Chapter 13
The Health Psychologist Role in Providing Services to Transgender Veterans

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1 General Overview of Population

Understanding the experience of transgender and gender-nonconforming (TGNC) veterans requires examining the fluctuating policies and work culture of the environment in which they serve. Internationally, openly transgender individuals' military service remains a rarity; as of 2017, only 19 nations allow transgender individuals to serve openly, including the United States (CBC, 2017). In the United States, transgender individuals were banned from serving openly until 2016, even though "Don't Ask, Don't Tell," which allowed lesbian, gay, bisexual service members to serve openly, was repealed in 2011 (The White House Office of the Press Secretary, 2011). Despite a long history of discrimination, transgender adults serve in the US military at significantly higher rates than their cisgender counterparts; research estimates that transgender adults comprise 22.9% of the veteran population, whereas prevalence rates in the general adult population are 4.3% (Blosnich et al., 2013).

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1.1 Early Experiences of Transgender Veterans in the Military

During the Civil War, an estimated 250–400 women served in the military disguised as men, although the exact number is debated among scholars (Blanton & Cook, 2002). Fear of social repercussion led some of these soldiers to minimize the extent to which they presented as male while in the military, making estimates all the more difficult. In their extensive study on women in the Civil War, DeAnne Blanton and Lauren Cook describe this research area as "the best-kept historical secret of the Civil War" (2002, p. 7). Several of these soldiers continued to live as male even after completing their military service and were only discovered after undergoing emergency medical treatment or, in other cases, after their death. While some of these examples may simply reflect a desire to maintain a level of independence only offered to men, many scholars posit that at least some of these soldiers would be considered transgender. This period of history offers a fascinating and portentous glimpse into how gender normativity impacted early American soldiers' experiences. For the next century, there was no explicit ban against transgender military service. In the 1960s, however, formal prohibitions were enacted against LGBT service members (Somashekhar & Whitlock, 2015). In the 1980s, several lawsuits emerged in which the military successfully defended their ban on transgender service members (i.e., Doe v. Alexander, 510 F. Supp. 900, 1981).

1.2 Repeal of Transgender Ban

In 2014, the independent research program Palm Center, affiliated with Francisco State University, released its findings that the ban on transgender troops was both medically unsupported and inconsistent with military values (Palm Center, 2014). In 2015, the Pentagon announced that it would allow transgender individuals to openly serve in the military and formulate plans to allow open service (Somashekhar & Whitlock, 2015). With increased support from medical and mental health experts, the ban on transgender service members was officially lifted on June 30, 2016 (Directive-Type Memo 16-005; Secretary of Defense, 2016). This policy reverted when the Trump administration announced that with consultation from military experts, the US military would no longer allow transgender individuals to serve in the military. After the announcement via Twitter, several lawsuits challenged the policy change, and in January 2018, transgender individuals were allowed to serve again. Two months later, the Trump administration reinstated the military ban, and transgender individuals could no longer serve except under certain circumstances (Zucker, 2018). The order disqualified any individual with gender dysphoria, who had either completed a gender transition or was taking hormones to enlist in the military. Transgender military members diagnosed with gender dysphoria and gender non-conforming members were required to serve in their assigned sex at birth. They were not permitted to take hormones or receive gender reassignment surgery during their time in the military (Gomez, 2019).

1.3 Reinstatement of Transgender Ban

On March 12, 2019, the Department of Defense signed a memorandum that effectively banned most transgender individuals from service or enlistment in the United States Armed Forces (Office of the Deputy Secretary of Defense, 2019). This policy retracted many of the rights extended during the Obama administration; it did not retreat to the more restrictive policies of the past. Service members whose transition was completed before the ban could continue to serve, as could individuals who identified as transgender but were willing to continue serving in their biological sex. Recruiters were cautioned that "the new policy is NOT a ban on the accession of transgender persons" (United States Military Entrance Processing Command, 2019), and noted that individuals were not required to hide their gender identity. Despite framing the change as minimally impactful, the policy effectively stymied recruitment of openly transgender service members and prevented existing service members from engaging in any form of transition. For example, under this new policy, service members were held to the standards of their biological sex (Office of the Deputy Secretary of Defense, 2019). New recruits could not have undergone sex reassignment procedures or gender confirmation surgery (Office of the Deputy Secretary of Defense, 2019). This policy was met with protests from the transgender community. Legally, the policy was first challenged by a naval officer who faced discharge for seeking to transition (Richer, 2020). Other lawsuits followed, as well as proposed legislation to reject the ban on transgender military service. As of early 2020, there were four legal cases (Doe v. Trump, Stockman v. Trump, Stone v. Trump, Karnoski v. Trump) seeking to overturn the transgender ban. These lawsuits were first filed in 2017. A 2019 Gallup Poll found that over 70% of US Americans favored transgender persons serving in the military. Many states have also expressed their support of transgender military persons (Transgender, 2020).

As this review of US policy demonstrates, transgender service members have served under hostile and uncertain circumstances. Transgender veterans felt a sense of hope after the ban was lifted in 2016, such as Captain Sage Fox of the US Army Reserves, who stated, "It's going to go through and send a message to the rest of the world that the US isn't behind everyone, that we do care about human rights" (Rizzo & Cohen, 2016). The sudden reversal of these rights under President Trump continues the historical trend of utilizing transgender service members in service, without providing them the rights afforded their cisgender counterparts. Despite these challenges, some research indicates that transgender veterans experience lower rates of depression and greater health-related quality of life than their non-veteran counterparts, a finding which may reflect the resilience and post-traumatic growth of these veterans (Hoy-Ellis et al., 2017).

1.4 Transgender Care Within the Veterans Health Administration

The Veterans Health Administration (VHA) instructs staff to provide health care to transgender Veterans "in a manner that is consistent with their self-identified gender identity" (Department of Veterans Affairs, 2020). In addition to protection against discrimination during treatment, this directive provides veterans the right to change their name in the medical record to reflect their preferred name and pronouns. More recently, the VHA provided veterans the option to list their "birth sex" and "self-identified gender identity" in their medical records. Additionally, this directive protects the rights of transgender Veterans to utilize bathrooms consistent with their gender identity.

