

**HELPING TRANSGENDERED CLIENTS:
A WORKSHOP**

by

Allison Crosby

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ABSTRACT

The purpose of this project is to develop a workshop to train mental health practitioners to effectively help transgendered clients. A review of the literature on transgendered mental health is provided, including the history of transsexualism and the gender identity diagnosis, the social and psychosocial experiences of transgendered individuals, biological and surgical treatments, and recommendations for counselling. The format of the workshop, the target audience, and ethical concerns are described. Finally, a detailed description of the workshop, outlining the intended schedule, activities, and lectures is presented.

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Chapter 1: Introduction

The word *transgender* is an umbrella term used to refer to individuals who transcend the cultural norms of their assigned gender (WPATH, 2012). Due to this disparity from societal standards of gender, transgendered individuals are often subject to discrimination, neglect, abuse, and trauma (Livingstone, 2008). Further, this population is at risk for the development of many other mental health issues including significant relationship problems, anxiety, depression, suicide, and substance use and abuse (American Psychological Association, 2000; Livingstone, 2008). These individuals may seek counselling to explore their gender identity, discuss possible treatment options including sex reassignment surgery, or work on additional mental health issues.

Despite the current focus on multiculturalism and diversity in counselling training programs, little attention is given to the unique needs of the transgendered community (Chen-Hayes, 2001). This lack of focus on specific transgendered issues is problematic given that the number of individuals seeking assistance for gender identity issues and sex reassignment surgery has increased in recent years (Johansson, Sundbom, Hojerback, & Bodlund, 2010; Zucker & Lawrence, 2009). With greater awareness of gender diversity among both professionals and the general population, society is becoming a more accepting place for transgendered clients to disclose their gender disparity (Zucker & Lawrence, 2009). Indeed, the need for mental health resources appears to be high among the transgendered community. Goldberg, Matte, MacMillan, and Hudspith (2003) conducted a survey on 177 transgendered individuals across British Columbia (BC). Eighty-six percent of respondents ($n = 154$) reported requiring counselling at some point. These above factors make it

increasingly likely that counsellors will work with a transgendered client at some point during their career.

Purpose

The purpose of this project was to develop a three-day, in-person, psycho-educational workshop to train and educate mental health practitioners on transgendered clinical issues and methods to provide effective support for this diverse population. In particular, this workshop serves to educate mental health practitioners within Northern BC.

According to a 2006 BC wide survey, there were 48 mental health clinicians in private practice who were clinically educated in transgendered mental health (Goldberg, Ashbee, Bradd, Lindenberg, & Simpson, 2006). None of these clinicians were practicing within Northern BC. The lack of resources available to transgendered individuals adds to the list of barriers and difficulties faced by this population. There is a clear need for more transgendered resources, particularly in the northern part of BC.

A major goal of the workshop is to challenge and broaden mental health practitioners' views of gender. This workshop also serves to educate mental health workers about the challenges facing transgendered individuals and how to provide effective and holistic care.

Clarification of Terms

There are several definitions that are important to understand when developing a workshop on transgendered mental health. The term *sex* refers to the classification of either male or female based on one's genitalia (WPATH, 2012). *Gender identity* describes one's inherent "sense of being male (a boy or a man), female (a girl or a woman), or alternative

gender” (WPATH, 2012, p. 96). In the literature and for the purposes of this project, the term *transgender* refers to individuals who either identify with a different gender than their assigned gender or transcend societal norms of gender expression (Bockting, Knudson, & Goldberg, 2006). It is a broad and flexible definition that encompasses many different individuals including cross-dressers (individuals who wear gender non-conforming clothing), drag kings/queens (performers who dress in gender non-conforming clothing), transvestites (individuals who dress as the opposite sex for sexual pleasure), androgynous individuals (individuals with both masculine and feminine characteristics), two-spirit individuals (among some Aboriginal communities, individuals who take on roles of the opposite gender), transsexuals (individuals who identify as the gender opposite their assigned gender), and many others (i.e., Gender Queer, Dyke, Bi-Gendered, etc.; Bockting, Knudson, & Goldberg, 2006; Grossman & D’Augelli, 2008; WPATH, 2012). It should be noted that the definitions for the above terms are flexible, that terminology seems to be constantly evolving, and that there may be other terms that could be included under the broad definition of transgender. Gender dysphoria is another important term within the transgender literature and refers to the “discomfort or distress that is caused by a discrepancy between a person’s gender identity and that person’s sex assigned at birth” (WPATH, 2012, p. 5). Not all gender non-conforming individuals will experience gender dysphoria or wish to receive hormonal or surgical treatment.

Individuals who experience gender dysphoria may meet the criteria for a mental disorder diagnosis. According to the *Diagnostic and Statistical Manual of Mental Disorders –IV - TR* (DSM; American Psychological Association, 2000), gender identity disorder (GID) is characterized by a pronounced and determined identification with the opposite sex and a

sense of discomfort with one's assigned sex. To be diagnosed, the individual must not have a co-occurring intersex condition and there must be evidence of serious impairment in functioning.

My Personal Location

I am a 25-year-old female living in Prince George, BC where I am currently completing my Master of Education in Counselling at the University of Northern BC (UNBC). As a novice counsellor, I have limited clinical experience with the transgendered population. My interest in exploring the mental health of transgendered individuals was inspired by my relationship with a friend who identified as transgendered. As I watched her try to gain acceptance from others, I became aware of the misfortunes affecting this population. This experience helped me become conscious of society's rigid views of gender as a dichotomy and how this inherently pathologizes gender diversity.

Having moved from Vancouver, BC, I have noticed a disparity between the number of resources available in the Lower Mainland and the Northern part of the province. Living in Prince George is ideal for the development of a workshop on working with transgendered individuals because of the lack of resources available in this part of the province.

My personal worldview. I approached the development of this workshop with my own beliefs and biases. My worldview stresses the importance of empathy, unconditional positive regard for the client, and maintaining congruence (Rogers, 1992). I believe these counsellor traits are particularly important when working with transgendered clients as many will have experienced discrimination, neglect, abuse, and trauma and may be mistrustful of mental health practitioners (Livingstone, 2008). Understanding and accepting clients' perspectives and identity are key for building trust with transgendered individuals. These

fundamental principles will be emphasized throughout the workshop. Participants will be encouraged to practice these qualities when working with others and during role-plays.

I also believe that the sociocultural environment affects an individual's identity development, including one's gender and sexuality. Social and cultural norms have affected and oppressed men, women, and transgendered individuals. A major goal of this workshop is to challenge the dominant cultural view of gender as a dichotomy, heighten awareness of socially created gender roles, and discuss the negative effects of rigid norms. If society's views of gender norms can be shifted, it is likely that transgendered individuals will experience less discrimination and more acceptance. In this workshop, participants will confront their own biases of gender.

Northern Focus

The transgendered population in Northern BC faces unique challenges in comparison to their Lower Mainland counterparts. Transgendered individuals in northern regions may feel lonely and unsupported due to the lack of resources (e.g., support groups or "hang outs") and few health care professionals with specific training on transgendered issues. In a qualitative thesis, two transgendered participants remarked on the significant lack of trained professionals in Northern BC (Okpodi, 2011). One participant stated, "...there are health care professionals who do not really address trans-issues, they really just address broad gay and lesbian sort of focus" (Okpodi, 2011, p. 56). This quote reflects a perception that although some health care professionals in Northern BC are aware of lesbian, gay, and bisexual issues, there does not appear to be much understanding regarding matters unique to transgendered individuals. In addition, although there are some resources available for the larger LGBTQ

community (e.g., Prince George PRIDE), there do not appear to be many supports specifically for the transgendered community.

Further, living in a small community may feel like “living in a fish bowl”. It may be difficult to access mental health resources discreetly and small-town gossip may force transgendered individuals to come out before they feel personally ready to do so. In addition, residents of Northern BC may not be as accepting of transgendered individuals as those in the Lower Mainland due to lack of exposure and education. Thus, transgendered individuals in smaller communities may experience more oppression and have less support for dealing with any discrimination, neglect, and abuse.

These potential challenges for the transgendered population make this workshop especially pertinent for the northern region. Educating mental health practitioners in Northern BC on transgendered issues may help this population to feel less alone and more accepted when accessing help. In addition, this workshop addresses the lack of educational opportunities for practitioners interested in learning more about transgendered issues.

Summary of Chapter One and Overview of the Project

The purpose of this psycho-educational workshop is to educate and train clinicians on transgendered specific issues including trans-phobia and the treatment options available. In addition, it will aim to challenge and broaden society’s rigid views of gender, maintaining that gender exists along a continuum rather than a dichotomy.

Chapter One has provided the rationale for this project. Chapter Two will provide an overview of the literature that has been conducted in the area of transgendered mental health. Chapter Three will describe the target audience, recommended facilitator, workshop goals,

and ethical considerations. Finally, Chapter Four will present a detailed description of each of the three days of the workshop.

Chapter 2: Literature Review

Chapter Two provides a comprehensive review of the relevant literature that forms the foundation of the workshop. It will begin by briefly discussing the history of transgenderism and the development of the diagnosis within the DSM. Next, the chapter will examine the oppression faced by transgendered individuals and the resulting co-occurring mental health issues. The chapter will review recent literature regarding transgendered clients' counselling experiences and recommendations by organizational bodies. The coming-out process and implications for family members, both partners and children, will then be explored. Chapter Two will also discuss some important developmental issues to consider when working with adult transgendered clients. Finally, this chapter will conclude with a concise overview of the hormonal and surgical treatment options available for transgendered individuals.

Background/History

In order to have a strong understanding of transgenderism, it is important to consider its evolution. There have been shifts in perspectives regarding gender identity and how mental health practitioners approach the subject.

