

Psychotherapists as Gatekeepers: An Evidence-Based Case Study Highlighting the Role and Process of Letter Writing for Transgender Clients

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In order to receive medically necessary gender-affirming treatments, transgender individuals are required to provide evidence of their readiness for gender transitioning. Most often, this evidence includes 1 letter for hormone therapy and 2 letters for surgery. According to the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC), psychotherapists or other eligible health professionals are the only individuals qualified to write these letters. The present case study examined how psychotherapist gatekeeping and letter writing for a transgender client were intertwined with psychotherapy processes and outcomes. Over the course of 12 months of treatment, the client was assessed through 8 time points using multiple methods. Six of the assessments were conducted with validated outcome measures (baseline; Sessions 5, 10, 15, and 20; and termination); 1 of the assessments was conducted as a clinical interview for letter-writing purposes and additional outcome measures (Session 8); and evaluating the process of letter writing was an aspect of psychotherapy (Session 20). Symptom alleviation, improvement in psychological well-being, and increases in overall quality of life occurred from baseline to termination. Results indicate that psychotherapy assisted with the process of gender transitioning, which in turn improved client outcomes. Recommendations for writing letters for clients who desire a gender transition are included.

Keywords: psychotherapy, transgender, gatekeeping, outcomes, standards of care

In a groundbreaking study, Grant et al. (2011) noted that 75% of transgender individuals (individuals whose current gender identity is not congruent with their sex assigned at birth) have engaged in psychotherapy currently or in the past, with an additional 14% indicating an intention to seek psychotherapy in the future. In comparison, 3.18% of the United States population utilizes psychotherapy (Olfson & Marcus, 2010). Prevalence estimates are outdated and underestimate the actual percentage of transgender people due to solely tracking those individuals who seek sexual reassignment surgery (Olyslager & Conway, 2007). van Kesteren, Gooren, and Megens (1996) estimated that approximately 2–5% of the population identifies as transgender.

As can be expected, a percentage of transgender clients enter therapy with the same concerns of cisgender clients (individuals whose sex assigned at birth is congruent with their current gender identity). Very little research has considered why transgender clients seek therapy at disproportionate rates when compared to other populations. One study indicated that transgender clients seek therapy for a myriad of reasons, including personal growth and help with their gender transition (Rachlin, 2002). However, this research only indicates the goals that transgender clients report when they arrive to therapy. It is likely that the numbers of clients seeking therapy are high for two reasons:

(a) clients who desire medical interventions will need one to two letters from health care providers (Coleman et al., 2012) and (b) clients wish to cope with experiences of prejudice and discrimination (Bess & Stabb, 2009). Though these two reasons may be interrelated for clients, the scope of this article will focus primarily on letter writing.

Very few psychotherapists find themselves in the role of gatekeeper to medically necessary treatments. The World Association for Transgender Health (WPATH) provides Standards of Care (SOC) that recommend standards to be used by all health professionals when working with transgender individuals. The current SOC (Version 7; Coleman et al., 2012) are considered to be the primary recommendations to assist health care providers with relevant and recent research findings and procedures to assist transgender individuals with medical interventions.¹

Practitioners and clients have expressed mixed feelings about the role the SOC have played within transgender health care (Bockting, Robinson, Benner, & Scheltema, 2004). Previous criticisms of the SOC noted the lack of research that validated the recommendations made within the SOC (Version 6, specifically; De Cuypere & Vercruyse, 2009; Fraser, 2009; Lev, 2009). For example, in SOC Version 6, transgender clients were required to attend psychotherapy sessions for at least 3 months prior to obtaining a letter from their mental health care provider for hormone therapy; they were also required to live as their current gender “full

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¹ The Standards of Care Version 7 can be accessed at the following website: http://www.wpath.org/uploaded_files/140/files/IJT%20SOC,%20V7.pdf.

time” for at least 1 year prior to obtaining a letter deeming them fit for gender-confirming surgeries (e.g., mastectomy, breast augmentation, orchiectomy, phalloplasty, vaginoplasty). The SOC Version 7 does not require psychotherapy for any amount of time for transgender clients seeking hormones or surgery; instead, there are strong recommendations for the benefits of psychotherapy during this transitional period and a requirement for a letter from one health care provider for hormone therapy and two health care providers for surgery.

The SOC Version 7 indicate that psychotherapists should (a) have specific knowledge related to gender dysphoria and must obtain continuing education related to working with transgender clients when writing letters for hormones and/or surgery, (b) be knowledgeable about general assessment procedures but also assessments to be provided for the information placed in the letter, (c) provide information regarding options for gender identity and possible medical interventions, (d) assess for comorbid diagnoses, (e) assess for eligibility for hormone therapy and surgeries (e.g., it is recommended that transgender women wait 1 year after starting estrogen- or testosterone-blocking therapies to obtain breast augmentation due to determining natural breast growth), (f) ensure that clients’ comorbid diagnoses are “reasonably well controlled” for hormone referrals, (g) check “full time” status, (h) have a master’s degree or PhD to write letters for hormones and chest surgery (only one letter required), and (i) have a PhD to write letters for genital surgery (two letters required).

Although the SOC Version 7 indicate clear guidelines for psychotherapists, the therapeutic impact and consequences of letter writing for transition-related purposes are unknown. It is well documented that the working alliance is one of the primary psychotherapeutic processes that accounts for a significant amount of client change (e.g., Horvath, Del Re, Flückiger, Symonds, 2011). Due to psychotherapists being gatekeepers for transgender clients’ medical transitions, the nature of the psychotherapy may closely represent therapy that is involuntary. Research indicates that the alliance is weaker in the beginning of treatment for clients who are involuntarily seeking therapy compared to clients voluntarily seeking therapy (Honea-Boles & Griffin, 2001; Sotero, Major, Escudero, & Relvas, 2014). There are several implications and consequences to the perception that psychotherapy is mandatory to receive a letter for transgender health care. First, many clients seek black market hormones (Reback, Simon, Bemis, & Gatson, 2001; Sanchez, Sanchez, & Danoff, 2009; Xavier et al., 2013), which can have multiple consequences. Without knowing baseline hormone levels, it makes it difficult to adjust to the correct levels for optimal effects. There can be serious side effects to hormone therapy that may go unnoticed if left untreated, as well as transmission of Hepatitis C and HIV/AIDS (Fletcher, Kisler, & Reback, 2014). Second, the mandated process of being told that a mental health care provider must deem one “fit” to obtain medically necessary surgeries causes distrust and also creates a pattern where clients may not provide completely genuine responses in order to appear to be “perfect” candidates for the medical interventions (Benson, 2013; Carroll, Gilroy, & Ryan, 2002).

The purpose of the current article is to illustrate the assessment and therapy process of letter writing for transgender individuals. In order to do so, I will present an evidence-based case study of a former therapy client,² Lia (a pseudonym). After presenting Lia’s background information, the process of letter writing within ther-

apy, and Lia’s outcome scores, I will also provide recommendations and suggestions based on best practices that are currently ongoing within the medical and mental health communities.