Regarding medical and mental health care, veterans are offered a range of specialty services, and each VA facility is required to have a local LGBT Veteran Care Coordinator to promote comprehensive, best-practice care (Department of Veterans Affairs, 2020). Veterans have access to hormone replacement therapy, pre-operative assessments, vocal coaching, and medical prosthetics. However, Veterans are still unable to receive gender-confirming surgery through the VA, nor will the VHA cover medical expenses for these procedures (Department of Veterans Affairs, 2020). Mental health treatment, including couples, individual, and group psychotherapy, and pre-operative psychological assessments, are also provided.

2 Transgender Health

TGNC veterans have historically faced health and social disparities, including financial challenges and reduced medical and mental health outcomes (Beckman et al., 2018; Carter et al., 2019). These discriminatory experiences extend beyond health care to employment and housing (Lehavot et al., 2016). Transgender veterans represent a highly marginalized subpopulation within the military and civilian populations. The US Department of Veteran Affairs (VA) reported a higher prevalence of transgender individuals than any other US general population (Beckman et al., 2018; Blosnich et al., 2016; Lehavot et al., 2016; Tucker et al., 2019). More specifically, VA records indicate that between 2000 and 2011, the number of individuals diagnosed with gender identity disorder was over five times higher for veterans than the general civilian population (Tucker et al., 2019). The Williams Institute at the University of California at Los Angeles (UCLA) conducted a study in 2014 and estimated almost 16,000 transgender individuals in either the active-duty military, Guard, or Reserves. Also, there were over 134,000 transgender veterans. Based on these large numbers, the Veterans Administration opened specialty transgender clinics in Cleveland, Ohio and Tucson, Arizona. There are large health disparities in the transgender population when compared to their cisgender counterparts, which has led to the National Academy of Medicine calling for increased research focused on

the variables that contribute to the health differences found in transgender persons (Bukowski et al., 2017).

2.1 2015 US Transgender Survey

The National Center for Transgender Equality conducted an anonymous online survey for transgender adults (age 18 and older; English and Spanish versions). It was one of the most extensive surveys to take a more in-depth look into the lives and experiences of 27,715 transgender individuals from the United States, including the District of Columbia, Guam, Puerto Rico, American Samoa, and overseas US military bases. The US Transgender Survey (USTS) revealed extensive discrimination and disparities related to employment, housing, family/community support, and accessing health care (James & Herman, 2017).

2.2 Housing

In 2009, the United States Interagency Council on Homelessness declared efforts to eliminate homelessness among veterans by 2015. Consequently, according to the US Department of Housing and Urban Development (HUD), the overall veteran population's national rates of homelessness decreased by nearly 50% (Carter et al., 2019). Furthermore, the number of veterans who identified as transgender increased by almost 90% between 2015 and 2018. While homelessness was generally trending downward, transgender veterans experienced difficulties with housing at rates two times higher than others (Carter et al., 2019). Furthermore, Carter and colleagues found that transgender veterans were more likely to experience housing instability if they were White, unmarried, younger, and women (Carter et al., 2019). Overall, the transgender population is less likely to own a home, and up to one-third of the population has experienced homelessness during their lifetime (James & Herman, 2017).

2.3 Employment

Based on the 2015 US Transgender survey, another gap is economic hardship. At the time of the US Transgender survey, the transgender unemployment rate (15%) was three times larger than the general US population (5%). Transgender individuals with disabilities faced a higher unemployment rate of 24%, and approximately 45% lived below the poverty line. In a 2015 national survey, 15% of transgender respondents indicated harassment (verbally, physically, sexually) at their place of employment in the last year (Beckman et al., 2018). In the 2010 National Transgender

Discrimination Survey, 90% of respondents reported discrimination or harassment at their jobs across their lifetime (Beckman et al., 2018). Particular concerns arose from dealing with the stigma and distress in concealing their gender identity to maintain employment and retirement benefits. Other relevant employment issues include forcibly using a restroom that did not match their gender identity, denial of promotion, and private information shared with others without their consent (James & Herman, 2017). Of note, protective factors include living in a state with hate crimes and employment discrimination protections (Blosnich et al., 2016).

2.4 Health Care Utilization

Fears of discrimination and stigmatization related to their distress and disorder by health care professionals often deter individuals from seeking health services. Thus, health care utilization is often much lower in transgender populations (Aboussouan et al., 2019; Ruben et al., 2019). Reduced utilization tends to lead to an increase in serious health implications and lower life expectancy. Seelman et al. (2017) found that transgender individuals had worse overall health in the last month than those who immediately sought medical attention. The delay in seeking help was due primarily to fear surrounding how health care providers may see them and noninclusive care from medical staff. TGNC persons often have difficulty openly sharing their gender identity without being questioned or attacked or addressed with incorrect pronouns.

Furthermore, many transgender people expressed fear they would receive substandard care. They shared they were scared their health may be compromised, and that they may continue to be poorly treated.

Medical care settings are often perceived as more discriminatory than other settings and resources, such as employment or housing (Ruben et al., 2019; Seelman et al., 2017; Xavier et al., 2007). Transgender persons with disabilities reported higher mistreatment rates by their medical providers in the 2015 US Transgender Health Survey. Furthermore, individuals who sought gynecological care, hormone therapy, or surgery were at an increased likelihood to experience discrimination than transgender individuals who did not reveal their transgender status or those who were not pursuing gender reassignment surgery (Seelman et al., 2017). Thus, TGNC individuals tend to have a negative perception of health care providers, which leads to other concerns, such as non-engagement in health care screenings, lower or missed opportunities for health education, and overall poorer health (Ruben et al., 2019).