Scientific interest. The medical community has formally recognized gender nonconformity since the 1920s (Reicherzer, 2008). English surgeons completed the first sex reassignment surgery on a male-to-female transgendered individual in 1931 (Abraham, 1997). By the late 1940s, the medical community had noticed an increase in the number of individuals seeking sex reassignment surgery (Reicherzer, 2008). In an article originally published in 1947, Sexologist David Cauldwell wrote, "there are men and women in countless numbers who are willing to pay heavy fees to have their sexuality destroyed" (Cauldwell, 2001a, para. 11). Cauldwell coined the term *psychopathic transsexual* to refer to

individuals who wish to be a member of the opposite sex (Cauldwell, 2001b). He initially viewed transsexuals as suffering from a disease and being “mentally deficient” (Cauldwell, 2001b, para. 2). However, Cauldwell (2001c) revised this position in a later publication by stating, “some [transsexuals] are not sound of mind, but this is true of heterosexuals” (para.13).

In 1952, a 26-year-old American man received sex reassignment surgery in Denmark (Gherovici, 2010). The story of her sex change became the most widely covered news story in the United States (MacKenzie, 1994). This widespread media coverage prompted other American transsexuals to enquire about possible surgery options (Reicherzer, 2008). At the same time, American researchers and scientists were also beginning to become curious about the topic of gender identity (Reicherzer, 2008). Sexologist Harry Benjamin presented a paper on transsexualism at a medical conference in 1953 in New York (MacKenzie, 1994). It was during this conference that the term transsexualism was first introduced to American scholars. The 1950s was truly the era that began the popularization of transsexualism both among the general population and academics.

Throughout the 1960s and 1970s, transsexualism continued to be medicalized and as many as 20 gender identity clinics were opened across the United States (MacKenzie, 1994). There was also a substantial increase in the number of published articles on transsexualism and in the number of academics interested in the topic (MacKenzie, 1994). In 1979, Harry Benjamin formed the Harry Benjamin International Gender Dysphoria Association, which is now known as the World Professional Association for Transgender Health (WPATH) (Reicherzer, 2008). This association consisted of a group of psychologists, psychiatrists, and

surgeons whose primary goal was to provide clinical care standards for diagnosing and treating transsexualism.

The 1960s and 1970s were decades that were well known for the feminist movement and liberation of gays and lesbians. However, these major social movements appeared to have had little influence on de-medicalizing transsexualism (MacKenzie, 1994). For instance, in 1980, homosexuality was removed from the DSM partially due to social pressures (Gherovici, 2010). Despite these social movements, “gender identity disorder” was introduced to the DSM in 1980 and remains in the manual to the present day (Reicherzer, 2008).

Before the 1980s, gender was largely associated with one’s external genitalia (natural or artificial) and transsexuals who had received sex reassignment surgery were expected to conform to the expectations of their newly assigned gender (Gherovici, 2010). However, gender non-conforming individuals began to challenge this gender dichotomy in the 1980s. Gender activist Virginia Prince coined the term *transgenderist* to refer to individuals “who fall somewhere between *transvestite* and *transsexual*” (Gherovici, 2010, p. 33). This definition included individuals who were unhappy living as their assigned gender but who did not desire a full transition to the opposite gender (Gherovici, 2010). The 1990s marked the beginning of a transgender revolution and the idea that gender exists along a continuum, rather than a simple binary (Gherovici, 2010).

Since the 1990s, the term transgender has become very inclusive and less stigmatized (Gherovici, 2010). Further, transgendered individuals are finally beginning to gain some basic rights. For instance, in 2011, Australia gave its citizens the option to choose a third

gender for their passport (male, female, or indeterminate; Bielski, 2011). While Canada and the United States allow transgendered individuals to change their passport gender identity to either male or female, Australia is the first country to allow a third gender option. Although a seemingly small change, this demonstrates social acceptance of gender diversity.

The development of a diagnosis. Although the DSM-II (American Psychiatric Association, 1968) included definitions for homosexuality and transvestitism, it did not consist of any disorders related to gender identity. The DSM-III (American Psychiatric Association, 1980) introduced Gender Identity Disorder of Childhood (GIDC), transsexualism (for adolescents and adults), and Psychosexual Disorder Not Elsewhere Classified (Zucker, 2009). These were included under the section of Psychosexual Disorders. The diagnostic labels were revised with the DSM-III-R and included: Gender Identity Disorder of Childhood, Transsexualism, Gender Identity Disorder of Adolescence of Adulthood, Non-transsexual Type (GIDAANT), and Gender Identity Disorder Not Otherwise Specified (American Psychiatric Association, 1987). These disorders were placed under the section Disorders Usually First Evident in Infancy, Childhood, or Adolescence. Finally, in the DSM-IV, only the terms Gender Identity Disorder and Gender Identity Disorder Not Otherwise Specified were maintained and were included under the section Sexual and Gender Identity Disorders (American Psychiatric Association, 1994).

The American Psychiatric Association plans to release the DSM-5 in May 2013 (American Psychiatric Association, 2012). One of the proposed revisions is to replace Gender Identity Disorder with two categories: Gender Dysphoria in Children and Gender Dysphoria in Adolescents and Adults (American Psychiatric Association, 2012). The suggested revision removes the term “disorder” from the title as an attempt to de-stigmatize

gender nonconformity (Kamens, 2011). Despite this step, some activist groups believe that any inclusion of gender variance in the DSM will continue to pathologize gender diversity (Kamens, 2011). Although it is likely that gender dysphoria will remain in the DSM-5, it seems possible that it could be removed by the next DSM revision.

Oppression and Co-occurring Mental Health Issues

Oppression and the subsequent co-occurring mental health concerns are important areas to consider when working with transgendered individuals.

Oppression. In 2009, the National Center for Transgender Equality and the National Gay and Lesbian Task Force surveyed 6,450 American transgendered participants (Grant et al., 2011). The results of this National Transgender Discrimination Survey demonstrate the appalling oppression and violence faced by many transgendered individuals. The unemployment rate reported by participants was 13%, almost double the American national average at that time. Over a quarter of participants (26%) reported being fired and 20% reported becoming homeless due to their gender identity. Transgendered individuals were also more likely than the general population to experience poverty (27% earning less than \$20,000 a year). Perhaps most striking, 97% of participants reported experiencing mistreatment, harassment, or discrimination while at work. This included privacy violations (e.g., enquiring about surgical status), discrimination (e.g., being denied access to the appropriate gender bathroom), verbal abuse, physical violence, and sexual assault. Discrimination also occurred outside the workplace with over half (53%) of the sample reporting verbal harassment or disrespect in a public place including restaurants, hotels, buses, airports, and government agencies. This discrimination also extended to medical settings, with 19% of participants reporting being denied medical treatment due to their

gender identity. Many transgendered individuals (22%) who had interacted with the police felt they were discriminated against because of their gender identity. Abuse in prison or jail was also very high for transgendered individuals, with 16% reporting physical assault and 15% reporting sexual assault while in prison.

In 2002, Lombardi, Wilchins, Priesing, and Malouf surveyed 402 transgendered individuals. Over half of their sample (59%) had experienced harassment or violence with nearly one-fifth (19%) experiencing physical assault with a weapon. Many participants (14%) also reported being the victim of a sexual assault. These results echo the findings of the National Transgender Discrimination Survey and demonstrate the victimization of transgendered individuals within our society.

A qualitative research study by Nadal, Skolnik, and Wong (2012) examined nine transgendered individuals' experience of "microaggressions". Microaggressions refer to "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups" (Nadal, 2008, p. 23). Participants reported experiencing both intentional and unintentional microaggressions. It appears that transgendered individuals are victims of both overt and covert oppression.

Co-occurring mental health issues. Research has shown that this gender-based discrimination, victimization, and violence are significantly linked to suicide attempts among transgendered individuals (Clements-Noelle, Marx, & Katz, 2006; Maguen & Shipherd, 2010). Indeed, transgendered individuals are at a greater risk than the general population for attempting suicide (Clements-Noelle, Marx, & Katz, 2006; Maguen & Shipherd, 2010). The National Transgender Discrimination Survey demonstrated a high suicidal attempt rate with

41% of transgendered participants reporting attempting suicide at some point (Grant et al., 2011). This statistic is especially significant when one considers the national suicide rate of the general population at the time was only 1.6%. Transgendered individuals are also at risk for the development of mental health disorders. According to the DSM-IV TR (2000), those diagnosed with gender identity disorder have an increased risk for relationship difficulties, substance-related disorders, and anxiety disorders.

The Role of the Counsellor

The transgendered population appears to be a marginalized group with unique needs. There may be specific counsellor traits and skills that could be beneficial when working with transgendered clients.

Transgendered clients' counselling experiences. The research community seems to be well aware of the mental health issues and problems facing transgendered clients. Organizations worldwide have published suggestions for counselling transgendered populations (e.g., American Counseling Association [ACA], 2010; Vancouver Coastal Health's TransCare Project, 2006; World Professional Association for Transgender Health [WPATH], 2012) and a large number of recently published articles outline effective means of counselling transgendered individuals (Chavez-Korell & Johnson, 2010; Dickey & Lowey, 2009; Kirk & Belovics, 2008; Riley, Wong, & Sitharthan, 2011). However, only two empirical studies could be located which examine the counselling experience from transgendered clients' perspectives.

Bockting, Robinson, Benner, and Scheltema (2004) conducted a study to compare transgendered clients and non-transgendered clients' satisfaction with healthcare. Satisfaction with their therapist was a variable included under this broad health care

umbrella. The researchers collected satisfaction ratings from 180 transgendered individuals and the results revealed that the majority of transgendered clients felt satisfied with their therapists. Some participants reported that they appreciated when their therapists demonstrated caring, openness, and safety, explored other mental health issues, and focused on self-discovery. Participants also mentioned the opportunity to connect with other transgendered individuals in group counselling as being a positive experience. The study found that some transgendered clients did not appreciate when therapists were unclear regarding the prognosis and reversibility of hormone and sex reassignment treatment. Some also felt resentful that a professional needed to act as a gatekeeper in their decision regarding treatment.

A study by Rachlin (2002) explored transgendered clients' perspectives of therapy. She conducted a survey of 93 transgendered participants regarding their experience of psychotherapy. Participants listed acceptance, flexibility with treatment, respect for their chosen gender identity, and connection to the transgendered community as the most helpful counsellor traits. In addition, counsellors with more experience regarding gender issues were rated more highly.

