provision of care policies, no providers are asked to provide care if they feel unprepared either by lack of clinical skill or ethical objection. The TGCT can be centralized to a post and is comprised of self-selected individuals who help create and execute local policies and provide care. The overarching document that outlines how care will be provided is DoD Instruction (DoDI) 1300.28, "In-Service Transition for Transgender Service Members" [12], effective since October 1, 2016. A key component of this policy is the need for determination of "medical necessity" of care for gender dysphoria. This ensures that a patient who is healthy enough to serve in the military is not denied care because of how well they are otherwise functioning and would psychologically and emotionally benefit from transitioning. The other unique component is that the patient must be diagnosed by a behavioral health professional working within the military system.

Initial diagnosis and engagement with the TGCT is often facilitated by behavioral health, and in the Army, care is readily available to the patient via their embedded behavioral health clinic, a multi-disciplinary team located within (ideally) walking distance of where the patient works. Since smaller bases may not have Endocrinology within their hospital system, there are regional TGCTs to support multiple locations remotely with endocrine consultation to local primary care providers and a second behavioral health case review to confirm the medical necessity to transition.

When soldier W came forward, she was well versed in recent policy changes and she understood there would be military-specific considerations to her transition; beyond the new policy changes there was also potential difficulty with future duty station options and her ability to deploy with her unit [13•]. Her command wanted to balance her medical care with unit readiness. The patient is responsible for discussing her transition plan with her command. In military medicine, it is not uncommon to discuss medical concerns with the patient's commander to ensure the command understands mission impact while still respecting patient privacy. Contacting someone's employer and openly discussing their medical care is not common medical practice, but in the military, occasions exist where this must occur, and transitioning is one of these instances as it impacts readiness and the overall mission. DoDI 6490.08 "Command Notification Requirements to Dispel Stigma in Providing Mental Health Care to Service Members" guides the "Military Command Exception" to the Health Insurance Portability and Accountability Act Privacy Rule.

Policy thus far has emphasized the role behavioral health providers and endocrinologists play within the diagnosis, development of a treatment plan, and then its execution. But the military serves worldwide, and not every area has ready access to these specialists, laboratory support for monitoring, or unfettered access to a pharmacy formulary. The prioritization of specialists to larger medical centers and limitations of care in remote areas are frustrating to the patient and their commanders. Patients with other diagnoses that require specialist care are either seen in non-military medical centers or moved to a location with the specialist they require. However, for a proper diagnosis of gender dysphoria that starts the process of transitioning, a military medical provider must make it. This automatically limits some access to care, as these patients do not get referred to civilian providers. The authors of this paper would wonder if this, and the close command involvement, leads to further increased stigma associated with a DSM-5 diagnosis.

Soldier W was diagnosed with gender dysphoria because she met more than the minimum criteria as outlined by the DSM-5. She felt there existed incongruence between the outwardly male appearance of her assigned gender at birth and her identified female gender. This incongruence was first recognized when she was in elementary school and found herself identifying in traditional female roles—she enjoyed playing house with other males because she could be the "mother" role. She would also go into her sister's room and wear her dresses and shoes until she was old enough to purchase her own clothing, which she hid in her closet. As an adult, soldier W desired to be identified and treated as her identified female gender. She saw herself as a heterosexual female, which caused relationships with male partners to end if her partner desired to view her as a homosexual male. Soldier W expressed that prior to the policy change regarding open service, she had been hopeless and at times suicidal. These thoughts changed when she came forward to seek treatment.

Once soldier W received a diagnosis of gender dysphoria from a military medical provider and was engaged with her local TGCT, they worked together to develop a plan that outlined her and the endocrinologist's plan for CSHT and an estimated time frame. These treatment plans can be modified as needed based on the patient's wants or needs (such as response to treatment) and as policy is further developed (especially as it relates to surgical care). Coordination of so many different clinicians and obtaining command approval does delay the process of actually starting treatment, especially compared to the civilian sector where there is no additional administrative review layer.