Method

Client Background Information

Lia is a Latina-Italian, queer, transgender woman (assigned a male sex at birth) who was 18 years old for the majority of psychotherapy treatment (she turned 18 after the first session). She had been referred to my independent practice from the director of the LGBT center at the university she was planning to attend in the fall. Lia attended the first therapy session with her mother, Carmela. Since Lia had come out to her mother a week prior to attending the first therapy session, both Lia and Carmela were using Lia’s birth name and male pronouns. Lia was dressed in gender-neutral clothing—a T-shirt and jeans—and wore her dark, curly brown hair in a short ponytail. She spoke with a naturally high, feminine voice and also used stereotypically female gestures and mannerisms. Within the first session, we had established that she wanted assistance with both a social and medical transition to a female identity and expression. She was also going to be a first-generation college student and was unsure how to navigate both the transition to college and a gender transition. From July 2013 to June 2014, Lia engaged in a total of 24 individual psychotherapy sessions and three sessions with her mother for a total of 27 sessions.

Process of Letter Writing

Within Session 1, Lia had expressed her desire for hormone therapy, top surgery (breast augmentation), and bottom surgery (orchiectomy and vaginoplasty). For the first eight therapy sessions, Lia and I navigated how she wanted to plan her social and medical transition. Before starting hormones, Lia wanted to come out to all of her family members. Although her mother was her primary legal guardian until she turned 18, she had spent the majority of her life living with her grandmother, grandfather, and two older brothers (her father was often not present in her life). She had come out as gay when she was in middle school and reported enduring an immense amount of bullying. Due to this bullying, she indicated that she began to cope by self-harming (primarily cutting) and attempting suicide one time when she was 14. She felt emotionally removed from her father and grandfather due to their outward homophobia and lack of support. Her brothers had both been diagnosed with bipolar disorder and struggled with substance use and being involved in the criminal justice system. From Sessions 1 to 5, she came out as transgender to all of her family members and reported that she received the expected reactions from family members—her father and grandfather were unsupportive of her gender identity, her grandmother provided support, and her brothers seemed “indifferent.” Although the following statements are not specific quotes from the sessions, this is an

² The client provided written consent for this evidence-based case study. Consent was provided for all deidentified information related to psychotherapy, outcome measures, and the letter in the Appendix. All names included in this evidence-based case study are pseudonyms.

example of an exchange related to Lia's coming-out process with her family:

Lia: I mean, I knew that it was going to be hard—my grandpa called me a freak [laughs and shrugs her shoulders].

Stephanie: Oh wow, that seems so hurtful.

Lia: It's not that big of a deal. Plus, my grandma took me shopping for new shoes and a dress, so that was really fun [smiles]. And now that everyone knows, it will not be that big of a deal for me to start hormones.

A common theme in the beginning of therapy for Lia was difficulty processing her emotions, specifically affect derived from transgender-related discrimination and prejudice. Lia indicating that things “were fine” or “not a big deal” was challenged frequently in our beginning processes.

Prior to writing Lia a letter for her medical transition processes, she and I discussed her health care options. Medicaid was Lia's only health insurance, and she was unsure if she could afford the medical interventions that she desired; she grew up in a low-income household where she was used to being financially savvy and figuring out difficult financial decisions. During Session 7, I referred Lia to the head of her university health services, since he had expertise in working with transgender patients. Also, as an undergraduate student at the university, she was able to receive many medical services at low or no cost. Immediately upon referring Lia to this medical doctor, I also requested that Lia sign a release of information form to the university health services in order to coordinate care between their clinic and my independent practice. I received a phone call from her medical doctor indicating that he would require a letter for hormone therapy for any patients referred to him. Although I have a standard assessment that I use for writing letters, I asked him to see if there were specific requirements that he had for the letter. He indicated that he did not have any requirements other than a diagnosis and an indication for readiness for hormones.

Before Session 8 began, I also asked Lia to fill out outcome measures so that I could accurately record her current mental health within the letter. Within Session 8, I supplemented background information about gender identity that I had not already asked about in our previous sessions. I asked her questions about her childhood and feelings about her gender identity, events that typically mark increased dysphoria (e.g., puberty), previous and current behaviors that she considered to be gendered (e.g., clothing choice, makeup), and her expectations for hormone therapy (e.g., emotional impact, physiological changes, side effects). In Session 8, I conducted an assessment with Lia to write her a letter for hormones. In the beginning of the session, I had a frank conversation with Lia about her own viewpoints on receiving a diagnosis of gender dysphoria according to the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association [APA], 2013) and gender identity disorder (International Classification of Diseases, Tenth Revision, Clinical Modification [ICD-10-CM]). Insurance companies and many medical providers will ask for a diagnosis within the letter, since they will need to provide a code for their own medical appoint-

ment. Below is a recreation of the intervention used to discuss the inclusion of a mental disorder diagnosis in the letter:

Stephanie: Lia, I'd like to talk to you about some of the information that I need to put in the letter. The university health services requires that transgender patients receive a diagnosis of gender dysphoria to receive hormones—how do you feel about this?

Lia: Um, well, I guess you need to do what you need to do.

Stephanie: I thought it would be important to bring this up, because I want you to know that I do not believe that being trans means you have a mental disorder. Instead, in the letter, I will indicate that you meet criteria for the diagnosis, since you have given me information that fits enough of the criteria to provide this diagnosis.

Lia: No, I get it. It makes me pretty mad to think that someone would think that I have some type of mental disorder, but I understand that it is part of the process.

Stephanie: I definitely understand how that could make you mad. How do you feel about working with me after I have given you this diagnosis as part of the letter?

Lia: Oh, it's okay—I know that you are writing the letter to help me get hormones and it helps to know how you see the diagnosis. I'm not mad at you, more mad that it even exists in the first place.

After Session 8, I indicated to Lia that I would write up the letter and that we could go over a draft together in the next session so she could change anything she felt did not fit her actual experience. In Session 9, we went over her letter (see the [Appendix](#)) together, and she determined that the letter fit her expectations. Because my psychotherapeutic theoretical orientation is psychodynamic and interpersonal in nature, I use many here-and-now techniques to process the therapeutic relationship. Below is a recreation of how we discussed the letter after she had a chance to read through it in session:

Stephanie: So, what was it like to read your letter?

Lia: It was weird.

Stephanie: Weird.

Lia: Yeah. I've never actually seen a document written about me that uses my name—Lia—or female pronouns [appears a little tearful]. It feels good . . . what's the word? Empowering. But I'm having a lot of feelings I'm not sure how to talk about. More than good, but also weird. Maybe a little overwhelming.

Stephanie: That makes sense—a lot of trans people tell me they feel the same way when they read their

letters for the first time. How are you feeling about our relationship after reading through the letter?

Lia: Oh, I feel good. I feel like you really advocated for me and that you understood the things I told you. It was funny to read the letter because I could see the things I told you written down. I feel like you really get it.

From Sessions 10–27, Lia attended regular appointments with a medical doctor at the university for hormone therapy. There was some suspicion from her medical doctor that she might have an intersex condition due to unusual hormone levels for someone who was assigned a male sex at birth. An intersex diagnosis was not confirmed over the course of our psychotherapeutic treatment due to Lia's insurance not being able to cover the required tests. Lia reported "I hope that I am intersex," because she indicated that this would provide a biological explanation for her transgender identity. She was initially given prescriptions that interfere with testosterone production (spironolactone; 100 mg/day) and estrogen (premarin; 10 mg/day). However, after Session 14, she was switched to estradiol (4 mg/day) due to inadequate changes with her hormone levels. She remained on estradiol for the course of psychotherapy. We discussed her desire for gender-reaffirming surgeries throughout the course of psychotherapy, but she indicated that she would likely not seek surgery because she could not afford any of the procedures.