These two studies demonstrate that counselling appears to be a positive experience for many transgendered clients. They also provide a basic understanding of the counsellor characteristics that would be effective when working with the transgendered population. Providing a safe space and demonstrating warmth, openness, and acceptance appear to be key variables that influence the counselling experience for transgendered individuals. Counselling guidelines published by worldwide transgendered organizations echo the importance of these agreeable counsellor traits.

Counselling organizations' recommendations. In 1979, the World Professional Association for Transgender Health (WPATH, at the time known as the Harry Benjamin International Gender Dysphoria Association) published a document outlining the Standards of Care for health professionals who work with transgendered clients (Reicherzer, 2008). Since this first edition, the Standards of Care document has been revised six times, with the seventh edition published in 2011 (WPATH, 2012). The report provides flexible guidelines for working with transgendered clients globally. The authors state that mental health professionals are responsible for many tasks when working with transgendered clients. Besides assessing clients' gender dysphoria and treating any additional mental health issues, mental health practitioners often act as teachers, educating transgendered clients about gender identity, possible treatment options, and potential medical procedures. The authors emphasize that the goal of psychotherapy should be focused on improving clients' quality of life, exploring gender identity, and helping clients become comfortable with themselves. It is therefore not the purpose of psychotherapy to attempt to change the person's gender identity. The Standards of Care document stresses that mental health practitioners should help transgendered clients explore how stigma has affected or could affect their mental health and psychosocial functioning. Finally, the authors argue that mental health workers need to become advocates for their transgendered clients by educating other professionals on gender dysphoria and the oppression the transgendered community faces.

In 2010, the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (LGBTIC) committee published a document outlining suggested competencies for counsellors who work with transgendered clients. The *American Counseling Association: Competencies for Counseling with Transgendered Clients* (2010) were intended to

complement the WPATH Standards of Care. The competencies are organized into eight different sections including human growth and development, social and cultural foundations, helping relationships, group work, professional orientation, career and lifestyle developmental competencies, appraisal, and research. Integrating multicultural, social justice, and feminist perspectives, the LGBTIC committee argues the importance of diverging from a deficit-based approach to a strength-based approach. Similar to the WPATH Standards of Care, the competencies state that mental health practitioners should understand the many ways prejudice and oppression can negatively influence all aspects of transgendered clients' lives and should become social advocates for this population. The authors recommend that counsellors also carefully scrutinize their own biases related to gender and request clinical supervision to minimize the impact these personal beliefs may have on the client and the therapeutic relationship. The LGBTIC committee maintains that counsellors should be aware of the mental health issues that often affect transgendered clients and how these may be the result of oppression. The suggested competencies stress the importance of creating and maintaining a counselling space that is affirming and welcoming.

While the WPATH Standards of Care and the ACA competencies provide broad suggestions for working with transgendered clients, there are guidelines available in BC for clinicians that are much more specific. In 2006, experts on transgendered care worked collaboratively with members of the transgendered community to create the Trans Care Project (Bockting, Knudson, & Goldberg, 2006). The purpose of the Trans Care Project (2006) was to provide guidelines and training materials for clinicians in BC who intend to work with individuals of the transgendered community. It consists of seven detailed documents outlining suggestions for both medical and mental health practitioners working

with transgendered clients. The topics covered include caring for transgendered adolescents, counselling transgendered adults and their loved ones, caring for clients who have undergone sex reassignment surgery, endocrine therapy for transgendered clients, speech feminization/masculization for transgendered clients, social advocacy for transgendered clients, and primary health care for transgendered clients. The purpose of the proposed workshop is to provide training for mental health workers who work or plan to work with adult transgendered clients; therefore, the next section will only discuss the document regarding counselling adult transgendered clients and their loved ones.

In *Counselling and Mental Health Care of Transgender Adults and Loved Ones*, Bockting, Knudson, and Goldberg (2006) detail a specific process for assessing, treating, and evaluating the progress of transgendered clients (Appendix A). During the initial evaluation, the counsellor builds the therapeutic relationship, confirms the client's capacity to make care decisions (i.e., informed consent), discusses the client's expectations and goals of therapy, enquires about and documents the client's history (e.g., medical, alcohol and drug use, family, sexuality, social, economic, and gender concerns), and gains an initial clinical impression of the client. Bockting et al. suggest the use of assessment tools to assist the counsellor in determining the client's general and mental health. The second step involves assessing and treating the client's gender concerns. During this stage, the counsellor asks specific questions regarding the client's gender identity, gender expression, sexuality, and supports and resources. An evaluation of Gender Identity Disorder (GID) could also occur at this point. While controversy exists about pathologizing gender diversity, Bockting et al. point out that transgendered individuals in BC must be diagnosed with GID to receive funding for surgery from the BC Medical Services Plan (MSP). Thus, the counsellor and

client will need to discuss the client's specific gender concerns and goals to determine whether a referral to a psychologist for a GID assessment is necessary. During this second step, the mental health practitioner also determines whether the client displays any indication of obsessive or compulsive characteristics, schizophrenia or delusions about gender, dissociation, Asperger's disorder, or a personality disorder as these particular mental health issues may influence their gender identity. The third step involves the development and implementation of a treatment plan for any of the above mentioned co-occurring mental health issues. If gender concerns still exist following the treatment of other mental health issues, the client and counsellor can move onto the fourth step. This step involves the development of a care plan for the client's gender concerns. Bockting et al. stress the importance of recognizing the diversity among transgendered individuals and understanding that each treatment plan will depend on the client's presenting concerns and goals. During this final stage, the counsellor helps clients explore their gender identity development, consider the options available for expressing gender identity, decide upon a course of action, and discuss preparation for potential gender identity disclosure to loved ones. If the client would like to receive hormonal treatment or sex reassignment surgery, the counsellor continues to stage five. During this step, the counsellor evaluates and discusses the client's eligibility and readiness for hormonal or surgery options. Bockting et al. state that in order for a client to be considered for coverage by the BC Medical Services Plan (MSP), either two psychiatrists or one psychiatrist and a psychologist must make recommendations. Mental health clinicians with a Masters degree or PhD in Counselling or Social Work are *not* considered qualified by MSP to assess for hormonal and surgical eligibility. For these

reasons, it is recommended that the counsellor refer the client to the appropriate mental health professional in order to be assessed for readiness.

The aforementioned documents demonstrate the importance of providing a safe and accepting counselling environment when working with a transgendered client. It is recommended that the counsellor take on many roles including supportive listener, educator, referral agent, and social activist (ACA, 2010; TransCare Project, 2006; WPATH, 2012).

Coming Out as Transgendered

Historically, the term “coming out” has referred to the declaration of one’s gay, lesbian, or bisexual orientation (Gagne, Tewksbury, & McGaughey, 1997). The transgendered community has adopted this phrase to refer to the declaration of their gender identity. Coming out as transgendered differs from the conventional act because it is more overt and conspicuous. As transgendered individuals attempt to pass as their preferred gender, they will likely wear clothing typical of that gender. The way they dress and the physical changes that occur due to hormonal medications and surgery often “force [transgendered individuals] out of the closet” (Gagne et al., 1997, p. 482). Other people may wonder whether the transgendered individual is male or female. Indeed, transgendered individuals report being asked intrusive questions by others regarding their bodies and gender (Nadal, Skolnik, & Wong, 2012).

Although limited in breadth, research has been conducted on the coming-out experiences of transgendered people. Gagne et al. (1997) completed interviews with 65 male-to-female transgendered participants. Their findings revealed that before coming out to family, friends, and society, the participants had to first come out to themselves. Coming out to oneself often occurred after a long, internal struggle of searching for their true identity.

Many felt ashamed, guilty, and anxious about their identification with the female gender. The majority of participants reported feeling extreme pressure to conform to male gender roles and often wondered if their desire to deviate from these roles meant they were homosexual.

The discovery that there were terms to describe how they were feeling and that there were others who felt similar helped participants resolve their gender identity conflict (Gagne et al., 1997). Inclusion within a subculture of individuals (i.e., Lesbian, gay, bisexual, and transgendered [LGBT] community) who had also experienced the same kind of confusion, guilt, and stigma fostered a sense of companionship and safety for individuals in transition. In addition, seeing transgendered individuals featured in magazines, articles, and on television normalized the experience of gender confusion and demonstrated to participants that there are others that feel the same way. Simply learning about the possibility of sex reassignment surgery helped some participants accept their gender identity because they realized that change was possible. Finding others who felt the same about their gender and recognizing that a transition could happen were important factors in accepting their preferred gender identity and decision to come out to others.

While coming out to oneself is important in establishing identity, validation from the transgendered individual's family, friends, and community appears to be key for affirming one's gender identity (Gagne et al., 1997). In Gagne's et al. (1997) study, the majority of participants mentioned feeling intimidated and anxious about coming out to their family. First, they displayed concern regarding their treatment by others. This is a valid concern given the amount of violence (Lombardi, Wilchins, Priesing, & Malouf, 2002) and discrimination (Nadal, Skolnik, & Wong, 2012) faced by transgendered individuals. Second, participants reported feeling worried about how significant others would manage with the

disclosure. These findings demonstrate the anxiety, stress, and intimidation transgendered individuals feel when considering disclosure to loved ones.

Transgendered individuals who are accepted by their family members appear to experience more favorable outcomes than their rejected counterparts, including lower rates of suicide, homelessness, and sex work (Grant et al., 2011). Nonetheless, as demonstrated above, coming out to oneself, family, and friends as transgendered can be daunting and anxiety-provoking. Counsellors working with transgendered individuals will likely need to support their clients through their coming-out process. It is important for counsellors and clients to understand that coming out is not a one-time occurrence but rather a lifelong process that involves both acceptance from oneself and others (Walinsky & Whitcomb, 2010). Bockting (2008) suggests counsellors should validate their clients' fears about coming out to loved ones but encourage them to "do it anyway" (p. 216). The WPATH Standards of Care also recommend helping one's client develop a plan for coming out to loved ones and discuss the possible consequences of disclosure.