Evaluations

There are published consensuses regarding transgender evaluation and treatment. DoD currently follows the Endocrine Society Clinical Practice Guideline "Endocrine Treatment of Transsexual Persons" published in 2009 and is currently under revision [14]. WPATH has since published the 7th Edition of their "Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People" (SOC) [11••], and there are differences between the two documents. Of note to the Behavioral Health provider, WPATH removed the requirement for psychotherapy prior to the initiation of CSHT. Their recommendation for behavioral health providers treating this population is to have at least a master's degree or its equivalent in a clinical behavioral science field with licensure and training in psychotherapy or counseling. Additionally, the provider should be able to recognize and diagnose coexisting conditions and differentiate these from gender dysphoria, have a fundamental understanding of the topic (to include competency in DSM or International Classification of Diseases verbiage when making the diagnosis) and how to assess and treat gender dysphoria. There is also an expectation to participate in continuing education of the same [11••]. Within the DoD, ongoing education at all levels is being developed and distributed to providers to ensure all have the minimum required training to provide care.

Initial evaluations can help clarify motives and expectations, identify potential psychological changes that will be associated with the physical ones, and assess how this will affect the individual in all aspects of their life. The evaluation should be from a biopsychosocial perspective in order to fully understand the person as a patient, military member, and part of society at large. Specifically for the diagnosis of gender dysphoria, the American Psychiatric Association identifies four "realms of assessment" in their best practice highlights: gender identification, gender role and expression, sexual attraction, and sexual behavior. These four together comprise

the consolidated sexual and gender identity, but sexual orientation and gender identity are not the same and need to be evaluated separately, in conjunction with race and ethnicity, socioeconomic status, religion and spiritual beliefs, etc. [15]. In our case, soldier W saw herself as a heterosexual female, not a homosexual male. Her gender identity is female, her sexual orientation heterosexual. Understanding the patient's view on relationships, previous experiences and ongoing social support can better facilitate the ongoing discussion and treatment planning beyond just making a diagnosis.

Recently there has been a shift to the "affirmative" approach to care, consistent with the American Psychological Association's guidance for evaluation and treatment [16, 17]. This shifts away from psychological testing as a mandatory part of the diagnostic evaluation. Practitioners may find using questionnaires helpful to assess how open the individual is about their trans status, social support, sense of psychological well-being, if the individual is open to seeking treatment, etc. [18] If testing is used, results obtained from standardized metrics need to be viewed in the proper context and with mindfulness of where the individual is in their transition process. The commonly used MMPI-2 will report elevations in "almost every scale" when used in the transgender population [16]. If these findings are inaccurately applied, there is risk of overdiagnosis and further maligning this population. It is better suited for use to monitor progress over time. In one study, it demonstrated an improvement towards health in a population of transgender men who were prescribed testosterone [19], which supports potential utility to monitor progress.

To proceed with treatment, mental health disorders need to be "reasonably well controlled" per WPATH SOC [11••] but the extent of how gender dysphoria contributes to the disorder needs to also be weighed as many symptoms will resolve with appropriate treatment. Given this population is subjected to not only general life stressors but also stressors unique to a minority population—discrimination, violence, isolation, and the ongoing expectation of suffering the same [20•], it is likely co-morbid psychiatric diagnoses are present. During the initial evaluation period, specific attention should also be paid to screening for and treating trauma, as there is a high prevalence of military sexual trauma (15% of one population screened) [21]. Also it is not unnoticed that these patients may have been less than fully truthful with their gender identity up to this point for various reasons, to include when being screened for "pre-existing conditions" as part of their accessions into active service. Further exploration of their untrustworthiness or sociopathy is unhelpful, if solely based on these self-protective behaviors such as enlistment in the military, despite potentially identifying as transgender prior to then. Similar to the "Don't Ask Don't Tell" era, these individuals volunteered to serve, despite signing up to be part of an organization that did not accept them until 2016. There is a risk of further ostracizing the patient if the focus shifts from their desire to transition to questioning honesty and trustworthiness not related to their ability to be compliant with medical recommendations.

For all patients, additional evaluation is required prior to gender-confirming surgeries, in addition to the TGCT evaluation as previously described. The current community standard for gender-confirming surgeries requires 1–2 letters (based on procedure, insurance and/or surgeon) from different mental health professionals unless the patient is receiving care as part of a team. While it is not intended to pathologize the diagnosis or the patient, it has the potential of putting the mental health professional into the role of "gatekeeper"—treatment cannot proceed without this letter writing process. [18] Viewing it from the perspective of ensuring "informed consent" exists prior to performing irreversible procedures that change the physical appearance of someone's gender [22] and the auspice of "do not harm" may be one way of approaching this mandate. Additionally, it can open the possibility of initiating a therapeutic relationship should the need then present itself.