Throughout our treatment, Lia reported her psychological outcomes. She had enrolled as part of a larger, institutional review board (IRB)-approved psychotherapy study. She was assessed at baseline, Session 5, Session 10, Session 15, Session 20, and termination.

Measures

Transgender Outness Inventory. The Outness Inventory (OI; Mohr & Fassinger, 2000) is an 11-item inventory adapted for my independent practice to determine how open transgender individuals are about their gender identity. Responses on OI items indicate the degree to which the participant's gender identity is known by and openly discussed with individuals in their social network. Participants rate their level of outness from 1–7, ranging from *person definitely does not know about your transgender identity* to *person definitely knows about your transgender identity, and it is openly talked about*. Higher scores indicate greater disclosure of identity. Cronbach's alphas for the OI for LGBT individuals have ranged from .80 to .92 (Balsam, Beachaine, Rothblum, & Solomon, 2008; Balsam & Szymanski, 2005). Studies report the following means (with standard deviations in parentheses) for LGBT individuals reporting outness: 5.03 (1.40; Carvalho, Lewis, Derlega, Winstead, & Viggiano, 2011) and 3.26 (1.32; Edwards & Sylaska, 2013).

Multidimensional Scale of Perceived Social Support (MSPSS; Zimet, Dahlem, Zimet, & Farley, 1988). The MSPSS is a 12-item, 7-point Likert scale with three four-item subscales: Significant Other (SO), Family (F), and Friends (FR). Previous research (Yeh et al., 2008) has yielded coefficient alphas for each of the three subscales: .92 for SO, .87 for F, and .85 for FR. Sample items for this scale include: "My family tries to help

me" and "I can talk about problems with my friends." Studies report the following means (with standard deviations in parentheses) for transgender individuals reporting social support: 3.70 (.64; Dargie, Blair, Pukall, & Coyle, 2014) and 4.89 (1.12; Meier, Pardo, Labuski, & Babcock, 2013).

Center for Epidemiologic Studies Depression Scale—Short (CES-D-10; Andresen, Malmgren, Carter, & Patrick, 1994). The CES-D-10 measures depressive symptoms in the general population. This scale is a 10-item measure that asks questions regarding the major components of depressive symptomatology. Sample items include: "I felt hopeful about the future" and "I felt lonely." Respondents answer items on a 4-point Likert scale, where 0 indicates *rarely or none of the time* and 3 indicates *most or all of the time* during the past week. Research using this scale with transgender individuals indicated a Cronbach's alpha of .87 (Fredriksen-Goldsen et al., 2014). Brennan, Crath, Hart, Gadalla, and Gillis (2011) report a mean of 9.95 ($SD = 4.40$) for gay men's depressive symptoms.

Schwartz Outcome Scale (SOS-10). The SOS-10 (Blais et al., 1999) is a measure of psychological well-being, specifically hope and satisfaction with psychological health. This 10-item measure was rated by respondents from 1 to 7, ranging from *never to all the time or nearly all the time*. A higher score is associated with greater well-being. Cronbach's alpha has been reported as .92 (Dragomirecká et al., 2008). Studies report the following means (with standard deviations in parentheses) for outpatient individuals reporting well-being: 36.76 (14.09; Haggerty et al., 2014) and 23.8 (2.1; Goppoldova, Dragomirecka, Motlova, & Hajek, 2008).

K10 Self-Administered Questionnaire (K10). The K10 (Kessler et al., 2003) is a widely used 10-item measure of anxiety. The K10 consists of 10 items measured on a 5-point scale and is rated from 1 to 5, ranging from *all of the time* to *none of the time*. The total score has been used as a gauge for the severity of mood and anxiety disorders. Scores were reversed so that higher scores indicated more severity. Two independent validation studies found the K10 to have a reliability of 0.86 and 0.89, respectively (Furu-kawa, Kessler, Slade, & Andrews, 2003; Kessler et al., 2003). Studies report the following means (with standard deviations in parentheses) for LGBT individuals reporting distress: 20.6 (8.2; Lea, de Wit, & Reynolds, 2014) and 10.5 (1.1; Cochran & Mays, 2007).

The Self-Stigma of Seeking Help Therapy Scale (SSOSH-T). The SSOSH-T (Owen, Thomas, Rodolfa, 2013) is a 10-item self-report instrument. Items are rated from 1 to 5 and range from *strongly disagree* to *strongly agree*. Example items include "My decision to go to therapy has made me feel inferior" and "My self-confidence would not be threatened if I sought professional help." The alpha for the Owen, Hilsenroth, and Rodolfa (2013) SSOSH-T was .89, with a mean of 2.19 ($SD = .75$).

Client Task-Specific Change Measure—Revised (CTSC-R). The CTSC-R (Watson, Greenberg, Rice, & Gordon, 1996) indicates clients' self-reported behavior change and awareness and understanding of how therapy has contributed to any changes that have occurred in their lives. The CTSC-R is a 16-item measure that ranges from 1 to 7 for clients to rate in-session change and postsession change and has shown adequate reliability (e.g., $\alpha = .93$; Watson, Schein, & McMullen, 2010). Owen et al. (2013) report a mean of 4.97 ($SD = .97$) for outpatient clients.

Working Alliance Inventory—Short Revised (WAI-SR).

The WAI-SR (Munder, Wilmers, Leonhart, Linster, & Barth, 2010) is a widely used 12-item inventory in psychotherapy research to assess the level of bond between therapist and patient. It is considered pantheoretical and assesses three alliance constructs: (a) agreement on the tasks of therapy, (b) agreement on the goals of therapy, and (c) development of an affective bond. Items are rated from 1 to 5, ranging from *never* to *always*. Cronbach's alphas of WAI-SR subscales show adequate reliability for the WAI-SR total score ($\alpha > .90$; Munder et al., 2010). Nordgren, Carlbring, Linna, and Andersson (2013) report the following pretreatment, Session 3, and posttreatment means and standard deviations (in parentheses): 5.25 (.72), 6.00 (.80), and 6.20 (.90).

Results

Table 1 includes total ratings of outness, support, depression, psychological well-being, distress, stigma of help seeking, psychotherapy-related change, and working alliance.

At baseline, Lia reported that she was not out to many individuals. This corroborated her self-report of just coming out to her mother and having a goal of coming out to others before she wanted to engage in hormone therapy. Her reported baseline for overall social support on the MSPSS—62.00—was relatively high compared to a large sample of transgender individuals in a community sample (39.68; Budge, Adelson, & Howard, 2013). She reported a depression (CES-D-10) score of 20, which is considered 10 points above the clinical cutoff (Andresen et al., 1994). She also reported a distress (K10) score of 40, where the scores of 30 and above are considered clinically significant (Kessler et al., 2003). In a study investigating the SOS-10 with multiple populations, the mean score for the SOS-10 for college students was 39, and the cutoff for maladjusted clients was 40 (with lower scores indicating higher distress; Young, Waehler, Laux, McDaniel, & Hilsenroth, 2003); Lia's SOS-10 baseline score was 33. Her initial mean score for stigma related to therapy (SSOSH-T)—2.33—was similar to previously reported scores for college students (2.19; Owen et al., 2013). As expected, Lia's baseline score for task-specific change within psychotherapy was much lower (total score = 75) than at the end of psychotherapy (total score = 105), which corroborates her self-report in therapy of acknowledging change attributed to psychotherapy. Lia also reported consistently

high working alliance scores throughout the process of psychotherapy.