In a 2011 survey of 6000 transgender people, roughly one-fifth of the respondents indicated they were refused health care due to their transgender or gender non-conforming status. One-third postponed necessary medical care when they were either injured or sick (Legal, 2016). In another study conducted in 2010, 70% of transgender respondents shared they had one or more of the following experiences with providers who:

1. Refused to touch transgender patients or used excessive precautions
2. Used abusive or harsh language
3. Blamed the transgender patient for their health concern and
4. Were physically rough or abusive with the transgender patient

Furthermore, transgender respondents indicated rude and inappropriate behavior by health care professionals, which included laughing and mockery, HIPAA violations, unusually long waits for care, inappropriate questions and exams, and failure to follow established standards of care (Legal, 2016). Seeking medical care may be a daunting task, and when it is coupled with discriminatory experiences, transgender patients are deterred by fields of care that are designated to serve and help those in need.

2.5 Suicide Risk

Considering the impact of minority stress, transgender patients are much more likely than the general population to experience suicidal ideation and make suicide attempts. Of particular concern are those who engage in NSSI (non-suicidal self-injury) and other suicidal-related behaviors. According to Van Orden et al.' (2010) interpersonal theory of suicide, they discuss the concept of thwarted belongingness, which is a phenomenon in which an individual possesses unmet needs to belong. Thwarted belongingness, perceived burdensomeness, and associated hopelessness collectively increase an individual's suicidal ideation and behaviors. Transgender individuals experience an array of psychosocial vulnerabilities, which contribute to unmet needs, disheartenment, and hopelessness; thus, transgender veterans experience higher rates of suicidal ideation, attempts, and completion.

Research has found that veterans with gender-identity dysphoria are at increased likelihood of experiencing suicide-related events (20 times the rate of general VA population) (Blosnich et al., 2013). A national transgender study found that roughly 40% of transgender individuals indicated a past suicide attempt, which is significantly higher than the 3% that is reported among the general population (Blosnich et al., 2016; James et al., 2016; Lehavot et al., 2016). In a sample of 212 transgender veterans, 57% of veterans reported struggling with suicidal ideation within the last year, 34% reported having a suicide plan during their lifetime, and 32% had made a suicide attempt (Lehavot et al., 2016). Interestingly, while transgender veterans had lower rates of NSSI, they were more likely to be hospitalized than the transgender non-veteran population (Aboussouan et al., 2019). Furthermore, 41% of those who endorsed NSSI also indicated a history of suicide attempts, and 86.7% indicated suicidal ideation (Aboussouan et al., 2019). It is unclear why the rates are lower, but it may be attributed to military culture and resistance in disclosing mental health concerns.

- Transgender veterans are more likely to die by suicide (Blosnich et al., 2014).
- Transgender veterans are at 20 times higher risk of suicidal ideation (SI) and suicide attempt (SA) than the general veteran population (Blosnich et al., 2013).
- In a study sample, two-thirds of transgender veterans reported planning their death during their lifetime (Tucker et al., 2019).
- Transgender veterans die by suicide at an earlier age (49) than cisgender veterans (Blosnich et al., 2014).
- History of SI was reported by 61% of transgender veterans (57% reported in the last year; 11–32% reported one or more suicide attempts) (Lehavot et al., 2016; McDuffie & Brown, 2010).

2.6 Mental Health

Along with suicide risk, many indicated other mental health problems. The three most common diagnoses were mood disorders, substance use disorders, and post-traumatic stress disorder (PTSD) (Blosnich et al., 2016). In a study by Blosnich et al. (2016), transgender individuals who resided in states that enacted employment nondiscrimination protection had lower prevalence rates of mood disorder (54% vs. 46%) and lower rates of self-injurious behaviors. The researchers found that a history of homelessness, perceived military stigma, and current depression and PTSD symptoms were correlated with past year suicidal ideation and lifetime suicide plans and attempts.

Access to care has significantly improved in recent years. As of 2017, the VA reported that approximately 5000 transgender Veterans are engaged in VA health care (Cramer, 2017). The utilization of VA services by transgender Veterans increased dramatically in the 2 years following a 2011 VHA directive requiring the provision of medically necessary care (Kauth et al., 2014). While veterans generally report high levels of satisfaction with the VA, transgender veterans encounter unique risk factors that impact their VA experience. In a recent study on the experience of transgender veterans in the VA, 79% of respondents reported satisfaction with their medical care, whereas 69% reported satisfaction with their mental health care (Lehavot et al., 2017). Notably, this study found that dissatisfaction was associated with lower income and being a transgender male veteran.

2.7 Sexual Assault and Associated Health Concerns

Military sexual assault (MSA) encompasses penetrative acts of sexual assault, which does not include physical assault or sexual harassment. Military sexual trauma (MST) is a broader concept that includes physical assault and/or battery of a sexual nature and sexual harassment that occurred while on active duty (Beckman

et al., 2018). Lindsay et al. (2016) found in a sample of 332 transgender veterans that nearly one in five transmen screened positive for military sexual trauma (MST) and one in seven transwomen. For transgender veterans, many experienced physical and sexual violence perpetrated by their peers (Beckman et al., 2018; Bukowski et al., 2017). Close to one-fourth of transgender people experience a form of violence motivated by gender bias and discrimination, and close to half were sexually assaulted during their lifetime (Beckman et al., 2018). Sexual assaults started as early as grade school (K-12) as these persons openly identified as transgender or appeared to others as transgender (13% of 2015 US Transgender Survey).

Studies have found that those with histories of MST had a higher prevalence of mental health disorders, especially depression, anxiety, and PTSD. Older transgender individuals are more likely to suffer from poorer health than cisgender individuals of the same age and report more significant perceived stress (Fredriksen-Goldsen et al., 2014). Transgender and gender non-conforming (TGNC) individuals may also struggle with body image concerns and eating disorders as transwomen may seek a slimmer figure or transmen may try to reduce their hip to shoulder ratio (Goldberg & Ashbee, 2006).

HIV/AIDS is another factor to consider as the TGNC population, mainly transwomen have high rates of the disease (De Santis, 2009). According to the 2015 US Transgender Survey, respondents were five times more likely than the general US population to be living with HIV (1.4% vs. 0.3%). HIV rates were much higher for transgender women, especially Black transgender women (19%). These findings are consistent with the 2008 study conducted by Herbst and colleagues, who found that 27.7% of male-to-female individuals acquired HIV/AIDS across a meta-analysis of four studies, with the highest rates being found among African American transwomen at 56.3%. Researchers wrote that these numbers could be explained by higher rates of unprotected sex, sex work, and substance use, which may be used to cope with minority stress or reflect efforts to survive.