The DSM-5 included gender dysphoria as a diagnosis with the intent to facilitate care, not because there is necessarily serious mental illness—despite experiencing distress being part of the criteria. Members of the military are provided "medically necessary" care, so it is presumed that if a patient is diagnosed with gender dysphoria, they will have a condition that requires treatment. But, simultaneously, this population has been successfully serving without transitioning due to the ban on open service. This creates an inherent disconnect, where the patient has to be functioning well enough for successful military service but in sufficient distress to meet the DSM-5 criteria of experiencing "distress." This apparent contradiction has led to some debate and discussion, especially as distress is highly subjective for both patients and providers.

Like soldier W, patients will often continue to perform well and promote up the ranks before presenting for treatment. This population has been serving quietly without being "out" as a matter of necessity. The authors feel it is unfair to use the criteria of occupational dysfunction as justification to say a transgender patient who wants to transition does not meet criteria for gender dysphoria and therefore no treatment is necessary. Worse, this could be counterproductive because patients either will learn to say what is needed to meet criteria for the diagnosis or become dysfunctional within the unit to "meet" the criteria.

In support of medical necessity, in December 2016, WPATH issued a position statement clarifying this debate. The overarching guidance was that anything that supports consolidation of gender identity (medical, surgical, legal, social) will lead to improved outcomes such as increased overall well-being, improved social functioning, and decreased severity of other psychiatric illness [23]. Both CSHT and gender affirming/confirming surgeries are considered medically necessary and have been evaluated as effective treatment by the

Centers of Medicare and Medicaid Services [24]. While not everyone will have a medical need for all of the potential interventions, WPATH's Board of Directors wrote sufficient evidence that treatments that are "properly indicated and performed as provided by the SOC have proven to be beneficial and effective." Further, WPATH clearly stated that these surgeries are not "cosmetic," "elective," or "for the mere convenience of the patient" [25].

As an aside, compared to the general active duty military population, the military veterans have a unique history of experiences that need to be considered in their evaluation and treatment planning, since those who are post-transition will have experienced military service in their natal gender. Women may have been much more likely to serve in combat as men, and men will have had different experiences serving as women. It is important to ensure assumptions and conclusions about experiences are not made due to this shifting of gender identity that existed, as open service was not previously allowed. Veteran populations have ongoing concerns that revealing their true gender identity will still place them at risk for losing health care benefits and may delay seeking care as a result [26].

Treatment

Ideally, treatment should begin before the diagnosis of gender dysphoria is made. This population is a population at risk and inherently reluctant to engage with health care providers due to previous experience many have had with inexperienced or biased individuals. Many providers have not been active in the care of this population, and there is a presumption that the provider will lack understanding about the diagnosis and life stressors, have an inability to ask questions, and, instead, will make assumptions or avoid the topic altogether due to ignorance or being uncomfortable [27]. Like any other provider-patient relationship, in order to facilitate treatment, a supportive environment must be created. In a military treatment setting, a full assessment similar to other chief complaints, with prioritization of identified problems and goal setting for care, can be accomplished similar to other initial intake appointments.

A significant difference between the Endocrine Society's Clinical Practice Guidelines published in 2009 [14] and WPATH SOC [11••] is the requirement by the Endocrine Society for 3 months psychotherapy or real-life experience. It was in the transition from the 6th edition to the 7th edition in the Standards of Care where the requirement for psychotherapy was removed because this population faces a significant amount of discrimination and mandating psychotherapy was thought to be reinforcing the belief that there is a psychiatric illness that needs to be treated. Additionally, to force real-life experience (RLE) before an individual is fully ready can lead to increased harassment, discrimination, and violence against the individual. It also reinforced the belief that the transgender community had to prove themselves to have the diagnosis, and diminished the therapeutic relationship much like any other mandated treatment session. Even the requirement for "full-time RLE" post-transition can be precarious because this determination is made in the context of a wide variety of gender expression and perpetuates a binary gender system that can place additional stressors on the patient. Instead of living their expressed gender experience, patients may feel obligated to express rigid gender stereotypes of their identified gender. In some patients, subsequent psychiatric symptoms developed as a result of the requirements developed with the intention of supporting them. So in a community that has high risk for depression and anxiety symptoms, adding a barrier to access mental health is counterproductive.