From baseline to termination, Lia reported change on every measure in the expected direction; however, none of the scales indicated direct linear change throughout the course of therapy. Although it is difficult to determine clinically significant change for one person, it is noteworthy that Lia's depression (CES-D-10) scores changed from indicating clinical levels of depressive symptomatology to being within the normal range at termination. Her distress (K10) and well-being (SOS-10) scores also dropped below the cutoff, indicating less distress and more well-being at termination.

Of particular interest was Lia's change in her CES-D-10 score from 20 to 11 from baseline to Session 5. At the time, she reported having higher levels of hope due to coming out and having a relatively positive response. She also indicated that she was feeling hopeful about having medical interventions in the future (specifically hormone therapy in the near future). Her depression score continued to decrease after the session where I wrote a letter for her and when she started hormone therapy. Her scores increased during the next two time points. She reported at the time that she was experiencing substantial financial stress that was impacting her mood; she was not performing as well as she wanted academically and was considering a change in major. However, at termination, she was out of school for the summer—she had changed her major and was working full time, so she was not experiencing the same stressors at the end of treatment. Upon termination, Lia indicated that there were five factors that she felt contributed to her change: (a) gaining confidence in herself, (b) starting hormones, (c) being perceived by others as a woman (also known as “passing” in the trans community), (d) experiencing life changes (her first year as a college student, transitioning genders, moving out of her grandparents' house) and seeing that “things work out,” and (e) having her emotional defenses challenged in psychotherapy.

For the purposes of this article, I will focus on her interpretation of how the letter-writing process impacted her well-being and her perceptions of herself. When I received consent from her to write about her experiences for this article, she talked with me about the process of therapy and letter writing in Session 20. Below are actual excerpts from this session:

Stephanie: So, what was your process like with me?

Table 1
Total Scores for Session Outcome Measures

	Range	Baseline	Session 5	Session 10	Session 15	Session 20	Termination	Change
Outness Inventory	9–63	19.00	43.00	45.00	46.00	46.00	46.00	27
Multidimensional Scale of Perceived Social Support	12–84	62.00	72.00	65.00	69.00	73.00	76.00	14
Significant Other subscale	4–28	20.00	22.00	18.00	16.00	19.00	20.00	0
Family subscale	4–28	17.00	22.00	20.00	25.00	27.00	28.00	11
Friends subscale	4–28	25.00	28.00	27.00	28.00	27.00	28.00	3
Center for Epidemiological Studies—Depression (Short)	0–30	20.00	11.00	8.00	13.00	13.00	6.00	14
Schwartz Outcome Scale	10–70	33.00	46.00	63.00	58.00	68.00	69.00	36
K10 Self-Administered Questionnaire	10–50	40.00	30.00	29.00	29.00	30.00	16.00	24
Self-Stigma of Seeking Help Therapy Scale	9–36	21.00	9.00	19.00	21.00	19.00	11.00	10
Client Task-Specific Change Measure	16–112	—	75.00	92.00	91.00	102.00	105.00	30
Working Alliance Inventory—Short Revised	12–84	—	78.00	80.00	79.00	80.00	82.00	4

Note. Change scores indicate the difference between baseline and termination.

Lia: [The director of the LGBT center] introduced me to you. And you were super sweet on the phone and then I came in here. I guess you could just tell I was “trans enough.” You asked really simple questions about my life as a child until now.

Stephanie: What do you think seemed like an easy part of the process or a hard part of the process?

Lia: Well, the easy part was answering your questions, because I knew the answers to your questions. There really was not a hard part. You made it easy.

Lia and I discussed that she felt that it was “easy” to go through the assessment with a therapist who had knowledge of the process. She also indicated that she felt that she did not have to worry about if she was saying the “right thing” or not—she felt as though she could be herself and not worry about the consequences.

Stephanie: Did you know that you had to get a letter before you started therapy?

Lia: I knew that you had to get a letter for SRS [sex reassignment surgery]; I did not know you needed one for hormones.

Stephanie: So, what was your reaction when you found out that you needed to get one before you could be prescribed hormones?

Lia: I was kind of shocked. I had never heard . . . I watched those transgender things on YouTube and none of them had said you needed letters. I thought maybe it was a [state] thing, because, you know, [state] has some weird laws.

Although age may not be a factor in this process, it seems that it might have impacted Lia’s knowledge of how to “jump through the hoops” within the process of letter writing. She was considered a minor (age 17) when she began psychotherapy. In addition, she lived in a traditionally conservative state that did not have protections for transgender individuals at the time therapy was being conducted. Although she does not describe it in detail here, she had talked throughout the course of psychotherapy about how she had internalized shame from feeling as though she was treated differently for identifying as transgender. Her reaction to the letter-writing process being a part of “weird” state laws seems to indicate how she has tried to make sense of the SOC.

Stephanie: How do you feel like taking hormones has impacted your mood?

Lia: Greatly. I used to be all types of crazy and wild and my moods would just pop up. During the first month or so of hormones it was worse, but now I just feel like, since I’m living my life as a woman, everything is just chill now. It just feels right.

Stephanie: How much of that do you attribute to the hormones?

Lia: A lot. Because I can see my progress through hormones, like getting boobs.

Stephanie: How do you think therapy interacted with the hormones?

Lia: Well, it helped me notice how different my moods actually were and how I’m much more open now than I was before. I attribute that to hormones, because I do not think I would have done it if I hadn’t started hormones. I do not know where I would be . . .

Stephanie: Where do you think you would be?

Lia: Well, I would still be that quiet do-not-want-to-talk-about-anything type of person.

Stephanie: So not wanting to open up to others or show who you are?

Lia: Yeah.

One of the primary aspects we had focused on throughout therapy was helping Lia to express and experience her emotions. Since she had experienced male socialization and had been intensely bullied as a young teenager, she was not used to experiencing her emotions. She tied emotions, psychotherapy, and hormone therapy together in the above statements. She indicated that she was now able to notice her moods and talk about her emotions differently than prior to psychotherapy and hormone therapy. Although it is difficult to interpret what the alternative might have looked like, it appears that the interaction of hormone therapy and psychotherapy enhanced one another to enable her psychological well-being to improve.

Stephanie: When you read the letter for the first time, what was that like?

Lia: I was like “Yay! It describes me!” But then, I was like—gender dysphoria? Gender Identity Disorder? But then I was like, this will help me get hormones, so I was happy overall.

Stephanie: Okay, so happy overall, but it sounds like when you were reading that part about the diagnosis . . .

Lia: Yeah, it felt like—I have a mental disorder?? [stated angrily] But you talking to me about it made me feel relieved because then it felt like I didn’t have a mental disorder.