2.8 Support

The 2015 US Transgender Survey explored family and community support among the transgender population. They found that 60% of respondents reported their immediate family was generally supportive, 22% indicated their family was neither supportive or unsupportive, and 18% shared their family was unsupportive of their transgender status. One-tenth of the respondents reported they experienced violence from a family member because they are transgender, and 8% stated they were forced to leave their home. Almost one-fifth of the survey participants left their spiritual/religious community due to the rejection of their transgender status. However, almost half of those respondents indicated they later found another spiritual/religious community where they felt welcomed and accepted. Overall, they found that transgender persons with supportive family members were less likely to be homeless, attempt suicide, and experience significant psychological distress.

3 Male to Female (MTF) and Female to Male (FTM) Transgender Veterans

The transgender population consists of male to female (MTF) and female to male (FTM) persons. Studies have shown that there are qualitative differences between these two subpopulations. The following are general distinctions between MTFs and FTMs:

- MTF group tended to transition at a later age than FTMs. The average age of transition for FTMs was 23 years.
- While MTFs were less educated than FTMs, they indicated higher yearly incomes.
- Due to transgender discrimination, MTFs are more likely to be fired from their employment.
- While FTMs experienced less job discrimination, they were more likely to lose housing and become homeless.
- FTMs are more likely to have children living with them and less likely to have biological or adopted children.

Regarding health and sexual practices:

- MTFs were more likely to receive transgender hormonal therapy and, most likely, from someone other than a medical doctor.
- MTFs are more likely to undergo genital sex reassignment surgery and cosmetic surgery.
- FTMs are more likely to be either uncomfortable or very uncomfortable revealing their transgender status and engaging in discussion with their health care provider when compared to MTFs.
- Approximately half of MTFs with primary partners never used condoms or other forms (protective barriers), whereas almost one-quarter of MTFs tend to use a form of protection consistently.
- Slightly over half of FTMs with primary partners tend not to use condoms or other protective barriers, whereas one-fifth tend to use a form of protection consistently.
- One-tenth of MTFs with other partners outside their primary partner rarely use protection.
- MTFs who shared they were HIV positive also indicated that the primary source of infection was unprotected sex with a non-transgender man (nearly 90%).
- FTMs strongly indicate they need transgender-sensitive gynecological care, but only one-third reported actually receiving transgender-sensitive gynecological care.
- FTMs rate the quality of transgender care services and provider sensitivity consistently lower than MTFs.

Mental health needs and concerns:

- FTMs are more likely to be physically attacked and sexually assaulted than MTFs.
- FTMs experienced higher rates of SI. Of note, there were little difference in rates of suicide attempts between MTFs and FTMs.
- FTMs reported higher rates of drug use and tobacco use and earlier age of first drug use.

3.1 Veteran MTFs and FTMs

When explicitly examining transgender veterans, military transgender men were more likely to experience military sexual assault than transgender women (30% MTF vs. 15.2% FTM), with an overall rate for transgender veterans at 17.2% (Beckman et al., 2018). Upon further examination, it was found that transgender men were more likely to be diagnosed with post-traumatic stress disorder and a personality disorder, specifically for those who have experienced military sexual trauma (MST). On the other hand, transgender women who have experienced MST were more likely to be diagnosed with PTSD, personality disorder, depressive disorder, and bipolar disorder. Additionally, when military transgender individuals were divided by ethnicity (white, non-Hispanic, or ethnic minority), they found that 50% of transgender men and nearly 20% of transgender women identified as an ethnic minority (Beckman et al., 2018; Lindsay et al., 2016). Thus, treatment and assessment need to include cultural sensitivity alongside inclusive, transgender-sensitive care.

4 Treatment Considerations

4.1 Minority Stress Model

The Minority Stress Model (MSM) identifies various types of stressors unique to an individual's minority identity. There are *distal minority* stressors, which are discriminatory and prejudicial events that occur in one's environment. *Proximal minority* stressors are characterized as internal processes. For transgender individuals in the military, distal minority stressors may include events such as losing housing or employment, being interrogated about their gender identity, or being forced into psychological treatment. Proximal minority stressors for this population take into account their stress, anxiety, and concern about how others may perceive them, or the immense amount of energy consumed in concealing their gender identity. This model suggests that overarching, general life stressors may influence both distal and proximal stressors. Thus, as transgender veterans not only navigate specific

stressors related to their gender identity, they also face daily life stressors, which create unique vulnerabilities and predispositions to illness, disease, and mental health disorders (Beckman et al., 2018). For example, these stressors contribute to the increased likelihood of suicidal ideation and military sexual trauma. The Minority Stress Model may help practitioners identify and understand existing health, housing, and employment disparities among the transgender population. As mental health practitioners actively engage with this population, it is imperative also to recognize their internalized stigmatizing beliefs and shame (Lehavot et al., 2016; Tucker et al., 2019). The Minority Stress Model also suggests that social support and an influential community connection act as a protective factor to a variety of problems.

4.2 Responding to Transgender Clients

The discrimination against transgender clients by providers violates human rights and the law. Mental health professionals are expected to uphold high standards of care and excellence and to do no harm (APA ethics). This means implementing and following standards of care that are respectful, sensitive, and inclusive. It is essential to be aware of workplace policies and procedures and to keep your eyes open. If you witness acts of discrimination, it is crucial to speak up or report the incident to your supervisor, employer, or human resources department. If you are unsure, seek guidance and consultation with another professional, your supervisor, human resources, licensing board, or a lawyer. Additionally, mental health providers should examine their own biases and seek avenues to challenge their personal and professional beliefs and educate themselves on culturally sensitive practice. Learning and discussing anti-discriminatory practices are a part of a lifelong journey that will positively serve both yourself and patients.