Consistent with that philosophy, psychotherapy is not mandated in the military patient seeking to transition. However, it is strongly recommended through all aspects of transitioning. Fortunately, patients have access to psychotherapy because in the military all active-duty cases are approached with a multidisciplinary team model within the Embedded Behavioral Health Clinics and these cases are no different [28]. In fact, multiple appointments may be required for the entire picture to be developed. Providers are encouraged to consult with colleagues as clinically indicated. Ongoing psychotherapy can be a support mechanism for the management of pre-existing conditions and navigating new challenges that may not have been anticipated. It can also be the start of education and exploration of options for transitioning.

In the case of soldier W, her behavioral health appointments helped explore her understanding about potential treatment options, cross-sex hormone therapies, "top" and "bottom" surgeries, changes in legal documentation, and, ultimately, reaching the point of living full time in her identified gender, after the military's personnel system has been changed to reflect the same.

It is important that patients like soldier W understand the options they have moving forward. CSHT is the main aspect of treating gender dysphoria, beginning the transition to the identified gender. But this is not a treatment that all will choose, and some may have medical contraindications that prevents them from receiving CSHT. When CSHT is used, it is proven to improve outcomes in mental health from reduced symptoms of anxiety and depression to improved quality of life [29•]. The process for obtaining CSHT and other gender-confirming care in the military is more complicated than in the civilian sector. Still, similar to the civilian sector, many military patients are interested in and will initiate CSHT.

Soldier W wanted to start with CSHT. After meeting with behavioral health and confirming the diagnosis and medical necessity to transition, she then met with a primary care provider (internal medicine in this instance) and a case manager to develop her treatment plan. Both someone in her military leadership chain (the Brigade Commander) as well as a senior

leader in the hospital leadership approved the treatment plan before it could be initiated. The military leadership cannot say "no" to a treatment plan, but based on mission requirements, they do have the ability to say "not now" and delay transitioning until a deployment or significant training event is over. (Anecdotally, when patients are given the choice to serve or to transition, many do choose to serve first and transition after returning from deployment.)

Surgical changes are a more individual decision, and cost can be a significant factor. Not all insurance companies are currently covering all surgeries, and as of this writing, ongoing discussion is occurring regarding coverage for the active-duty service member. As in the case of CSHT, improved outcomes are seen when the phenotype is consistent with the identified gender, which is often fully achieved through gender affirming surgery. For example, as a male during the summer, it is common to go without ones' shirt on—however, as a transgender male who has not yet had a subcutaneous mastectomy (creation of a male chest) this societal norm is interfered with due to persistent presence of breast tissue [30].

Once the treatment plan had been approved, soldier W saw Endocrinology for initiation of hormone therapy in accordance with the developed plan. It can take a few months between having the diagnosis made and starting CSHT due to these additional administrative hurdles. As of the paper's publishing, soldier W has not made a determination regarding additional surgeries. The recommendation is a minimum of 12 months (per WPATH) on hormonal therapy before considering breast augmentation (which is generally considered cosmetic). She is exploring her options and desire regarding fertility before making a decision for gonadectomy. Keeping with WPATH's 7th Edition of Standards of Care recommendations, she needs to be on 12 continuous months of hormone therapy and 12 continuous months of living full time in her identified gender for before considering sex-reassignment surgery (and there is no current policy for active military members to have this surgery).

Having legal identification in the assigned gender is currently viewed as the "end" of a treatment plan. There are administrative aspects to this within the military system, similar to any other name change that occurs such as in cases of marriage or divorce. Once the gender marker is changed, the patient will be expected to meet body composition and physical fitness standards of their gender and utilize the appropriate berthing facilities.