When Lia described her feelings at seeing the diagnoses in the letter, she exclaimed this component of the session with shock and disgust. We had talked about this exchange throughout the course of therapy and how I had explained my personal feelings about the diagnosis the day of the assessment (which helped her to feel relief), but even when she discussed this process 6 months later, it still seemed as though it had a negative impact.

Discussion

The purpose of this article is to highlight the gatekeeping role of psychotherapists when assisting transgender clients with their

medical transition process. As noted by the evidence-based case study, Lia reported improvements in her mental health, support, and identity processes across all measures from baseline to termination. She highlighted that psychotherapy was an important component of assisting her with her mood, specifically learning how to experience and express her emotions. At Session 5, three sessions prior to the letter writing, she reported a distinct decrease in symptomology and an increase in well-being. She reported throughout Sessions 3–8 that knowing in the immediate future that she was going to have a letter written and engage in hormone therapy provided her with increased hope. Her increased well-being associated with hope is in line with psychotherapy research indicating that increased agency and hope at the beginning of therapy predicts higher well-being at the end of therapy (Irving et al., 2004).

Lia noted two important aspects of the letter-writing process: (a) having a therapist who knew the process well made it “easy” and (b) having a mental health diagnosis was considered to be a barrier. Therapist clinical knowledge of transgender issues appears to be a facilitative process within psychotherapy for clients who are transitioning (Pinto & Moleiro, 2015). Although this seems like a “no-brainer,” it is a significant piece of information that was reiterated from Lia—her lived experience was being around people who had no idea how to help her with her identity process or who had any expertise or cultural competence with transgender individuals. It was significant to her that I knew the process of how to help her navigate her medical and social transition processes.

In addition, Lia indicated that it was difficult for her to see that she was considered to have a mental health diagnosis. Lia is not the first client to indicate this difficulty to me. I started addressing the diagnostic issue with clients after I had conducted qualitative interviews with transgender individuals, where they described the negative impact of the diagnosis (e.g., Budge, Katz-Wise, et al., 2013). Lia indicated that she felt supported and understood when we talked about why I was giving her a diagnosis and also my own viewpoints on the subject. Lev (2013) strongly argues against the gender dysphoria diagnosis; however, psychotherapists must continue to weigh the importance of ensuring that their clients receive medically necessary care with the psychological impact of providing a (potentially) harmful diagnosis. Lia reported a direct connection between feeling relief and candidly processing the diagnosis within psychotherapy.

There are several limitations to the evidence-based case study presented in this article. First, it is impossible to provide a thorough account of 27 sessions of rich, nuanced psychotherapy in limited space. Much of the psychotherapy process did not include Lia and me discussing her transgender identity; often, we discussed her difficulties with being a first-generation college student or navigating being a person of color on a college campus. Also, even though there were six assessment time points included within the analysis, if outcomes had been gathered on a per-session basis, they likely would have shown a much more erratic process (as such, it only appears that Lia reports a decline in symptomology toward the end of psychotherapy), where she actually had more ups and downs in reality. In addition, since there is no research supporting the need for letters written by psychotherapists or

psychotherapist readiness to write letters, it is highly suggested that future research focus on these aspects.

Suggestions for Writing Letters

When I was asked to write my first letter as a predoctoral intern, I had no idea where to begin, and none of the supervisors at my internship site had any experience writing letters for transgender clients. I started off by e-mailing a therapist in the community who was well known for working with transgender clients. She indicated that she would talk to me on the phone and walk me through the letter-writing process. She sent me a deidentified letter for me to use as a template and indicated that she would read over a copy of the letter and give me feedback (upon having a release signed). After this introduction to the letter-writing process, I felt much more confident in my ability to engage in this process with transgender clients. I provide four recommendations below for letter writing that have been successful within my own psychotherapeutic practice (and with Lia specifically).

1. When a client indicates their desire for a medical transition, it will be important to ask specific questions about their insurance company and if they plan to use a specialist (e.g., endocrinologist, plastic surgeon specializing in gender-confirming surgeries) or generalist (e.g., primary care physician to obtain hormones). Psychotherapists should become familiar with the SOC Version 7 and have a direct conversation with clients about what the SOC are and what clients can expect from a psychotherapist. Psychotherapists will want to obtain releases of information during this process so any coordination of care with medical doctors or medical clinics will be streamlined. I often offer to assist clients in reading through insurance policies, since they are often unaware of how to find out if their insurance company will cover transition-related services. (Note: In my clinical experience, most insurance policies do not cover transition-related services and often specifically exclude these services in the policy; it is possible that after this article is published, more policies will cover transition-related services under the Affordable Care Act.)
2. Once a client has chosen where they want to seek medical services, I will call the medical doctor or the clinic in order to find out what they require in the hormone or surgery letters. Most of the time, I am told that I should just “do what you normally do.” However, clinics that specialize in transgender care usually have documents that outline specifically what they require in letters. Two documents I recently received require: (a) a legal and/or preferred name, (b) statement of sex assigned at birth, (c) affirmed gender, (d) preferred gender pronouns, (e) reason for referral, (f) dates of evaluation and treatment, (g) any collateral contact (e.g., parents, siblings, previous therapist), (h) psychiatric diagnoses, (i) a specific statement describing gender dysphoria, (j) a statement regarding whether there are any comorbid diagnoses that confound the gender dysphoria diagnosis, (k) psychiatric history, (l) gender development history (age when transgender identity was realized and disclosed, age when social transition began), (m) indication of medical

necessity for the transition-related procedure, (n) indication of the client's readiness to transition, and (o) indication of the client's understanding of the effects of the medical treatments.

3. Once the client indicates readiness to receive a letter and to engage in medical treatment(s), we will schedule the evaluation session. I will send them a packet of assessment materials (including symptom measures, social support measures, and gender identity measures). These materials are different from what I generally use for session outcome measures—usually longer measures that will highlight more of the nuances of their current experiences (see the [Appendix](#)). Within the evaluation session, I will talk with the client about the information that I am going to include in the letter and will ask specific questions to ensure that I have a comprehensive understanding of the client's gender identity (history and current experiences). As highlighted with Lia, I will talk with the client about the requirement to include the gender dysphoria and/or gender identity disorder diagnoses and assess the impact the diagnoses will have on our therapeutic relationship, as well as on the well-being of the client. I then let the client know that I will write the letter and that we will go over the letter in our next session to determine if there are any changes that need to be made.
4. Some clients may call psychotherapists to ask for a letter and an evaluation session without engaging in psychotherapy. It will be a personal decision whether or not the psychotherapist would like to conduct evaluations without engaging in psychotherapy. In my clinical experience, if clients believe that they need to enter psychotherapy in order to receive a letter, they may engage in psychotherapy until the letter is written and then drop out of therapy. The process of letter writing will be similar to that of writing a letter for a longer term client, but the evaluation may need to be longer in order to obtain comprehensive information about psychiatric history, diagnoses, and gender identity.