5 Intake and Clinical Interview

Transgender and gender-nonconforming (TGNC) patients may seek psychological services for various reasons, whether to address concerns that any patient may bring to treatment, such as depression or anxiety, or more specific problems, like discrimination or identity questions. They may also seek more specific expertise for transition-related services, such as readiness evaluations for hormone replacement therapy or gender affirmative surgeries. When assessing transgender patients, it is vital to consider the impact of minority stress (Meyer, 2003) on symptom presentation to avoid over-pathologizing patients. This means that practitioners should consider how the impact of familial, societal, economic, and political stressors can create collective trauma for transgender individuals as they navigate their day-to-day lives and how these cumulative experiences can create psychological distress. This approach can help clinicians avoid assumptions that patient distress is due to

gender dysphoria when it may be better explained by oppressive societal factors (American Psychological Association [APA], 2015).

6 Considerations for Clinical Interviews with Transgender Patients

Clinicians should ask all their patients about gender identity when assessing for cultural identities and experiences. This can be done verbally in the clinical interview or in the history and symptom paperwork completed prior to the intake (Trittschuh et al., 2018). When asking about gender identity in paperwork, it is advisable to leave the question open-ended, or provide options such as Cisgender (meaning that one's biological sex matches their gender identity) Male and Female, Transman/transgender man/female-to-male, Transwoman/transgender woman/male-to-female, Other, or Choose not to answer (Kauth, 2017). When patients disclose having a transgender identity, several factors are helpful to consider. TGNC patients may identify with a binary perspective of sex as either male or female, but many TGNC individuals also identify as gender nonbinary, such as androgynous genderqueer, gender-fluid, or two-spirit (Hendricks & Testa, 2012).

Terms	Definitions
Androgynous	Identify/present as neither masculine or feminine
Asexual	Lack of sexual attraction or desire for other people
Bisexual	Emotionally, romantically, or sexually attracted to more than one sex, gender, or gender identity
Cisgender	Gender identity aligns with the sex assigned to the individual at birth
Gender Non-Conforming	Gender expression does not conform to the traditional expectations of that specific gender
Genderqueer/Third Gender/Gender Fluid	A general rejection of gender categories and embraces a fluidity of gender identity; may see themselves as both male and female, neither male or female, or they may see themselves completely outside of these categories
Non-binary	Adjective used to describe a person who does not exclusively identify as a man or a woman
Queer	Term often used to express fluid identities and orientations; often used interchangeably with LGBTQ
Transgender	Term for individuals whose gender identity and/or expression is different from the cultural expectations based on the sex they were assigned at birth.
Two-Spirit	Individual who identifies with the Native American tradition of characterizing members of the community as having the spirit of both the male and female genders.

Asking patients about their preferred pronouns offers another affirmative approach in working with TGNC patients. TGNC patients may be gender binary or nonbinary (i.e., patients may use they/them pronouns). It is essential to ask if the patient has a preference for the name and pronouns used in clinical notes and assessment reports, depending on whether the patient has publicly come out as transgender. Trittschuh et al. (2018) noted this could impact the gendered forms of address that clinicians should use (such as Mr., Ms., Mrs.). It can also be helpful to refer to TGNC individuals without a gendered title, such as "Veteran Smith" or "Smith" as opposed to "Mr. Smith." The authors also recommended giving ticket numbers as another approach to avoid assuming and misgendering individuals. These considerations demonstrate respect and can assist clinicians in building rapport with their TGNC patients.

Determining the history and development of gender dysphoric feelings is an important step in the assessment process, along with ensuring that gender dysphoria is not better explained by another diagnosis (WPATH, 2012). Clinicians should assess if the patient has received any medical procedures related to transitioning, such as hormone replacement therapy or gender affirmative surgeries. Additionally, Trittschuh et al. (2018) wrote that conceptualizing patients from a developmental model can help gather information to track the progression from birth gender to where the patient currently experiences authenticity. The authors recommended Lev's (2004) model of transgender identity development, which includes the stages of Awareness, Seeking information/Reaching out, Disclosure to significant others, Exploration-Identity and self-labeling, Exploration-Transition issues/Possible body modification, and Integration-Acceptance and post-transition issues. However, identity does not always develop in a linear progression, so caution should be exercised when utilizing any model (Bockting et al., 2016). Trittschuh et al. (2018) wrote that developmental models could provide clinicians with a heuristic to conceptualize a patient's background and direct services for the patient.

Clinicians should also remember that sexual orientation and gender identity are two separate constructs (APA, 2015). A TGNC individual may identify as heterosexual or as a sexual minority. Sherman et al. (2014) found that 24% of sexual and gender minority veterans (n = 58) had never disclosed their sexual orientation to a Veterans Affairs (VA) provider, while 33% had disclosed this information to all their providers, leaving 43% of veterans who had shared with some number of their providers. Over 60% of veterans reported none of their providers asked about their sexual orientation, and 81% reported that none of their providers had asked about their gender identity. Not all veterans believe they are safe to share this information with their health care providers, so clinicians should take the initiative to ask about sexual orientation and gender identity and facilitate safety during the intake interview. Fifty-nine percent of the sample expressed being quite or very comfortable talking about their sexual and/or gender identity with their providers. Yet, there may be a gap in understanding how these constructs connect to veterans' physical and mental health.

Hendricks and Testa (2012) recommended that clinicians consider Meyer's (2003) minority stress theory when assessing transgender patients. These factors

include "prior discrimination or victimization, expectations of future victimization or rejection, internalized transphobia, and resilience" (p. 465). Discrimination toward TGNC individuals comes in many forms, including difficulty obtaining housing, access to health care, finding and maintaining employment, barriers in education, and difficulties receiving social services (APA, 2015). TGNC patients have likely had experiences of being misgendered (referring to a TGNC person by the wrong pronouns) or deadnamed (calling a TGNC person by their birth or former name), along with potentially dealing with inappropriate questions about their bodies (APA, 2015). Psychologists should also consider an intersectional approach for transgender and gender-nonconforming patients of color who may have unique experiences of trauma and discrimination, even perpetrated by those within the larger LGBTQ+ community targeting their racial/ethnic or transgender identities (APA, 2015; Chang & Singh, 2016). TGNC women, especially those of color, are particularly vulnerable to violence and homicide, including violence from police officers (APA, 2015). Thus, it is important to consider other diversity variables and the potential impact on one's overall development and experiences as the clinical interview is conducted and during the process in which one is determining the assessment battery.