DSM-5 has included the annotation of "post-transition" for gender dysphoria to indicate these patients are currently living in their identified gender but need ongoing treatment for this diagnosis in order to be able to maintain their current functioning. CSHT will likely continue and medically necessary gender-confirming surgeries as well as optional surgeries generally considered to be cosmetic in nature may occur in this post-transition period. The active-duty military member will return to being able to support a worldwide mission consistent with their specific job.

Patient W looks forward to continuing to serve her country in a field she immensely enjoys with an improved sense of self secondary to receiving treatment for her gender dysphoria.

Conclusions

In this article, we have attempted (through description of a typical case) to describe gender dysphoria and how it is currently being evaluated and treated in the military medical system. There have been similar shifts in the history of DSM development where disorders were once regarded as pathological, such as homosexuality, and later removed as a focus on treatment. Conversion and reparative therapies are widely recognized by leading organizations as ineffective and potentially harmful. The diagnostic shift from gender identity disorder to gender dysphoria continues to embody this trend—these individuals are experiencing a variation of normal human experience rather than a pathological disorder or disease process. The military system is in place to ensure appropriate treatment plans to support both the patient and the command team needs—proceeding with cross-sex hormones and surgeries does have an impact on unit readiness, and while there are times when cisgender soldiers have similar procedures (such as a gynecomastia surgery in a male), these, too, are scheduled around mission requirements. We have emphasized that the verbiage of "dysphoria" does not equate to non-functional, severely impaired, or grossly unstable. Rather, it is the inner turmoil an individual experiences when their natal gender and identified gender are not one and the same. The transgender population volunteers for military service almost twice that of the general population, but are at equal or greater risk of being cared for by health care providers with little to no experience working with the population [10]. We recommend ongoing discussion and training, incorporating best practices used in civilian facilities that have a high volume of transgender patients. It would be helpful to consolidate data about the patients who are presenting for initial evaluation and medical transition across the military services to assess for commonalities and differences in order to better resource and support this minority population. Prospective research regarding their military service, concomitant medical and behavioral health diagnoses, response to treatment, and exploration of how transitioning while on active duty can affect progress through rank and leadership positions will help in further integration of this population both in the military and society at large.

Acknowledgements The views expressed in this document are those of the authors and do not reflect the official policy of William Beaumont Army Medical Center, the Department of the Army, or the United States Government.

Compliance with Ethical Standards

Conflict of Interest Shannon C. Ford and Carla Schnitzlein declare that they have no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

References

Papers of particular interest, published recently, have been highlighted as:
- • Of importance
- •• Of major importance