Although it may be intimidating to provide gatekeeping services to transgender clients, it can be helpful to remember that psychotherapists will find themselves in new situations with any client. Many psychotherapists who primarily work with transgender clients are willing to consult in order to ensure that more therapists are competent. Even though there have not been any published articles about the letter-writing process, there has been an increase in published articles and books about clinical processes (e.g., [Coolhart, Baker, Farmer, Malaney, & Shipman, 2013](#); [Coolhart, Provancher, Hager, & Wang, 2008](#); [Donatone & Rachlin, 2013](#); [Griffin, 2011](#); [Hagen & Galupo, 2014](#); [Heck, Croot, & Robohm, 2015](#); [Holmes & Freeman, 2012](#); [Pinto & Moleiro, 2015](#); [Tishelman et al., 2015](#)). Due to the high rate of transgender individuals who have sought or are seeking therapy ([Grant et al., 2011](#)), it is imperative that psychotherapists become familiar with the clinical needs of transgender clients. Even if the gatekeeping or learning a new skill in working with transgender clients can feel daunting, it is a beautiful process to assist someone in becoming their authentic self.

References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Andresen, E. M., Malmgren, J. A., Carter, W. B., & Patrick, D. L. (1994). Screening for depression in well older adults: Evaluation of a short form of the CES-D (Center for Epidemiologic Studies Depression Scale). *American Journal of Preventive Medicine, 10*, 77–84.
- Balsam, K. F., Beauchaine, T. P., Rothblum, E. D., & Solomon, S. E. (2008). Three-year follow-up of same-sex couples who had civil unions in Vermont, same-sex couples not in civil unions, and heterosexual married couples. *Developmental Psychology, 44*, 102–116. <http://dx.doi.org/10.1037/0012-1649.44.1.102>
- Balsam, K. F., & Szymanski, D. M. (2005). Relationship quality and domestic violence in women's same-sex relationships: The role of minority stress. *Psychology of Women Quarterly, 29*, 258–269. <http://dx.doi.org/10.1111/j.1471-6402.2005.00220.x>
- Benson, K. E. (2013). Seeking support: Transgender client experiences with mental health services. *Journal of Feminist Family Therapy, 25*, 17–40. <http://dx.doi.org/10.1080/08952833.2013.755081>
- Bess, J., & Stabb, S. (2009). The experiences of transgendered persons in psychotherapy: Voices and recommendations. *Journal of Mental Health Counseling, 31*, 264–282. <http://dx.doi.org/10.17744/mehc.31.3.f624154681133w50>
- Blais, M. A., Lenderking, W. R., Baer, L., deLorell, A., Peets, K., Leahy, L., & Burns, C. (1999). Development and initial validation of a brief mental health outcome measure. *Journal of Personality Assessment, 73*, 359–373. http://dx.doi.org/10.1207/S15327752JPA7303_5
- Bockting, W., Robinson, B., Benner, A., & Scheltema, K. (2004). Patient satisfaction with transgender health services. *Journal of Sex & Marital Therapy, 30*, 277–294. <http://dx.doi.org/10.1080/00926230490422467>
- Brennan, D. J., Crath, R., Hart, T. A., Gadalla, T., & Gillis, L. (2011). Body dissatisfaction and disordered eating among men who have sex with men in Canada. *International Journal of Men's Health, 10*, 253–268. <http://dx.doi.org/10.3149/jmh.1003.253>
- Budge, S. L., Adelson, J. L., & Howard, K. A. (2013). Anxiety and depression in transgender individuals: The roles of transition status, loss, social support, and coping. *Journal of Consulting and Clinical Psychology, 81*, 545–557. <http://dx.doi.org/10.1037/a0031774>
- Budge, S. L., Katz-Wise, S. L., Tebbe, E. N., Howard, K. A., Schneider, C. L., & Rodriguez, A. (2013). Transgender emotional and coping processes: Facilitative and avoidant coping throughout gender transitioning. *The Counseling Psychologist, 41*, 601–647. <http://dx.doi.org/10.1177/0011000011432753>
- Carroll, L., Gilroy, P. J., & Ryan, J. (2002). Counseling transgendered, transsexual, and gender-variant clients. *Journal of Counseling & Development, 80*, 131–139. <http://dx.doi.org/10.1002/j.1556-6678.2002.tb00175.x>
- Carvalho, A., Lewis, R., Derlega, V., Winstead, B., & Viggiano, C. (2011). Internalized sexual minority stressors and same-sex intimate partner violence. *Journal of Family Violence, 26*, 501–509. <http://dx.doi.org/10.1007/s10896-011-9384-2>
- Cochran, S. D., & Mays, V. M. (2007). Physical health complaints among lesbians, gay men, and bisexual and homosexually experienced heterosexual individuals: Results from the California Quality of Life Survey. *American Journal of Public Health, 97*, 2048–2055. <http://dx.doi.org/10.2105/AJPH.2006.087254>
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., . . . Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, Version 7. *International Journal of Transgenderism, 13*, 165–232. <http://dx.doi.org/10.1080/15532739.2011.700873>
- Coolhart, D., Baker, A., Farmer, S., Malaney, M., & Shipman, D. (2013). Therapy with transsexual youth and their families: A clinical tool for assessing youth's readiness for gender transition. *Journal of Marital and*