Emerson and Rosenfeld (1996) argue that when transgendered individuals disclose their gender identity, their family members progress through several specific stages of adjustment. The authors describe these steps as similar to the stages of grief outlined by Kubler-Ross (1969). During the first stage, family members may experience denial and shock. They may claim that their transgendered relative is simply going through a phase and will grow out of it. There is hope that the transgendered individual will discontinue the gender transition.

During the second stage, loved ones may experience anger and frustration (Emerson & Rosenfeld, 1996). Spouses may feel furious and betrayed by their partner for putting them

through such a confusing and uncomfortable experience. These angry feelings are often coupled with feelings of shame and concerns of potential rejection and stigmatization from other family members, friends, and society (Ellis & Erikson, 2002).

During the third stage, family members bargain with the transgendered relative (Emerson & Rosenfeld, 1996). They may offer incentives for abandoning the transition or state that they will withdraw their support, either financial or emotional if the transgendered relative continues with the transition. For example, partners may threaten to end the relationship if the transgendered individual does not cease the transition. Family members at this stage possess hope that their transgendered relative will not continue with a planned gender change.

The fourth stage of adjustment is characterized by depression and grief (Emerson & Rosenfeld, 1996). By recognizing the permanency of their loved one's transition, family members may experience an extreme sense of loss and unhappiness (Zamboni, 2006). For instance, spouses may feel that the partner they initially fell in love with has died and they must grieve this loss. Family members' depression may manifest as somatic complaints such as headaches and upset stomachs (Emerson & Rosenfeld, 1996).

The acceptance stage comes last as family members no longer attempt to change their transgendered relative or dwell on how things could be different. While they still experience a deep sense of loss, family members begin to recognize how living as one's preferred gender has positively influenced their loved one. They may become concerned for their transgendered relative's wellbeing. For instance, family members may worry about their loved one being discriminated against and the effects that surgery and hormonal treatment will have on the individual's body.

The authors emphasize that like Kubler-Ross's (1969) stages of grief, people do not progress through the above stages in a clear-cut, linear fashion (Emerson & Rosenfeld, 1996). Some people may stay in the denial stage and never progress any further, others may skip stages, and some individuals may regress to earlier steps. Individuals are unique and diverse in how they respond to their loved one's revelation and these stages are meant only as a guideline.

Bockting et al. (2006) recommend that counsellors need to help their clients understand that their families may need time to adjust to their disclosures. Nonetheless, coming out to one's family is an important task and can result in improved relationships. Indeed, the majority of participants (61%) in the National Transgender Discrimination Survey reported improved relationships following disclosure of their gender identity to their families (Grant et al., 2011). Further, less than one quarter of the participants in Gagne et al.'s (1997) study reported a negative experience during their first disclosure.

Family and Loved Ones

As mentioned above, family members of transgendered individuals often require some time to adjust to the news of their loved one's gender identity. A smoother coming-out process seems more likely if transgendered individuals are sensitive and mindful to how their gender disclosure could affect their loved ones. The following section will include a brief summary of the research regarding the experience of specific family members following their relative's transgendered identity disclosure. Research examining the experience of parents of adult transgendered individuals could not be located.

Partners. Three studies could be located that examined the experiences of the partners of transgendered individuals. Partners of transgendered clients reported feeling confused

about their own sexual orientation (Algeria, 2010; Chase, 2011; Joslin-Roher & Wheeler, 2009), worried about not being accepted by their friends and family (Algeria, 2010), and concerned for their loved one's welfare (Joslin-Roher & Wheeler, 2009). Participants also stated that they felt hostility from other people and lost friends and family following their partner's gender identity disclosure (Chase, 2011; Joslin-Roher & Wheeler, 2009). In Joslin-Roher and Wheeler's (2009) study, participants described how they adopted a "caregiver" role for their transgendered partner. Perhaps the most notable finding from these studies was that partners often felt neglected and unsupported once their partner's transition had begun (Algeria, 2010; Chase, 2011; Joslin-Roher & Wheeler, 2009). Some mentioned that their needs became less important than their partner's needs and that the transition took over their whole life (Joslin-Roher & Wheeler, 2009). It should be noted that these three studies examined the perspectives of lesbian female or heterosexual female partners. Research that explored the experiences of gay male or heterosexual male partners of transgendered individuals could not be located. Therefore, the results from this research cannot necessarily be generalized to other populations. Nonetheless, the aforementioned studies demonstrate that partners may struggle with their own sense of loss, their sexual orientation identity, and the loss of support from a partner now encompassed with their gender exploration and transition. A partner's transgender identity and choice to transition may result in relationship dissolution. In the National Transgender Discrimination Survey (Grant et al., 2011), 55% of transgendered individuals who chose to transition ended their relationship with their partner.

Children. There appears to be very little research examining the experiences of children who have a transgendered parent. One reason for this lack of research may be that transgendered individuals are less likely to have children than the general population. For

instance, only 38% of participants in the National Transgender Discrimination Survey reported having children, compared to 64% of the general population at that time (Grant et al., 2011). Nonetheless, how a parent's gender identity disclosure and/or transition affects children is an important avenue to explore. White and Ettner (2004) mailed questionnaires to therapists who work with individuals experiencing gender dysphoria. The questionnaire enquired specifically about transgendered clients with children. It assessed how transgendered clients disclosed their gender identity to their child or children and the nature of the parent-child relationship. Only 10 therapists completed the survey; however, altogether they had counselled 4,768 transgendered clients. Most therapists felt strongly that clients should disclose their gender identity to their children and that non-disclosure would be more harmful to the children. If the transgendered client's child was a teenager, some therapists recommended that the disclosure and gender transition of the client should wait until after the child became an adult. Indeed, therapists rated adolescents as having the most difficulty adjusting to their parent's gender identity disclosure and transition and preschool children as having the easiest time adjusting. Therapists collectively agreed that familial factors affected children more than the gender transition. Sudden separation from either parent, a spouse who was extremely opposed to the transition, and parental conflict regarding the transition were thought to be risk factors for the child's poor adaptation to a parent's transition. On the other hand, close emotional ties to both parents, cooperation between parents, extended family support for the transitioning parent, and continued contact between parents were thought to be protective in helping children adjust to their parent's transition.

To further understand how children adjust to their parent's transition, White and Ettner (2006) interviewed 27 transgendered parents of 55 children. According to parents' reports,

children who experienced their parent's transition at a younger age tended to have a healthier and less-antagonistic relationship with their transgendered parent. A positive relationship between parents also predicted a better relationship between the child and transgendered parent. Most children who had had a positive relationship with their transgendered parent before the transition experienced improvement within the relationship.

These studies demonstrate that a healthy relationship between both parents can help children adjust to their parent's gender transition. White and Ettner (2004) suggest that counsellors assist parents in developing a collaborative relationship. Further, they recommend working with both parents and to educate the non-transitioning parent about gender identity disorder. The authors also mention that transitioning parents may feel incompetent as parents and these feelings should be addressed in therapy. These studies used outside sources to understand children's adjustment (therapists and parents) and did not include children directly. Clearly more research is required to better understand the experience of children with a transgendered parent.

Developmental Considerations

The focus of this project is on transgendered adults; however, because adults will have progressed through childhood and adolescence, it is important to consider unique factors that may affect these younger age groups. The following section will provide a brief literature review of child and adolescent transgendered mental health.

When babies are born in Western society, many are dressed in either pink or blue depending on their sex. Indeed, gender socialization begins at birth and continues throughout one's life (Ryle, 2012). Children appear to be aware of gender and gender roles at a very young age. Infants as young as 18 months old begin using gender labels such as "boy" and

“girl” and children begin to prefer gender-type play between 17 and 21 months (Zosuls et al. 2009). However, there are some children who transcend these socially constructed gender norms. Transgendered individuals often recall feeling different from other children at a young age. In a study by Grossman, D’Augelli, and Salter (2006), 31 male-to-female and 24 female-to-male transgendered adolescents participated in an interview and completed a questionnaire regarding their gender development. The average age reported for “feeling different from others” was 7.5 years. It appears that many transgendered individuals begin the struggle of being different from others at a young age. However, it should be noted that not *all* transgendered people recognize their gender variance in childhood (Menvielle, 2009). Individuals are unique and carve out their own path towards realizing and expressing their gender identity.

In the National Transgender Discrimination Survey (2011), only 13% of the sample began their gender transition before the age of 18. Nonetheless, as both social and legal acceptance of the transgendered population grows, it is likely that more transgendered individuals will come out or transition at a younger age (Minter, 2012). The idea of beginning a gender transition during childhood and adolescence is controversial. Some individuals argue that children are still unaware of their gender identity and that their gender dysphoria could simply be a phase. Zucker (2005) completed a summary of the follow-up studies on gender dysphoric male children. The percentage of children still experiencing gender dysphoria in adolescence ranged from 2% to 20%. A study conducted on female children with gender dysphoria revealed that only 12% of the sample still felt gender dysphoric in adolescence (Drummond, Bradley, Peterson-Badali, & Zucker, 2008). These studies demonstrate that gender dysphoria in childhood may not necessarily persist into

adolescence. However, it appears that adolescents are more stable in their gender identity than children. In a follow-up study of 70 gender dysphoric adolescents, all participants chose to continue with sex reassignment surgery (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010). This study suggests that gender identity remains stable from adolescence and into adulthood.

Puberty suppression is a relatively new medical treatment that can relieve gender dysphoria, allow children more time to discover their preferred gender identity, and suppress the development of sexual characteristics that will be difficult to reverse if the individual does choose to undergo sex reassignment surgery (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010; WPATH, 2012). In de Vries et al.'s (2010) study, depressive symptoms and behavioural problems decreased, while general functioning increased among participants after beginning puberty suppression. This demonstrates that it may be a viable option for gender dysphoric youth. It should also be noted that puberty suppression is an entirely reversible treatment option (WPATH, 2012).