TGNC patients also present a variety of protective factors that should be considered beyond symptom complaints and risk factors that can help patients achieve treatment goals or direct recommendations (Chang & Singh, 2016). Family support can be an especially salient protective factor for TGNC individuals (Bockting et al., 2013; Moody & Smith, 2013; Ryan et al., 2010). Instruments like the Gender Minority Stress and Resilience measure (Testa et al., 2015) can help provide information about not only stressors but strengths like community connectedness and transgender pride.

7 Holistic Treatment of Transgender Veterans

As clearly indicated, this population is poorly connected with inclusive health care services. Considering the multiple layers of risk and problems, a multi-level intervention approach is warranted to engage and treat the transgender veteran population. As a psychologist, it begins with the field addressing one's own biases, beliefs, and competencies. It is strongly suggested that psychologists and other mental health professionals complete cultural competence and humility training and training on sexual identities and the transgender population specifically. As one builds their expertise and gains valuable experience, one may even consider providing training to mental health clinicians and other fields, such as medicine, social work, shelters, substance use programs, transitional housing, and employment programs. An area to consider focusing on is how to engage in relationship-building and apply a culturally humble, inclusive, on-going discussion about the veteran's transgender status and health care needs. It is imperative the treating clinician foster openness, trust, sensitivity, and relational repair if there is a rupture in the relationship. This

will likely increase the likelihood of seeking help and meaningful engagement in services. Practitioners may employ their diversity training by honing their sensitivity and awareness of the population, including risk and protective factors. Another focus may include assisting transgender clients with navigating systems and advocating for care, including transgender-sensitive gynecological care to FTMs or housing or providing education on the client's needs (Xavier et al., 2007).

As a mental health clinician and advocate, thinking holistically and systemically about the needs of the transgender veteran includes the following:

- Medication.
- Hormones.
- Financial costs.
- Individual, family, couples, group therapy.
- Substance use treatment.
- Case management.
- Sexual health (testing and protective methods).
- Housing.
- Employment.
- Transportation.
- Psychiatric services.
- Health concerns.
- Surgery.
- Food banks.
- School/academic.
- Parenting.
- Spirituality.
- Legal.
- Changing ID documents.
- Telehealth.

Psychological services may consider implementing prevention and outreach programs and workshops, which promote transgender-specific materials. This may include educational programs for transgender veterans about transgender care. A study involving both urban and rural VA providers utilized a VA Transgender e-consult program to assist medical professions with care plans, hormone therapy recommendations and sexual, reproductive health education, surgery treatment education, patient-provider communication, and consultation. This VA program permits transgender veterans to seek local health care providers, who receive consultation and support from others with expertise in transgender health. The four main consultation topics were: psychotherapy, mental health evaluation and hormone readiness, prescription of hormone therapy, and primary medical care. The providers reported time constraints, unrealistic recommendations for under-resourced VA sites, communication problems, and misunderstanding the purpose of the e-consult platform created barriers in treatment. The study found that providers and patients were not using the program because they were unaware of the program (over half), received assistance elsewhere, or did not feel a need for the program. Participants shared the program would be further utilized if they were given information on where to locate the program, utilization guidance, discussion points to address with patients, and email announcements to improve awareness of the e-consult program (Blosnich et al., 2016). As a treating clinician, it may be beneficial to create one's own personal network of other expert practitioners for consultation purposes, especially as unexpected needs and concerns arise with transgender clients.

8 Psychological Assessment Considerations with Transgender Patients

TGNC patients may pursue psychological assessments like other patients to seek answers for different questions, such as differential diagnosis, treatment recommendations, or specific questions like memory concerns. TGNC may also seek specialized assessment services, such as readiness evaluations to obtain access to hormone treatment and gender affirmative surgeries. Mental health providers should consider what the literature states on working with TGNC individuals to provide competent care.

8.1 Psychological Testing

8.1.1 Norms and Test Selection

A major problem in testing psychology for the transgender population is the lack of norms (Keo-Meier & Fitzgerald, 2017; Trittschuh et al., 2018). When psychologists do not consider factors such as Meyer's (2003) minority stress theory, there is potential for over-pathologizing transgender and gender-nonconforming patients. Keo-Meier and Fitzgerald (2017) recommended either using gender-stratified tests that incorporate norms from both cisgender men and women or tests with non-gendered norms. Specific tests like the MMPI-2 have been found to have significant scale elevations for transgender patients compared to their cisgender counterparts and should be used with caution. Trittschuh et al. (2018) suggested that it can also be helpful to examine both male and female norms to examine whether there are significant differences in the results.

Clinicians should also consider the length of time their patient has been on exogenous hormones that may affect brain structures, though the research remains unclear how this may impact testing (Trittschuh et al., 2018). Postmortem data have shown differences in the brain's overall size and different regions of the brain, such as the hypothalamus (Hulsho Pol et al., 2006; Seiger et al., 2016). The research revealed mixed findings about how transgender participants compared to cisgender individuals in control groups. Some found that transgender participant scores fell between cisgender male and female scores (Smith et al., 2015), nearer to the scores of controls from their birth sex (Luders et al., 2009), and neared to those of their gender identity (Rametti et al., 2011a, b). Studies have also indicated that hormone treatment may increase spatial intelligence in transmen on testosterone (Slabbekoorn et al., 1999) and may increase verbal intelligence in transwomen on estrogen (Van Goozen et al., 1994, 1995). However, the research remains inconsistent and unclear. Trittschuh et al. (2018) wrote that given the conflicting data from the research, clinicians should consider results from norms of both sexes and weigh the findings in light of the referral question, the individual, and the background information of the

patient to determine which norms are most appropriate to determine test interpretation.

8.1.2 Interpretation and Report Writing

While clinicians desire expectations for performance in psychological testing, Trittschuh et al. (2018) warned against using instruments with gendered norms to determine premorbid abilities because of the increased risk of bias and skewing interpretations. Additionally, the researchers expressed that clinicians should exercise great caution when any subjective or objective performance validity concerns manifest themselves in test interpretation, given the difficulties and health disparities the TGNC population encounter. The authors also suggested discussing the limitations uncovered during the testing process and making looser diagnostic conclusions than might be typical in an assessment report.