- Family Therapy*, 39, 223–243. <http://dx.doi.org/10.1111/j.1752-0606.2011.00283.x>
- Coolhart, D., Provancher, N., Hager, A., & Wang, M. N. (2008). Recommending transsexual clients for gender transition: A therapeutic tool for assessing readiness. *Journal of GLBT Family Studies*, 4, 301–324. <http://dx.doi.org/10.1080/15504280802177466>
- Dargie, E., Blair, K. L., Pukall, C. F., & Coyle, S. M. (2014). Somewhere under the rainbow: Exploring the identities and experiences of trans persons. *The Canadian Journal of Human Sexuality*, 23, 60–74. <http://dx.doi.org/10.3138/cjhs.2378>
- De Cuypere, G., & Vercruyse, H., Jr. (2009). Eligibility and readiness criteria for sex reassignment surgery: Recommendations for revision of the WPATH Standards of Care. *International Journal of Transgenderism*, 11, 194–205. <http://dx.doi.org/10.1080/15532730903383781>
- Donatone, B., & Rachlin, K. (2013). An intake template for transgender, transsexual, genderqueer, gender nonconforming, and gender variant college students seeking mental health services. *Journal of College Student Psychotherapy*, 27, 200–211. <http://dx.doi.org/10.1080/87568225.2013.798221>
- Dragomirecká, E., Bartonová, J., Eisemann, M., Kalfoss, M., Kilian, R., Martiny, K., . . . Schmidt, S. (2008). Demographic and psychosocial correlates of quality of life in the elderly from a cross-cultural perspective. *Clinical Psychology & Psychotherapy*, 15, 193–204. <http://dx.doi.org/10.1002/cpp.571>
- Edwards, K. M., & Sylaska, K. M. (2013). The perpetration of intimate partner violence among LGBTQ college youth: The role of minority stress. *Journal of Youth and Adolescence*, 42, 1721–1731. <http://dx.doi.org/10.1007/s10964-012-9880-6>
- Fletcher, J. B., Kisler, K. A., & Reback, C. J. (2014). Housing status and HIV risk behaviors among transgender women in Los Angeles. *Archives of Sexual Behavior*, 43, 1651–1661. <http://dx.doi.org/10.1007/s10508-014-0368-1>
- Fraser, L. (2009). Psychotherapy in the World Professional Association for Transgender Health's Standards of Care: Background and recommendations. *International Journal of Transgenderism*, 11, 110–126. <http://dx.doi.org/10.1080/15532730903008057>
- Fredriksen-Goldsen, K. I., Cook-Daniels, L., Kim, H. J., Erosheva, E. A., Emler, C. A., Hoy-Ellis, C. P., . . . Muraco, A. (2014). Physical and mental health of transgender older adults: An at-risk and underserved population. *The Gerontologist*, 54, 488–500.
- Furukawa, T. A., Kessler, R. C., Slade, T., & Andrews, G. (2003). The performance of the K6 and K10 screening scales for psychological distress in the Australian National Survey of Mental Health and Well-Being. *Psychological Medicine*, 33, 357–362. <http://dx.doi.org/10.1017/S0033291702006700>
- Goppoldova, E., Dragomirecka, E., Motlova, L., & Hajek, T. (2008). Subjective quality of life in psychiatric patients: Diagnosis and illness-specific profiles. *Canadian Journal of Psychiatry*, 53, 587–593.
- Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at every turn: National Trans Discrimination Survey*. Washington, DC: National Center for Trans Equality and National Gay and Lesbian Task Force.
- Griffin, L. (2011). The other dual role: Therapist as advocate with transgender clients. *Journal of Gay & Lesbian Mental Health*, 15, 235–236. <http://dx.doi.org/10.1080/19359705.2011.553777>
- Hagen, D. B., & Galupo, M. P. (2014). Trans* individuals' experiences of gendered language with health care providers: Recommendations for practitioners. *International Journal of Transgenderism*, 15, 16–34. <http://dx.doi.org/10.1080/15532739.2014.890560>
- Haggerty, G., Siefert, C., Stoycheva, V., Sinclair, S. J., Baity, M., Zodan, J., . . . Blais, M. A. (2014). Determining adolescents' suitability for inpatient psychotherapy: Utility of the clinician-rated Readiness for Inpatient Psychotherapy Scale with an adolescent inpatient sample. *Bulletin of the Menninger Clinic*, 78, 349–372. <http://dx.doi.org/10.1521/bumc.2014.78.4.349>
- Heck, N. C., Croot, L. C., & Robohm, J. S. (2015). Piloting a psychotherapy group for transgender clients: Description and clinical considerations for practitioners. *Professional Psychology: Research and Practice*, 46, 30–36. <http://dx.doi.org/10.1037/a0033134>
- Holmes, J., & Freeman, S. B. (2012). Assessment and management of female-to-male transgender patients: A psychosocial and hormonal approach. *American Journal for Nurse Practitioners*, 16, 6.
- Honea-Boles, P., & Griffin, J. E. (2001). The court-mandated client: Does limiting confidentiality preclude a therapeutic encounter? *Journal of Professional Counseling, Practice, Theory, & Research*, 29, 149.
- Horvath, A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011). Alliance in individual psychotherapy. *Psychotherapy*, 48, 9–16. <http://dx.doi.org/10.1037/a0022186>
- Irving, L. M., Snyder, C. R., Cheavens, J., Gravel, L., Hanke, J., Hilberg, P., & Nelson, N. (2004). The relationships between hope and outcomes at the pretreatment, beginning, and later phases of psychotherapy. *Journal of Psychotherapy Integration*, 14, 419–443. <http://dx.doi.org/10.1037/1053-0479.14.4.419>
- Kessler, R. C., Berglund, P., Demler, O., Jin, R., Koretz, D., Merikangas, K. R., . . . Wang, P. S. (2003). The epidemiology of major depressive disorder: Results from the National Comorbidity Survey Replication (NCS-R). *JAMA: Journal of the American Medical Association*, 289, 3095–3105. <http://dx.doi.org/10.1001/jama.289.23.3095>
- Lea, T., de Wit, J., & Reynolds, R. (2014). Minority stress in lesbian, gay, and bisexual young adults in Australia: Associations with psychological distress, suicidality, and substance use. *Archives of Sexual Behavior*, 43, 1571–1578. <http://dx.doi.org/10.1007/s10508-014-0266-6>
- Lev, A. I. (2009). The ten tasks of the mental health provider: Recommendations for revision of the World Professional Association for Transgender Health's Standards of Care. *International Journal of Transgenderism*, 11, 74–99.
- Lev, A. I. (2013). Gender dysphoria: Two steps forward, one step back. *Clinical Social Work Journal*, 41, 288–296. <http://dx.doi.org/10.1007/s10615-013-0447-0>
- Meier, S. C., Pardo, S. T., Labuski, C., & Babcock, J. (2013). Measures of clinical health among female-to-male transgender persons as a function of sexual orientation. *Archives of Sexual Behavior*, 42, 463–474. <http://dx.doi.org/10.1007/s10508-012-0052-2>
- Mohr, J., & Fassinger, R. (2000). Measuring dimensions of lesbian and gay male experience. *Measurement & Evaluation in Counseling & Development*, 33, 66–90.
- Munder, T., Wilmers, F., Leonhart, R., Linster, H. W., & Barth, J. (2010). Working Alliance Inventory-Short Revised (WAI-SR): Psychometric properties in outpatients and inpatients. *Clinical Psychology & Psychotherapy*, 17, 231–239. <http://dx.doi.org/10.1002/cpp.658>
- Nordgren, L. B., Carlbring, P., Linna, E., & Andersson, G. (2013). Role of the working alliance on treatment outcome in tailored internet-based cognitive behavioural therapy for anxiety disorders: Randomized controlled pilot trial. *JMIR Research Protocols*, 2, e4. <http://dx.doi.org/10.2196/resprot.2292>
- Olfson, M., & Marcus, S. C. (2010). National trends in outpatient psychotherapy. *The American Journal of Psychiatry*, 167, 1456–1463. <http://dx.doi.org/10.1176/appi.ajp.2010.10040570>
- Olyslager, F., & Conway, L. (2007, September). *On the calculation of the prevalence of transsexualism*. Paper presented at the WPATH 20th International Symposium, Chicago, IL.
- Owen, J., Hilsenroth, M. J., & Rodolfa, E. (2013). Interaction among alliance, psychodynamic–interpersonal and cognitive–behavioural techniques in the prediction of post-session change. *Clinical Psychology & Psychotherapy*, 20, 513–522. <http://dx.doi.org/10.1002/cpp.1792>
- Owen, J. J., Thomas, L., & Rodolfa, E. (2013). Stigma for seeking therapy: Self-stigma, social stigma, and therapeutic processes. *The*