Transgendered children and youth appear to experience much of the same oppression faced by the transgendered adult population. Those who identify as transgendered during primary and secondary school years experience high rates of harassment and assault. In the National Transgender Discrimination Survey (2011), 78% of those who came out as transgendered in grades kindergarten to 12 reported experiencing harassment from either other students or school staff. In addition, 35% of this group stated they were physically assaulted and 12% asserted they were sexually assaulted while at school. These findings demonstrate that transgendered children and adolescents are likely to be victims of bullying and assault from both other students and staff. It is likely that this mistreatment at a young

age influences transgendered individuals' psychological, emotional, and social functioning as adults.

Treatment Options

While mental health counselling can be beneficial, there are other treatment options available to assist individuals struggling with gender dysphoria. It is likely that transgendered clients will request some form of medical treatment. In the National Transgender Discrimination Survey, 62% of participants had received hormonal therapy and 23% hoped to receive it in the future (Grant et al., 2011). Therefore, it is important that counsellors have a strong understanding about the hormonal and surgical options available so that they can better assist their client in making an informed choice. Further, the ACA competencies (2010) recommend that mental health practitioners become familiar with transgendered medical health care (e.g., hormone therapy, sex reassignment surgery, where and how to access treatment). The WPATH guidelines (2012) state that if clients choose to continue with feminizing or masculinizing treatments, it is the mental health practitioner's responsibility to assess clients' eligibility for hormonal treatment and/or sex reassignment surgery, prepare them for what to expect from the treatment, and refer them to a qualified practitioner. It should be noted that mental health counsellors are not expected to act as experts regarding endocrine therapy or surgical procedures. Mental health counsellors can provide basic information regarding treatment options; however, referral for additional care is mandatory. The following section will outline basic information about the available hormonal and surgical treatment options.

Hormonal treatment. Medication to feminize or masculinize an individual can be prescribed by a physician, endocrinologist, or a nurse-practitioner (Dahl et al., 2006).

Male-to-female. Medication to feminize the male body works by repressing the effect of male hormones, androgens (Cohen-Kettenis & Gooren, 1999). To achieve the desired feminine result, the individual usually takes a combination of estrogen and androgen antagonists (Dahl et al., 2006). Moore, Wisniewski, and Dobs (2003) conducted an extensive literature review to examine the effects of hormonal treatment for transgendered individuals. Male-to-female individuals on hormonal therapy will likely notice decreased libido, difficulty reaching orgasm, and fewer spontaneous erections (Moore, Wisniewski, & Dobs, 2003). Fat will redistribute, muscle mass and upper body strength will decrease, and skin will soften (Dahl et al., 2006; Elbers, Asscheman, Seidell, & Gooren, 1999; Moore, Wisniewski & Dobs, 2003). Body and facial hair becomes finer; however, in most cases electrolysis or laser surgery is required to eliminate it completely (Levy, Crown, & Reid, 2003). These procedures may be uncomfortable and can result in scarring. After two to three months, breasts begin to develop and continue to do so for up to two years (Levy, Crown, & Reid, 2003). Most clients do not achieve their desired breast size and may wish to consider breast augmentation surgery. While most feminizing hormonal treatments are reversible, it should be noted that breast growth is not (Dahl et al., 2006). Further, it is still unknown whether hormonal treatment affects fertility. Feminizing hormones can increase the client's risk of developing blood clots (venous thrombosis), gallstones (cholelithiasis), breast cancer, and depression (Moore, Wisniewski, & Dobs, 2003). Further, individuals may experience an increase in prolactin levels that can be associated with benign tumors of the pituitary gland (Moore, Wisniewski, & Dobs, 2003).

Female-to-male. Medication to masculinize the female body works by using testosterone to promote male physical attributes (Dahl et al., 2006). Female-to-male

individuals on masculinizing hormonal therapy will likely notice increased muscle mass and upper body strength, increased libido, redistribution of fat, weight gain, oilier skin, voice deepening, and breast atrophy (Dahl et al., 2006; Davies & Goldberg, 2006; Elbers et al., 1999; Futterweit, 1998; Moore, Wisniewski, & Dobs, 2003). Facial hair will increase in thickness and coarseness and some clients may experience male pattern baldness (Dahl et al., 2006). The clitoris will begin to grow (on average, 4 -5 cm) and menstruation will cease (Moore, Wisniewski, & Dobs, 2003). Many of these changes are reversible; however, it should be noted that voice deepening, baldness, and development of facial hair are not (Dahl et al., 2006). Masculinizing hormones can increase the client's risk of developing acne, sleep apnea, elevated liver enzymes, and ovarian cancer (Moore, Wisniewski, & Dobs, 2003). Further, individuals taking these hormones may develop decreased insulin sensitivity, increased red blood cell count, and a poor lipid profile (Moore, Wisniewski, & Dobs, 2003). These symptoms can increase the chance of heart attack or stroke (Moore, Wisniewski, & Dobs, 2003).

Surgical treatment. Some transgendered individuals may opt to receive surgical treatment to live more fully as their desired gender.

Male-to-female. There are several different surgical procedures available for feminizing the male body, allowing male-to-female transgendered individuals to live more fully as women.

Augmentation mammoplasty (breast augmentation). Breast augmentation surgery is performed by a plastic surgeon and involves inserting silicone or saline-filled implants under the breast (Bowman & Goldberg, 2006; Kanhai, Hage, Asscheman, & Mulder, 1999). It is typically performed at least 18 months after the male-to-female individual has started

hormone treatment to allow for maximum development of the breast before surgery (Bowman & Goldberg, 2006). Because the anatomy of a biological male chest differs from a biological female's chest, it is unlikely that breast implants will perfectly simulate an adult woman's breasts (Bowman & Goldberg, 2006; Kanhai et al., 1999).

Genital reconstruction. Vaginoplasty is a procedure performed by a plastic surgeon and involves transforming the male genitalia into a vagina, labia, and clitoris (Bowman & Goldberg, 2006). The client must ensure daily dilation of the newly constructed vagina to avoid vaginal closure (Bowman & Goldberg, 2006). Some individuals may decide to receive a penectomy instead of the full vaginoplasty. During this procedure, a small depression is created that does not require daily dilation (Bowman & Goldberg, 2006). The individual is also able to urinate sitting down.

There are risks associated with genital reconstruction including post-operative bleeding, infection, tissue death (necrosis), decreased sensation, or narrowing of the urethra or vagina (urethral or vaginal stricture), scarring, and intravaginal hair growth (Bowman & Goldberg, 2006; Eldh, Berg, & Gustaffson, 1997; Eldh & Edgerton, 1993; Kwun Kim et al., 2003). There is also the risk that the client may be dissatisfied with the appearance of their newly constructed genitalia (Bowman & Goldberg, 2006).

Facial surgery. Some male-to-female transgendered clients may wish to receive plastic surgery to create a more feminine face. This can include forehead surgery, rhinoplasty, cheek augmentation, chin reduction, jaw reduction, and lip augmentation (Bowman & Goldberg, 2006). Risks can include nerve damage, infection, and dissatisfaction with the results (Bowman & Goldberg, 2006).

Female-to-male. There are several different surgical procedures available for masculinizing the female body, allowing female-to-male transgendered individuals to live more fully as men.

Subcutaneous mastectomy. This purpose of this surgical procedure is to create a chest that resembles the male form (Bowman & Goldberg, 2006; Hage & van Kesteren, 1995). This involves removing the breasts, reducing and repositioning the nipple and areola, and removing the crease below the breast (Bowman & Goldberg, 2006; Hage & van Kesteren, 1995). Some individuals may choose to receive a breast reduction instead of the full mastectomy. Mastectomies may result in post-operative bleeding, infection, healing problems, scarring, loss of a nipple, and asymmetrical appearance (Bowman & Goldberg, 2006; Hage & Bloem, 1995).

Hysterectomy and oophorectomy. Some female-to-male clients may request surgical removal of the uterus and ovaries to reduce gender dysphoria (Bowman & Goldberg, 2006). Removal of these organs results in the cessation of menstruation and may be a viable option for individuals who are unable to handle high doses of testosterone (Bowman & Goldberg, 2006). These surgeries also eliminate any concerns regarding the development of uterine or ovarian cancer and remove the need for pap tests (Bowman & Goldberg, 2006).

Genital reconstruction. Genital reconstruction for female-to-male transgendered individuals is more complicated than for male-to-female transgendered clients. Phalloplasty is a long and complex surgical procedure that involves the creation of a penis that is capable of sexual intercourse (Bowman & Goldberg, 2006; Gilbert, Schlossberg, & Jordan, 1995). Using tissue from the forearm, the surgeon forms a tube that will act as the urethra. This tube is rolled inside another tube of tissue to form the penis. This newly formed organ is capable

of transmitting urine and can achieve erection by inserting an erectile prosthesis. Erogenous sensation remains because the clitoris is not removed (Bowman & Goldberg, 2006; Gilbert, Schlossberg, & Jordan, 1995). Female-to-male transgendered individuals may also wish to receive a scrotoplasty, the creation of a scrotum using tissue from the labia (Bowman & Goldberg, 2006). Testicular implants can be inserted into the newly created scrotum (Hage, Bouman, & Bloem, 1992).

Metaidoioplasty offers a genital reconstruction option that is less intensive, complicated, and risky than the phalloplasty (Bowman & Goldberg, 2006; Perovic & Djordjevic, 2003). In this procedure, tissue from the labia is wrapped around the enlarged clitoris to form a small penis (Bowman & Goldberg, 2006; Perovic & Djordjevic, 2003). Although the phallus is not large enough for sexual penetration, it retains more sensitivity to sexual stimulation than in the phalloplasty (Bowman & Goldberg, 2006; Perovic & Djordjevic, 2003).

Some female-to-male transgendered individuals may opt for the most simple genital reconstruction surgery available. This surgery involves a vaginectomy (removal of the vagina) and urethra lengthening (Bowman & Goldberg, 2006).

All genital reconstruction surgery options have risks including post-operative bleeding, infection, and scarring (Bowman & Goldberg, 2006). Phalloplasty surgery runs the risk of infection or losing sensation and function in the donor arm (Fang, Kao, Ma, & Lin, 1999). In addition, the tissues used in the newly formed phallus may die or be rejected by the body (Fang, Kao, Ma, & Lin, 1999; Kregel, Bex, Lommen, & Rubben, 2001). Clients may also be unsatisfied with the appearance of their newly formed genitalia (Bowman & Goldberg, 2006).