As psychologists create recommendations for TGNC patients, they should explore what resources are available in the client's specific community that could be beneficial for the patient. This could include affirming health care and mental health providers, housing services, religious and spiritual communities, or local LGBTQ+ centers, LGBTQ+ care providers, and/or services offered by the provider's facility or practice (APA, 2015).

8.1.3 Providing Feedback to Transgender Patients

The feedback session is one of the most crucial parts of assessment as the provider communicates the patient's findings in a way that the patient can understand. This is especially important for TGNC patients given the complexity of their cases. Trittschuh et al. (2018) provided several suggestions for managing feedback sessions well with TGNC patients. First, they remind clinicians to remain relaxed. Providers tend to be more anxious than their patients. The researchers recommended having a clear rationale and transparent discussion with the patient, along with having an open attitude on the subject of gender identity and willingness to be corrected when wrong. Second, framing the feedback session with the referral question can help the provider and patient stay on track and help the patient form questions to discuss. Third, reminding the patient of discussions in the clinical interview, such as the impact of sex and hormones on cognition can help direct the conversation. Fourth, asking permission to discuss gender identity and the patient's transition process can help build a spirit of collaboration between the clinician and patient. Fifth, clinicians should be transparent in dialoguing about the normative differences by sex in testing. The researchers note it can be helpful to discuss with patients when there are interpretive differences by sex, and also show the patients when there are discrepancies between male and female scores to have a collaborative conversation. Having these discussions in the feedback session can minimize future questions about written implications about gender in the report. Lastly, clinicians

should also express positive contributions of the transition for the TGNC patient. The authors provide examples of cognitive congruence that can occur after transitioning and improved mental health benefits. This strength-based approach can help foster hope in the feedback session.

8.2 Readiness Evaluations

The WPATH (2012) established multiple guidelines for ensuring competent care of TGNC individuals, especially those seeking gender affirmative medical interventions. Providers discuss the various options and roles that TGNC patients can pursue to find an identity that best fits their experience. Providers should screen for other diagnoses that could be associated with gender dysphoria and minority stress or could be unrelated to these experiences, such as "anxiety, depression, self-harm, a history of abuse and neglect, compulsivity, substance abuse, sexual concerns, personality disorders, eating disorders, psychotic disorders, and autistic spectrum disorders" (WPATH, 2012, p. 24). When these conditions remain unaddressed, they can complicate identity exploration and create barriers to resolving gender dysphoria. The WPATH guidelines note that while these conditions may not mean a TGNC patient would be disqualified from receiving medical services, these clinical concerns should be addressed and managed well before beginning hormone treatment or surgical procedures.

Mental health clinicians play an essential role in the health care of TGNC patients, especially in readiness evaluations. They ensure that the patient is fully informed and prepared for the major changes ahead. Family and community provide important support for navigating hormonal changes or healing from surgical procedures. Patients should also know the impacts that hormone replacement therapy and surgical interventions have on fertility and reproductive health, allowing them to consider options before proceeding.

8.2.1 Guidelines for Referrals to Feminizing/Masculinizing Hormone Therapy

Within the Veterans Health Administration (VHA), mental health providers evaluate TGNC veterans for the presence of the DSM diagnosis of Gender Dysphoria must be given to initiate a referral for hormone treatment (VHA, 2020). Providers should create a referral letter or document in the patient's chart and include the patient's personal and treatment history, progress, and eligibility for the procedure (WPATH, 2012). This would include identifying the patient's characteristics, the results of the patient's psychological evaluation and any diagnoses given, dates for how long the provider has worked with the patient, including the type of evaluation and/or therapy conducted. The provider must also explain what criteria have been met for hormone therapy and a clinical rationale that supports the patient's request for

hormones. Clinicians should also write that informed consent has been obtained from the patient and that the provider is available to coordinate care and welcomes phone calls to begin this process.

WPATH (2012) criteria for hormone treatment include persistent and well-documented gender dysphoria, the ability to make informed decisions, consent to treatment, and be of age of majority in the given country. If there are any physical or mental disorders present, they must be relatively managed. If the patient has been taking illicit hormones, this may be a rationale for bypassing the criteria to ensure the patient is properly monitored by a licensed professional. It is also unethical to deny hormone treatment for patients with HIV/AIDS or hepatitis B or C. However, certain health conditions may be contraindicated for hormone treatment, and other options should be considered.

When obtaining informed consent, WPATH (2012) recommends that the provider discuss the irreversible changes from hormone treatment with the patient. It should be documented that the patient is legally able to give informed consent, which can include those declared by the court to be emancipated minors, incarcerated individuals, and cognitively impaired patients who have been deemed competent to participate in their medical decisions. Providers should discuss all the relevant considerations of hormone therapy with the patient that includes the benefits and risks of the intervention and the impact on reproductive health, which should be all documented.

Physical changes that can be expected for female-to-male patients include an enlarged clitoris, deepened voice, increased facial and body hair, cessation of menses, atrophy of breast tissue, and lowered body fat percentage compared to muscle mass. In male-to-female patients, this can include breast growth, lowered erectile functioning, smaller testicular size, and increased body fat percentage compared to muscle mass. These physical changes tend to occur over 2 years and will be variable in each patient. This can depend on the dose received, how the hormones are administered, the medications used, and the medical risk profile (WPATH, 2012).

WPATH (2012) lists several categories of risks for hormone replacement therapy that vary in level of likelihood. Likely increased risks include "venous thromboembolic disease," "gallstones," "elevated liver enzymes," "weight gain," and "hypertriglyceridemia" for feminizing hormones and "polycythemia," "weight gain," "acne," "androgenic alopecia (balding)," and "sleep apnea" for masculinizing hormones (p. 40). Additional risk factors will likely increase the cardiovascular risk for those taking feminizing hormones. Possible risks include "hypertension" and "hyperprolactinemia or prolactinoma" for feminizing hormones and "elevated liver enzymes" and "hyperlipidemia" for masculinizing hormones (p. 40). With additional health risk factors, additional risks can include "Type 2 diabetes" for feminizing hormones and "destabilization of certain psychiatric disorders," "cardiovascular disease," "hypertension," and "Type 2 diabetes" with masculinizing hormones (p. 40). Lastly, there is not a risk or the evidence is inconclusive for the following conditions: "breast cancer" for feminizing hormones and "loss of bone density", "breast cancer," "cervical cancer," "ovarian cancer," and "uterine cancer" for masculinizing hormones (p. 40).