- Counseling Psychologist*, 41, 857–880. <http://dx.doi.org/10.1177/0011000012459365>
- Pinto, N., & Moleiro, C. (2015). Gender trajectories: Transsexual people coming to terms with their gender identities. *Professional Psychology: Research and Practice*, 46, 12–20. <http://dx.doi.org/10.1037/a0036487>
- Rachlin, K. (2002). Transgender individuals' experiences of psychotherapy. *International Journal of Transgenderism*, 6, 1–19.
- Reback, C. J., Simon, P. A., Bemis, C. C., & Gatson, B. (2001). *The Los Angeles Transgender Health Study: Community report*. Los Angeles, CA: Author.
- Sanchez, N. F., Sanchez, J. P., & Danoff, A. (2009). Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City. *American Journal of Public Health*, 99, 713–719. <http://dx.doi.org/10.2105/AJPH.2007.132035>
- Sotero, L., Major, S., Escudero, V., & Relvas, A. P. (2014). The therapeutic alliance with involuntary clients: How does it work? *Journal of Family Therapy*. Advance online publication. <http://dx.doi.org/10.1111/1467-6427.12046>
- Tishelman, A. C., Kaufman, R., Edwards-Leeper, L., Mandel, F. H., Shumer, D. E., & Spack, N. P. (2015). Serving transgender youth: Challenges, dilemmas, and clinical examples. *Professional Psychology: Research and Practice*, 46, 37–45. <http://dx.doi.org/10.1037/a0037490>
- van Kesteren, P. J., Gooren, L. J., & Megens, J. A. (1996). An epidemiological and demographic study of transsexuals in the Netherlands. *Archives of Sexual Behavior*, 25, 589–600. <http://dx.doi.org/10.1007/BF02437841>
- Watson, J. C., Greenberg, L. S., Rice, L. N., & Gordon, L. B. (1996). *Client Task-Specific Change Measure—Revised: Unpublished measure*. Toronto, ON, Canada: University of Toronto.
- Watson, J. C., Schein, J., & McMullen, E. (2010). An examination of clients' in-session changes and their relationship to the working alliance and outcome. *Psychotherapy Research*, 20, 224–233. <http://dx.doi.org/10.1080/10503300903311285>
- Xavier, J., Bradford, J., Hendricks, M., Safford, L., McKee, R., Martin, E., & Honnold, J. A. (2013). Transgender health care access in Virginia: A qualitative study. *International Journal of Transgenderism*, 14, 3–17. <http://dx.doi.org/10.1080/15532739.2013.689513>
- Yeh, C. J., Okubo, Y., Ma, P. W., Shea, M., Ou, D., & Pituc, S. T. (2008). Chinese immigrant high school students' cultural interactions, acculturation, family obligations, language use, and social support. *Adolescence*, 43, 775–790.
- Young, J. L., Waehler, C. A., Laux, J. M., McDaniel, P. S., & Hilsenroth, M. J. (2003). Four studies extending the utility of the Schwartz Outcome Scale (SOS-10). *Journal of Personality Assessment*, 80, 130–138. http://dx.doi.org/10.1207/S15327752JPA8002_02
- Zimet, G. D., Dahlem, N. W., Zimet, S. G., & Farley, G. K. (1988). The Multidimensional Scale of Perceived Social Support. *Journal of Personality Assessment*, 52, 30–41. http://dx.doi.org/10.1207/s15327752jpa5201_2

Appendix

Sample Letter

This letter is to serve as a record of Lia X's eligibility for hormone therapy on the basis of her transgender identity and readiness to begin a medical gender transition. Lia identifies as a transgender woman and was assigned a male sex at birth. Lia has been working with me as a psychotherapy client since [date]. She has attended seven individual therapy sessions and one family session with her mother for a total of eight sessions.

Lia's legal name is Anthony X, but she plans to change her name legally in the near future. In most settings, she is introducing herself as Lia rather than Anthony and has asked those who know about her gender identity to refer to her as Lia and to use female pronouns. Lia reports that she began presenting as a woman since July 2013 but has been presenting femininely since she was a toddler. She states that she can remember being a child around the age of 4, indicating to her aunt and uncle "I'm a girl" and having her uncle correct her but having her aunt affirm her gender-nonconforming behavior. She indicates that she has expressed her gender in a feminine manner since "I could walk and talk." She states that she played with "girl toys" and would wear pink at any moment throughout her childhood. The Recalled Childhood Gender Identity/Gender Role Questionnaire asks 23 questions to assess

childhood nonconformity. Lia indicates that her behaviors and feelings as a child were "always feminine" across all 23 questions.

Lia reported that she came out as gay when she was in seventh grade, which she stated did not "come as a surprise" to many, since she had been expressing herself femininely in most settings. At the age of 17, she came out as a transgender woman to her mother in July 2013 and has subsequently come out to her other family members and friends (with mixed positive and negative reactions). She indicates that she has been receiving accommodations at the university to assist her with her gender transition. For example, she describes living in housing that will accommodate her request for a single-stall restroom and that her professors have changed her name on their rosters to reflect the name she currently uses. Lia reports that she has a strong sense of social support related to her transition. On the Multidimensional Scale of Social Support, she indicated that she has "strong social support" (e.g., 77 out of 84) from family and friends. Although Lia reports high levels of social support currently, she describes being bullied in middle school, which led to self-harm behaviors and a suicide attempt at the age of 14. Lia denies any current self-harm or suicidal ideation.

(Appendix continues)

Related to Lia's mental health, she endorsed a higher than average level of anxiety at the time this letter is being written (e.g., a score of 31 on the Burns Anxiety Inventory, which is the cutoff for severe anxiety). Although she mostly endorsed experiencing anxiety symptoms "somewhat" (sudden panic spells, difficulty concentrating, pressure in her chest, etc.), there were several symptoms related to her gender identity, which she reported to experience a "moderate" amount (feeling detached from her body, concerns about looking foolish, and fears of criticism or disapproval). Lia also endorsed a higher than average level of depression. Lia scored 22 on the Center for Epidemiological Studies for Depression scale; the cutoff score for clinical depression is 16. It should be noted that she endorsed items such as "I felt I was just as good as other people" and "I felt hopeful about the future." Lia describes a substantial amount of distress that is derived from feeling incongruence with her body. She reports strong feelings of disgust when she looks at herself in the mirror and tries to avoid seeing herself naked. She indicates that she feels tearful every day when her facial hair becomes apparent.

Lia presents with symptoms that are consistent with a diagnosis of gender dysphoria. Although she meets criteria for social anxiety disorder and persistent mood disorder, it is my clinical opinion that these are symptoms related to dysphoria. Based on her self-report in therapy, her depressive and anxiety symptoms appear to be related to her feeling "in between" genders at the moment and wanting to move her transition forward. Lia reports an extensive family history of bipolar disorder; however, she does not present

with any symptoms that are congruent with bipolar disorder or other psychiatric diagnoses.

Lia and I have discussed the possibility of hormone therapy, and she appears well versed in her knowledge of the possible side effects and what she will gain from using hormones. When asked about what she is expecting from taking hormones, she reports that she is excited to see physical changes (breast growth, skin texture, etc.). She also indicates that she believes that the hormones will greatly improve her mental health and decrease some of the incongruence that she experiences related to her gender.

In sum, Lia X (legal name: Anthony X) is an 18-year-old transgender woman who meets the criteria for gender dysphoria. She has engaged in psychotherapy with me since July 2013 and continues to engage in therapy sessions in pursuit of hormone therapy and support throughout her transition process. There is no evidence of impaired judgment. In addition, I believe that Lia's psychopathology related to anxiety and depression will dissipate as she engages in hormone therapy. I certify Lia to be a fit candidate for hormone therapy and assert that these treatments are medically necessary to improve her well-being. Pursuant to the enclosed signed release, feel free to contact me at [include phone number and e-mail] if there are any further questions regarding this individual.

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