Other masculinizing surgeries. Some female-to-male transgendered clients may seek other plastic surgery to achieve a more masculine appearance. This could include rhinoplasty, chin/jaw implantation, liposuction, or pectoral implantations (Bowman & Goldberg, 2006).

Regret following surgery. Given that sex reassignment surgery is irreversible, concerns regarding postoperative regret are inevitable. Michel, Ansseau, Legros, Pitchot, and Mormont (2002) conducted a review of the literature regarding transgendered individuals' satisfaction following sexual reassignment surgery. The vast majority (more than 90%) of transgendered participants stated that they were satisfied with the surgical results and only 10% reported unsatisfactory results. Regret following surgery was typically felt by individuals immediately after the operation but tended to diminish after one year. Participants' reasons for regret often related to pain and complications from the surgery, disappointment with the results, loss of a job or partner, and/or familial disputes. It appears that long-term regret following sex reassignment surgery is rare. Less than 1% of female-to-male transgendered individuals and 1% - 1.5% of male-to-female transgendered clients report long-term regret. Those who reported long-term regret were misdiagnosed (e.g., were experiencing psychosis instead of gender dysphoria), did not receive prolonged assessment for their gender identity before surgery, or did not experience adequate surgical results (i.e., not aesthetically pleasing or functional). The results of this literature review demonstrate that although some individuals feel regret following sex reassignment surgery, it is a relatively rare phenomenon. It seems that if clients are properly diagnosed and are well-informed regarding the process and results of sex reassignment surgery that regret following surgery is less likely to occur. Although counsellors do not need to be experts regarding sex

reassignment surgery, it is important that they have a basic understanding of the procedures and side effects to help inform the client.

Summary of Chapter Two

This chapter discussed the relevant research regarding transgendered client care. It outlined important topics with which counsellors should be familiar, including the history of transsexualism and the gender identity diagnosis, the social and psychosocial experiences of transgendered individuals, biological and surgical treatments, and recommendations for counselling. Each of these topics will be discussed in detail in the workshop. Chapter Three will describe the workshop format, ethical considerations, and content areas.

Chapter 3 - Project Description

This chapter will provide important information for the facilitator regarding preparation and implementation of the workshop.

Target Audience

This workshop will be geared towards individuals who are employed or plan to be employed in the field of mental health. This broad group could include counsellors, therapists, psychologists, case managers, social workers, nurses, undergraduate and graduate students, and others. It is recommended that the workshop consist of at least eight participants to allow for small group work.

Facilitator

Individuals who choose to facilitate this workshop must be adults who have been employed in the field of mental health. It is also mandatory that facilitators have read through this project and have a clear understanding of the workshop goals. There are some traits and skills that may be beneficial when facilitating this workshop. It is important that facilitators are friendly, respectful, flexible, patient, empathic, professional, and aware of their biases and beliefs. Facilitators should possess group facilitation skills including active listening (e.g., paraphrasing, reflecting, and non-verbals), resolving conflict, summarizing, linking, and balancing participation. It is also beneficial if facilitators are organized and possess good time management skills. Co-facilitation may be beneficial for implementing this workshop, particularly during the role-play activities.

Workshop Goals

There are three primary goals for this workshop. The first goal is to provide mental health practitioners with an in-depth understanding of the unique needs of transgendered

individuals. The second aim is to help mental health practitioners learn and develop the skills to be able to successfully assist the transgendered population. The final objective is to challenge society's strict gender dichotomy and instill an awareness regarding the oppression faced by transgendered individuals.

Adult Learning

Because the participants in this workshop will consist of adults, it is important to consider the principles unique to adult learning. Adult learners have many life experiences that influence how they learn (Mackeracher, 2004). Instead of creating new knowledge and skills, they tend to incorporate and modify new material to fit their experiences (Mackeracher, 2004). It is recommended that facilitators both acknowledge participants' knowledge and provide a safe space to practice new behaviours (Mackeracher, 2004).

Learning techniques that allow adults to access past learnings are important and can include (but are not limited to) role-playing, group discussion, the case method, and skill-practice (Knowles, 1981). In addition, most adults prefer education that has a practical application and can be applied to their everyday life (Knowles, 1981). Thus, it is may be beneficial for the teacher or facilitator to provide opportunities to brainstorm and practice ways for participants to use their new knowledge. Most adults are self-directed learners who also enjoy developing relationships with the facilitator and other participants (Knowles, 1981; Mackeracher, 2004). Thus, the facilitator should provide participants with opportunities for both independent and collaborative learning (Mackeracher, 2004). The proposed workshop will strive to incorporate all the learning principles unique to adults to provide the best possible educational experience for the participants.

Ethical Considerations

I do not foresee any psychological or physical harm occurring from participating in this workshop. Some of the material (e.g., gender, sexuality, hormonal treatment, surgery options) may be uncomfortable for some participants to discuss. Therefore, it is important that the workshop facilitators provide potential participants with information regarding the topics that will be covered.

The workshop facilitator should discuss the importance of confidentiality and safety during the beginning of the first day. Participants may share personal information during the workshop and their privacy should be respected. Although the facilitator cannot ensure confidentiality, it is important to encourage it among the group.

This workshop is aimed towards mental health practitioners in Northern British Columbia, many of whom may work in small, rural communities. It is likely that participants will be familiar with each other and with each other's clients. Therefore, client confidentiality is a major concern for this workshop. The facilitator should remind participants of the importance of client confidentiality and encourage them to withhold sharing any stories about their clients.

Workshop Topic List

The workshop will take approximately three 7-hour days to complete. This section provides an outline of the topics to be discussed on each day.

Day One

- Introduction
- Ethics and Group Norms
 - Participant rights, confidentiality, and group norms
- Overview of the workshop
 - Workshop goals and topics to be covered
- Clarification of terms
- History/background of gender identity disorder

- Scientific interest and the evolution of a diagnosis
- Oppression
- Challenging the gender dichotomy
 - Examining society's and one's beliefs about gender and sexuality

Day Two

- Oppression and co-occurring mental health disorders
- Role of the Counsellor
 - Transgendered clients' counselling experience
 - Organization counselling recommendations
 - WPATH Standards of Care
 - American Counselling Association: Competencies for counselling with transgendered clients
 - TransCare project
- Northern Focus

Day Three

- Coming out
- Family issues
 - Partners
 - Children
 - Parents
- Treatment options
 - Hormonal treatment
 - Male-to-female endocrine care
 - Female-to-male endocrine care
 - Surgical treatment
 - Male-to-female surgery options
 - Female-to-male surgery options
- Resources
- Closing activity
- Evaluation

Summary of Chapter Three

This chapter described the format of the workshop. It outlined the intended audience, desirable facilitator characteristics, the relevant principles of adult learning, ethical issues to consider, and the intended topics to be covered. Chapter four will provide a detailed description of the content and process of the three-day workshop.

Chapter 4 - The Workshop

This chapter will provide the objectives, outline, materials needed, and a detailed description of each day of the workshop.

Day One Outline

Objectives of Day One

- To create a safe atmosphere.
- To establish guidelines for confidentiality.
- To provide participants with an understanding of specific terms.
- To help participants understand the historical and social development of transgenderism.
- To challenge the gender dichotomy.
- To instill awareness regarding transgender oppression.

Day One Topic Outline

PART I	Introduction	5 minutes
	Icebreaker	25 minutes
Introduction to the Workshop	Ethics & Group Norms	10 minutes
	Overview of Workshop	15 minutes
	Clarification of Terms	20 minutes
BREAK		15 minutes
PART II	History Lecture	15 minutes
	Media Activity	40 minutes
History of Gender Identity Disorder	Diagnosis Lecture	10 minutes
	DSM Activity	40 minutes
LUNCH		60 minutes
Part III	Oppression Lecture	15 minutes
	Video Case Study & Group	80 minutes
Oppression	Discussion Activity	

BREAK		15 minutes
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PART IV	Gender Hot Seat Activity	35 minutes
	Homework and Closing	20 minutes

Challenging the
Gender Dichotomy

Preparation for Day One

- Prepare any slides needed for the lectures.
- Chart paper and pens.
- YouTube videos (Appendix E).
- Appendices B – G.

Day One Description

PART I - Introduction to the Workshop

Introduction

5 minutes

- Materials needed: None.
- Begin the first day by introducing yourself and welcoming participants to the workshop.

Icebreaker

25 minutes

- Materials needed: None.
- Divide participants into pairs. If there are an odd number of participants, allow for a group of three. Explain that participants will have 15 minutes to chat and get to know each other. Have participants ask their partners about their gender identity and preferred gender pronouns.
- After 15 minutes, have participants introduce their partner to the group. Ask that each participant use the wrong pronouns to introduce their partner. For example, a participant introducing their female partner will use male pronouns. Instead of saying, "She likes downhill skiing" they would say, "He likes downhill skiing".
- After all participants have introduced their partner, conduct a short debrief with the group. Ask participants how it felt to be introduced with the wrong pronoun. Explain that the purpose of the activity was to get to know people in the group but to also demonstrate the uncomfortableness transgendered individuals feel when people use the wrong pronoun.

Discussion of Ethics and Group Norms

10 minutes

- Materials needed: None.

Participant Rights.

- State that some of the topics (gender, sexuality, hormonal and surgical treatment) discussed in the workshop may make people feel uncomfortable. However, encourage participants to be open and curious about any discomfort regarding any of the material. Explain that as counsellors, it is important to explore and challenge one's own assumptions and biases.

Confidentiality.

- Convey to participants that everything that is shared in the workshop should be kept confidential.
- Remind participants to withhold sharing any stories about their clients. This is especially important in a small geographical region like Northern BC where participants may know each other's clients. It is important that this rule be upheld in the workshop to respect client confidentiality.

Group Norms.