Additionally, reproductive options should be discussed with patients, such as sperm-preservation options and sperm-banks for male-to-female patients and oocyte or embryo freezing for female-to-male patients. These options are not available in all locations and can be expensive. However, TGNC individuals should never be refused reproductive options, and this should be discussed as part of the evaluation process.

8.2.2 Guidelines for Referrals to Surgery

Mental health professionals would follow similar guidelines for making surgical referrals as they would for hormone treatment. Providers create a referral letter or document in the patient's chart that includes the patient's personal and treatment history, treatment progress, and eligibility. The provider recognizes that they share in the ethical and legal responsibility in this decision with the surgeon. A major difference for gender affirmative surgical interventions is that two letters of reference are required from mental health professionals for some of these procedures, which will likely be written by the patient's therapist and an evaluating mental health provider (WPATH, 2012).

Again, the letter from providers should cover identifying characteristics of the patient, the assessment results and any diagnoses given to the patient, the history of the relationship between the provider and patient and what types of services have been utilized such as assessment or therapy. Providers should specify what criteria the patient has met for the surgery and the clinical rationale that supports the patient's request. The provider must document that informed consent was obtained from the patient and the provider must state that they are available for coordination of care and to take calls to begin this process.

The WPATH (2012) criteria is similar for gender affirmative surgical procedures, yet some considerations are depending on the type of surgery. For chest surgeries, only one referral is typically needed. For mastectomies in female-to-male patients to create a male chest, hormone treatment is not a prerequisite. Breast augmentation in male-to-female patients includes a recommendation of feminizing hormones for 12 months to maximize breast growth and ensure better surgical results. Genital surgeries require two referral letters from mental health providers. In addition to the criteria for hormone treatment, a fifth criterion is included for hysterectomies and salpingo-oophorectomies in female-to-male patients and orchiectomies in male-to-female patients. This additional criterion includes 12 months of continuous hormone therapy tailored to the patient's goals unless hormone treatment is contraindicated for the patient. A sixth criterion is included for metaoidioplasty or phalloplasties in female-to-male patients and vaginoplasties in male-to-female patients. This criterion involves living 12 months in the gender role that is congruent with one's gender identity.

If the patient has been diagnosed with a severe psychiatric disorder and suffers from impaired reality testing, the WPATH (2012) recommends that efforts must be made to utilize psychotropic medication and psychotherapy prior to surgery. These

disorders can include psychotic episodes, bipolar disorder, dissociative identity disorder, and borderline personality disorder. The patient should be reexamined by a mental health professional who has competency with severe and persistent mental illness. The provider should assess the patient's current condition, mental status, and readiness for surgical procedures. In addition, surgery should not be performed on actively psychotic patients.

8.2.3 Additional Considerations

Providers should also consider several factors when conducting readiness evaluations. Hendricks and Testa (2012) wrote that transgender patients may be reticent to share about their experiences of trauma, transphobia, or psychological distress because their own research revealed that divulging a certain level of psychopathology can create barriers in their ability to obtain a letter of recommendation for gender-affirming medical procedures. Providers should recognize that they are not gatekeepers but function to assist transgender patients with preparedness for the changes that will come with hormone therapy or gender-affirmative surgical interventions. Spending time clarifying the provider's role, the purpose of the evaluation, and any concerns of the patient can help create more transparency in the assessment along with helping the patient determine the steps that will ensure a smooth transition process that will set up the patient for success.

9 Conclusion

Working with TGNC patients can be a complicated yet rewarding experience. Mental health providers should be aware of the pertinent literature on conducting clinical intakes and avoiding bias in test administration. Maintaining competency can assist clinicians with facilitating an affirmative and meaningful experience for their TGNC patients who encounter prejudice and discrimination in many other domains of their lives, even in their health care. Mental health providers can create emotionally corrective experiences in the assessment experience and advocate for their TGNC patients to receive the services they need.

General Recommendations for Mental Health Providers

- Recognize and attend to personal and professional biases toward transgender persons and other diversity variables.
- Seek and attend specific training regarding best standards of practice and care of transgender persons.
- Ask clients about their gender identity and preferred pronouns; inquire about their preference for the name and pronouns they wished to use in clinical notes and assessment reports.
- Instead of referring to TGNC individuals by a gendered title (e.g., Mr., Ms., Mrs.), you may consider referring to them as "Veteran Smith" or "Smith."
- Explore barriers to accessing other systems of care (e.g., employment, housing, education).
- Explore current support systems and collaborate with the TGNC individual to discover other avenues to obtain and receive support.
- Provide inclusive and transgender-sensitive care via an open, trusting, genuine relationship with the TGNC patient.
- Consult with expert professionals in the field.
- Connect with other service providers on the treatment team to foster continuity of care.
- For psychological assessment batteries, use gender-stratified tests that incorporate norms from cisgender men and women or measures with non-gendered norms.
- Discuss limitations in the testing process and, consequently, make looser diagnostic conclusions.

Resources

- Camouflaged Identity: How Trans Veterans Survive Military Culture: https://time.com/camouflaged-identity/
- Identity Documents: https://www.lambdalegal.org/know-your-rights/article/trans-identity-document-faq
- Summary of VHA Care for Transgender Veterans: https://transequality.org/issues/resources/veterans-health-administration-care-for-transgender-veterans
- Transgender American Veterans Association: http://transveteran.org/
- Transgender Law & Policy Institute: http://www.transgenderlaw.org/
- Transgender Resources: https://www.glaad.org/transgender/resources
- Transgender Rights Toolkit: https://www.lambdalegal.org/publications/trans-toolkit

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