1. Carter A.. Memorandum for secretaries of the military departments. Transgender service members. https://www.defense.gov/Portals/1/features/2016/0616_policy/memo-transgender-service-directive-28-July-2015.pdf. 2015.
2. Belkin A. Caring for our transgender troops–the negligible cost of transition-related care. N Engl J Med. 2015;373(12):1089–92.
3. Delegates AMAHo. Revised Resolution 011 (A-15). Military medical policies affecting transgender individuals. http://archive.palmcenter.org/files/A-15Resolution 011.pdf
4. Gates GJ, Herman J. Transgender military service in the United States. https://escholarship.org/uc/item/1t24j53h: The Williams Institute UCLA. 2014.
5. Elders MJ, Brown GR, Coleman E, Kolditz TA, Steinman AM. Medical aspects of transgender military service. Armed Forces & Society. 2014;I-22:1–22.
6. Association AP. Diagnostic and statistical manual of mental disorders. 5 ed Washington, DC. 2013.
7. James SE, Herman JL, Rankin S, Keisling M, Mottet L, Anafi M. Executive summary of the report of the 2015 U.S. transgender survey. Washington, DC: National Center for Transgender Equality; 2016.
8. Grant JM, Mottet LA, Tanis J, Harrison J, Herman JL, Keisling M. Injustice at every turn: a report of the National Transgender Discrimination Survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force; 2011.
9. Henry JL. A transgender military internist's perspective on readiness for treating patients with gender dysphoria. JAMA Intern Med. 2017;177(5):729–30.
10. Schvey NA, Blubaugh I, Morettini A, Klein DA. Military family physicians' readiness for treating patients with gender dysphoria. JAMA Intern Med. 2017;177(5):727–9.
11. •• Coleman E, et al. Standards of care for the health of transsexual, transgender, and gender-nonconforming people. 7 ed. http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926 World Professional Association for Transgender Health; 2012. 220 p. **Worldwide standards and treatment guidance.**
12. 11.28 DoDID. In-Service Transition for Transgender Service Members. October 1, 2016.
13. • Folaron I, Lovasz M. Military considerations in transsexual Care of the Active Duty Member. Mil Med. 2016;181(10):1182–6. **One of the few articles about care for the transgender service member in the military setting**
14. Hembree WC, Cohen-Kettenis P, Delemarre-van de Waal HA, Gooren LJ, Meyer WJ, Spack NP, et al. Endocrine treatment of transsexual persons: an Endocrine Society clinical practice guideline. J Clin Endocrinol Metab. 2009;94(9):3132–54.
15. Cabaj RP. Best practice highlights lesbian, gay, bisexual, transgender and people who may be questioning their sexual orientation or sexual identity (LGBTQ) https://www.psychiatry.org/psychiatrists/cultural-competency/treating-diverse-patient-populations/working-with-lgbtq-patients [Brochure].
16. Keo-Meier CL, Fitzgerald KM. Affirmative psychological testing and neurocognitive assessment with transgender adults. Psychiatr Clin North Am. 2017;40(1):51–64.
17. Association AP. Guidelines for psychological practice with transgender and gender nonconforming people. Am Psychol. 2015;70(9):832–64.
18. Budge SL. Psychotherapists as gatekeepers: an evidence-based case study highlighting the role and process of letter writing for transgender clients. Psychotherapy (Chic). 2015;52(3):287–97.
19. Keo-Meier CL, Herman LI, Reisner SL, Pardo ST, Sharp C, Babcock JC. Testosterone treatment and MMPI-2 improvement in transgender men: a prospective controlled study. J Consult Clin Psychol. 2015;83(1):143–56.
20. • Hendricks ML, Testa RJ. A conceptual framework for clinical work with transgender and gender nonconforming clients: an adaptation of the minority stress model. Professional Psychology: Research and Practice. 2012;43(5):460–7. **Provides a different model for conceptualizing this population as they are engaged in care**
21. Lindsay JA, Keo-Meier C, Hudson S, Walder A, Martin LA, Kauth MR. Mental health of transgender veterans of the Iraq and Afghanistan conflicts who experienced military sexual trauma. J Trauma Stress. 2016;29(6):563–7.
22. Murphy TF. Should mental health screening and psychotherapy be required prior to body modification for gender expression? AMA J Ethics. 2016;18(11):1079–85.
23. Position statement on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A. [press release]. https://s3.amazonaws.com/amo_hub_content/Association140/files/WPATH-Position-on-Medical-Necessity-12-21-2016.pdfDecember 21, 2016.
24. Summary of clinical evidence for gender reassignment surgeries https://www.cms.gov/Medicare/Coverage/DeterminationProcess/Downloads/Kalra_comment_01022016_b.pdf: Centers for Medicare and Medicaid Services; 2016.
25. WPATH position statement on medical necessity of treatment, sex reassignment, and insurance coverage in the U.S.A. [press release]. 21 December 2016.
26. Brown GR, Jones KT. Mental health and medical health disparities in 5135 transgender veterans receiving healthcare in the Veterans Health Administration: a case-control study. LGBT Health. 2016;3(2):122–31.
27. Winter S, Diamond M, Green J, Karasic D, Reed T, Whittle S, et al. Transgender people: health at the margins of society. Lancet. 2016;388(10042):390–400.
28. Johnson L, Shipherd J, Walton HM. The psychologist's role in transgender-specific care with U.S. veterans. Psychol Serv. 2016;13(1):69–76.
29. • Costa R, Colizzi M. The effect of cross-sex hormonal treatment on gender dysphoria individuals' mental health: a systematic review. Neuropsychiatr Dis Treat. 2016;12:1953–66. **Evidence-based findings supporting medical necessity for care**
30. Bluebond-Langner R, Berli JU, Sabino J, Chopra K, Singh D, Fischer B. Top surgery in transgender men: how far can you push the envelope? Plast Reconstr Surg. 2017;139(4):873e–82e.