- Discuss the importance of consistent attendance and respect for each other. Inform participants of when breaks and lunchtime will occur. This particular workshop consists of three 7-hour days. Each day will include two 15-minute breaks (one in the morning, one in the afternoon) and an hour-long lunch.
- Ask the group if there are any other ethical or administrative issues they wish to address for the workshop.

Overview of the Workshop

15 minutes

- Materials needed:
 - Slide presentation outlining the goals and topics of the workshop.

- Referring to the slide presentation, explain the prescribed goals of the workshop:
 - To provide participants with knowledge regarding transgendered mental health issues.
 - To help participants learn skills to effectively work with transgendered clients.
 - To challenge society's gender dichotomy and instill an understanding of the oppression faced by transgendered individuals.
- Ask participants if there are any other goals they wanted to achieve by participating in this workshop. This will help you learn participants' expectations and allows for time to modify the workshop if necessary.
- Referring to the slide presentation, provide participants with a brief overview of the topics that will be covered in the workshop.
- Ask participants if they have any questions regarding the aims or the topics of the workshop.

Clarification of Terms

15 minutes

- Materials Needed:
 - *Clarification of Terms* handout (Appendix B).
 - Definition Script.
- Explain that terminology and language among the transgendered and research community is constantly evolving. It can be confusing to keep terms straight. Therefore, it is important to understand some of the common terminology that will be used in this workshop.

- Give each participant a copy of the handout *Clarification of Terms* (Appendix B) and read through each definition.

Definition Script.

- Gender identity: One's inherent "sense of being male (a boy or a man), female (a girl or a woman), or alternative gender" (WPATH, 2012, p. 96).
- Sexual orientation: "An enduring pattern of emotional, romantic, and/or sexual attractions to men, women, or both sexes" (American Psychological Association, 2010, para. one). Sexual orientation is related to gender identity but it is not the same thing. One's gender identity does not determine one's sexual orientation.
- Gender dysphoria: "Discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth" (WPATH, 2012, p. 5). People who experience gender dysphoria may feel that they were born in the wrong body.
- Transgender: Is a broad umbrella term that typically refers to individuals who either identify with a different gender than their assigned gender or transcend societal norms of gender expression. It is a broad and flexible definition that encompasses many different kinds of individuals. The following are some terms that may be included under the transgender term.
- Drag kings/queens: Performers who dress in gender non-conforming clothing.
- Transvestites: Individuals who dress as the opposite gender for sexual pleasure.
- Androgynous: Individuals with both masculine and feminine characteristics. These individuals may identify as both male and female or may lie somewhere between the two genders.

- Two-spirit: Among some Aboriginal communities, individuals who take on the roles of the opposite gender.
- Transsexual: Individuals who identify with the opposite gender and may wish to change their assigned gender. These individuals often opt to receive sex reassignment surgery to change their external genitalia to match their preferred gender.
- Not all gender non-conforming individuals will experience gender dysphoria or wish to receive hormonal or surgical treatment. It should be noted that the definitions for the above terms are flexible, that terminology seems to be constantly evolving, and that there may be other terms that can be included under the broad definition of transgender. Some of these other terms could be GenderQueer, Dyke, or Bi-Gendered.

BREAK

15 minutes

PART II - History/Background of Gender Identity Disorder

Lecture: History

20 minutes

- Materials needed:
 - Slide presentation with timeline of major events.
 - Lecture script.
- Using the slide presentation, present a summary of the history of gender identity disorder and transgenderism.

Lecture Script.

- To provide a bigger picture of transgenderism, we will begin by learning a bit about the history of gender nonconformity.

- The scientific community has recognized gender non-conformity since the 1920s. English surgeons performed the first sex reassignment surgery in 1931 on a male-to-female individual.
- By the 1940s, sex reassignment surgeries were on the rise. David Cauldwell, a famous sexologist, is quoted in his 1947 publication, "there are men and women in countless numbers who are willing to pay heavy fees to have their sexuality destroyed" (Cauldwell, 2001a, para. 11). His use of the word "destroy" demonstrates the general sentiment of the time towards individuals who chose to receive sex reassignment surgery.
- Cauldwell originally coined the term "psychopathic transsexual" and believed that these individuals were suffering from a disease. However, he revised this opinion in 1950 by stating in an article, "Are transsexuals crazy? One may as well ask whether heterosexuals are crazy. Some are and some are not. Some transsexuals are brilliant. Now and then one may be a borderline genius. Transsexuals are eccentric. Some of them are not of sound mind, but this is true of heterosexuals".
- In 1952, a significant event occurred. An American male-to-female transsexual by the name of Christine Jorgensen received sex reassignment surgery in Denmark. This was important because it sparked widespread interest in the United States and North America. In fact, it was the most widely covered news story of that year in the United States. Due to this publicity, more and more American transgendered individuals began inquiring about sex reassignment surgery.
- During this time, gender identity was also becoming a very popular topic among American scholars. In 1953, sexologist Harry Benjamin presented a paper on

transsexualism. This was the first time the term “transsexualism” had been used among American scholars.

- The 1960s and 1970s saw a further increase in the medicalization of transsexualism.

As many as 20 gender identity clinics were opened across the United States at this time and there was also a surge in the number of publications on transsexualism.

In 1979, Harry Benjamin formed the Harry Benjamin International Gender Dysphoria clinic. The purpose of this clinic was to collaborate with psychologists, psychiatrists, and surgeons to provide quality care for transsexuals. Benjamin’s work has had a lasting impact and the association still exists today. It is now known as the World Professional Association for Transgender Health and has published Standards of Care for working with transgendered individuals.

- The 1960s and 1970s also saw the beginning of the feminist movement and the liberation of gays and lesbians. It was during this time that homosexuality was removed from the DSM partially due to social pressures. Surprisingly, this instrumental social movement had little impact on de-medicalizing transsexualism and it remains in the DSM to this day.

- Before the 1980s, gender was thought to be determined simply by one’s external genitalia. People who received sex reassignment surgery were expected to act the social roles of their newly assigned sex. However, in the 1980s, gender nonconforming individuals started to challenge the gender dichotomy.

Gender activist Virginia Prince coined the term “transgenderist” to refer to individuals “who fall somewhere between *transvestite* and *transsexual*” (Gherovici, 2010, p. 33). This definition included individuals who were unhappy living as their

assigned gender but who did not desire a full transition to the opposite gender. This definition has helped to de-medicalize gender nonconformity by acknowledging that sex reassignment surgery may not be beneficial for everyone. The 1990's marked the beginning of a transgender revolution and the idea that gender exists along a continuum, rather than a simple binary.

- The term “transgender” has since become a very inclusive term and transgendered individuals are slowly gaining more rights. For instance, in 2011, Australia gave their citizens the option to choose a third gender for their passport (male, female, or indeterminate).

Media Activity

40 minutes

- Materials needed:
 - Three newspaper or magazine articles discussing transgendered individuals or transgendered related topics. You may use the articles provided in Appendix C – Media Activity Articles or you can find your own.
- Divide participants into three groups. Each group will receive one of the three media articles (ensure enough copies of the articles so that every participant receives one).
- Explain that as demonstrated in the lecture, media played a profound role in the recognition of transsexualism. The media continues to influence public perception of the transgendered population. Indeed, it is not unusual today to come across articles discussing transgendered individuals or transgendered related topics. This inevitably sparks controversy and debate.

- Explain that each group has been given an article. Ask participants to read through the article individually and then discuss it in their small groups.
- Allow participants 20 minutes to read and discuss the article. Provide an additional 20 minutes for each group to share key points of the article or discussion with the larger group.

Lecture: Diagnosis

15 minutes

- Materials needed:
 - Lecture slides outlining the development of the gender identity diagnosis
 - Lecture script.
- Using the slide presentation, present on the development of gender identity disorder as a diagnosis.

Lecture Script.

- The second version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) was published in 1968. At this time, the publication included homosexuality and transvestitism as mental disorders, but did not include any diagnosis related to gender identity or gender dysphoria.
- Under the section Psychosexual Disorders, The DSM-III (American Psychiatric Association, 1980) introduced Gender Identity Disorder of Childhood (GIDC), transsexualism (for adolescents and adults), and Psychosexual Disorder Not Elsewhere Classified (Zucker, 2009).
- These diagnostic labels were revised with the DSM-III-R in 1987 and included: Gender Identity Disorder of Childhood, Transsexualism, Gender Identity Disorder of Adolescence of Adulthood, Non-transsexual Type (GIDAANT), and Gender Identity

Disorder Not Otherwise Specified (American Psychiatric Association, 1987). These disorders were placed under the section Disorders Usually First Evident in Infancy, Childhood, or Adolescence.

- Finally, in the DSM-IV, only the terms Gender Identity Disorder and Gender Identity Disorder Not Otherwise Specified were maintained and were included under the section Sexual and Gender Identity Disorders (American Psychiatric Association, 1994).
- The DSM-5 is scheduled to be released May, 2013 (American Psychiatric Association, 2012). There is controversy regarding whether gender identity disorder should be kept in the DSM.

DSM Group Activity

40 minutes

- Materials needed:
 - Appendix D: Gender identity disorder diagnostic criteria handouts – one for each participant.
 - Chart paper and pens for group activity.
- State that the purpose of this activity is to discuss the controversy surrounding the diagnosis of gender identity disorder. Give each participant a copy of the current diagnostic criteria for gender identity disorder and ask them to read it (Appendix D).
- Divide participants into two groups and ask them to discuss the following questions (it may be helpful to write these on a blackboard or whiteboard):
 - What are some pros and cons of including gender identity disorder in the DSM-5?
 - Do you think that gender identity disorder should be included in the DSM-5?

- If gender identity disorder were to be included in the DSM-5, are there any changes you would like to make to the diagnostic criteria?
- Ask participants to record their answers to the questions on chart paper. Allow groups approximately 25 minutes to brainstorm answers to these questions.
- After 25 minutes, lead a larger group discussion. In this discussion, have each group take turns sharing a pro or con of the diagnosis. This should take approximately 15 minutes.
 - These are a few key points that should be covered in the larger group discussion. Ensure that these are discussed if the groups do not think of them.
 - Pros for including gender identity disorder diagnosis in the DSM-5:
 - A diagnosis can help the medical community with identification and treatment of a condition that creates distress. It can help inform practitioners about the best treatment options for the client.
 - A diagnosis could help encourage research on transgenderism by having a common definition.
 - A diagnosis can make access to treatment easier for transgendered individuals. For instance, for sex reassignment surgeries to be covered by insurance, the individual must be diagnosed with a mental disorder. Many transgendered individuals may be unable to afford hormonal or surgical treatment without insurance.

- A diagnosis demonstrates to the medical community that hormonal and surgical treatment is sought to alleviate gender dysphoria and not simply for cosmetic purposes.
- Cons for including gender identity disorder in the DSM-5:
 - A diagnosis will continue to pathologize gender diversity.
 - A diagnosis could reinforce and lead to further stigmatization of transgendered individuals.
 - A diagnosis of gender identity disorder is inherently sexist and reinforces gender stereotypes.
 - A diagnosis may be disempowering to transgendered individuals. Because a diagnosis is required to receive access to medical care, psychiatrists and other mental health providers are inevitably “gate keepers” and possess power over transgendered individuals. Transgendered clients should be allowed to make their own informed decisions regarding their treatment.
 - A diagnosis could affect transgendered individuals in the legal arena. For instance, a lawyer could argue that a transgendered father is unfit to care for his child because he suffers from a mental disorder.

LUNCH

60 minutes

PART III - Oppression

Oppression Lecture

15 minutes

- Materials needed:

- Lecture slides outlining the definition of oppression and a few statistics from the National Transgender Discrimination Survey and other studies.
 - Lecture script.
- Using the slide presentation, present on oppression and how transgendered individuals experience it.

Lecture Script

- The term oppression refers to “unjust or cruel exercise of authority or power” (Merriam-Webster, 2012). It can include discrimination, neglect, physical abuse, sexual abuse, and emotional abuse.
- In 2009, the National Center for Transgender Equality and the National Gay and Lesbian Task Force surveyed 6,450 American transgendered participants (Grant et al., 2011). The results of this National Transgender Discrimination Survey demonstrate the appalling oppression and violence faced by many transgendered individuals.
- The unemployment rate reported by participants was 13%, almost double the American national average at that time. Over a quarter of participants (26%) reported being fired and 20% reported becoming homeless due to their gender identity. Transgendered individuals were also more likely than the general population to experience poverty (27% earned less than \$20,000 a year).
- Perhaps most striking, 97% of participants reported experiencing mistreatment, harassment, or discrimination while at work. This included privacy violations (e.g.,

enquiring about surgical status), discrimination (e.g., being denied access to the appropriate gender bathroom), verbal abuse, physical violence, and sexual assault.

- Discrimination also occurred outside the workplace with over half (53%) of the sample reporting verbal harassment or disrespect in a public place including restaurants, hotels, buses, airports, and government agencies. This discrimination also extended to medical settings, with 19% of participants reporting being denied medical treatment due to their gender identity.

- Many transgendered individuals (22%) who had interacted with the police felt they were discriminated against because of their gender identity. Abuse in prison or jail was also very high for transgendered individuals, with 16% reporting physical assault and 15% reporting sexual assault while in prison.

- Other studies have also demonstrated the mistreatment of the transgendered population. In 2002, Lombardi, Wilchins, Priesing, and Malouf surveyed 402 transgendered individuals. Over half of their sample (59%) had experienced harassment or violence with nearly one-fifth (19%) experiencing physical assault with a weapon. Many participants (14%) also reported being the victim of a sexual assault. These results echo the findings of the National Transgender Discrimination Survey and demonstrate the victimization of transgendered individuals within our society.

- Finally, a qualitative research study by Nadal, Skolnik, and Wong (2012) examined nine transgendered individuals' experience of "microaggressions". Microaggressions refer to "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile,

derogatory, or negative slights and insults toward members of oppressed groups” (Nadal, 2008, p. 23). Participants reported experiencing both intentional and unintentional microaggressions.

- It appears that transgendered individuals are victims of both overt and covert oppression.

Video Case Study and Group Discussion Activity

80 minutes

- Materials needed:
 - Five video clips on YouTube. The URL addresses are found in Appendix E.
 - Appendix E: Video Links and Summaries (in case the video links do not work).
 - Appendix F: Video Case Study Discussion Worksheet (one copy for each participant).
- Explain that the purpose of this exercise is to demonstrate the life experience of transgendered individuals by using real life examples. Divide participants into small groups (three or four). Give each participant a copy of the Video Case Study Discussion Worksheet.
- Show each video to the whole group. After each video, give participants four or five minutes to complete the section on their worksheet that corresponds to the video. Then show the next video until participants have seen all five videos. This first part of the activity should take approximately 40 minutes.
- After the participants have seen each video and completed each section on their worksheet, they move onto part two of the activity. During part two, have participants

use the discussion questions in the Video Case Study Discussion Worksheet to help facilitate a dialogue among their group.

- Allow participants approximately 30 minutes for the discussion portion of this activity.
- After participants have discussed within their small groups, ask participants if they would like to share anything they learned in their small group with the larger group.

This should take no longer than 10 minutes.

BREAK	15 minutes
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Gender Hot Seat Activity	35 minutes
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- Materials needed:
 - Hot Seat Questions provide below.
- State that for the purposes of this activity, it will be assumed that everyone in the group is not transgendered. That is, that everyone in the room identifies with their gender assigned at birth.
- Explain that each person will be asked a question. State that although they may choose not to answer the question by saying, “pass”, they should try to answer the question; despite any uncomfortable emotions they may feel.
- Hot Seat Questions:
 1. When did you realize that you were a man/woman (change depending on the person’s gender)?
 2. What is it like to be a man/woman (change depending on the person’s gender)?
 3. Are you attracted to men or women or both?
 4. When in public, do you use a bathroom designated for males or for females?

5. How do you have sex?

6. Have you had surgery “down there”?

7. How do you go to the bathroom?

- One round of questions should take approximately 15 minutes. Following one round of questions, debrief with the group. Explain that the purpose of this activity was to instill an awareness of the uncomfortableness transgendered individuals likely feel when asked personal questions. The facilitator will state that the questions the group was asked are just some of the very personal questions that transgendered individuals are asked by others.

- Some questions that could be asked during the debrief:

- What did it feel like to be asked such personal questions?

- Was your question easy or difficult to answer?

- What did you learn from this activity?

- These questions likely felt inappropriate and intrusive. Despite this, people still ask transgendered individuals these kinds of questions. Why do you think that is?

- How can your learnings from this activity be applied to your work or future work with transgendered clients?

- This debrief should take approximately 20 minutes.

Homework

10 minutes

- Materials needed:

- Appendix G: Gender Roles: Homework Assignment (one copy for each participant).

- Explain that the purpose of this homework assignment is for participants to get in touch with their own ideas regarding gender.
- State that the assignment consists of 11 statements about gender. A five point Likert scale follows each statement. Remind participants that there are no right or wrong answers. Encourage participants to answer each question according to their initial gut feeling.
- After explaining the assignment instructions, give each participant a copy of Appendix G: Gender Roles: Homework Assignment. Ask participants if they have any questions regarding the homework assignment.

Closing

10 minutes

- Materials needed: None.
- Ask each participant to share one thing they learned during the day that will be useful in their current practice or future work with clients.

Day Two Outline

Objectives of Day Two

- To help participants understand the link between oppression and mental health issues.
- To instill awareness regarding other mental health issues that may occur among the transgendered population.
- To educate participants about what counsellor traits and skills are important when working with transgendered clients.
- To share with participants the counselling guidelines available for working with transgendered clients.
- To give participants a chance to practice their counselling skills.

Day Two Topic Outline

PART I	Introduction	10 minutes
	Icebreaker	25 minutes
Introduction to Day Two	Discussion of Homework	25 minutes
PART II	Video Clip & Discussion Activity	50 minutes
Oppression and Comorbid Mental Health Issues		
BREAK		15 minutes
PART II (Continued)	Co-occurring Mental Health Lecture	15 minutes
Oppression and Comorbid Mental Health Issues		
PART III	Counsellor Trait/Skills Activity & Lecture	25 minutes
The Role of the Counsellor	Counselling Guidelines Lecture	35 minutes
LUNCH		60 minutes

PART III (Continued)	Individual Case Study and Discussion	35 minutes
The Role of the Counsellor	Northern Focus Activity	25 minutes
BREAK		15 minutes
PART III (Continued)	Counselling Role-Play & Debrief	65 minutes
	Homework	10 minutes
The Role of the Counsellor	Closing	10 minutes

Preparation for Day Two

- Prepare any lecture slides.
- Chart paper and pens.
- Left-handed Video Clip (Appendix H).
- Appendix G, Appendix A, and Appendices H – M.

Day Two Description

PART I - Introduction to Day Two

Introduction

10 minutes

- Materials needed: None.
- Begin day two by welcoming participants back. State that the homework assignment will be discussed later on in the day and ask participants if they have any other questions from day one.
- Once any questions are answered, explain that the purpose of day two. State, "Today, we will continue to explore the impact of oppression. Another objective of the session is to provide a better understanding of the role of the counsellor when working with transgendered clients and to give you an opportunity to practice some of these skills".

Icebreaker

25 minutes

- Materials needed: None.
- State that the name of this icebreaker is "Two Truths, One Lie". Explain that participants will take turns to share with the group two truths about themselves and one lie. The other participants will then be asked to guess which statement is the lie.
- Encourage participants to share information that is personal – about their inner self or personality.
- After each participant has had a turn, begin a discussion by stating, "Transgendered individuals may live with the secret of their preferred gender identity for many years. What was it like for you to share a lie with the group? What feelings came up when you were holding on to that lie?"

Discussion of Homework

25 minutes

- Materials needed:
 - A copy of Appendix G - Gender Roles homework assignment
- Divide participants into pairs. Ask them to share their answers and discuss the homework assignment together.
- The following questions may be used to guide the discussion:
 - Which question did you find the most difficult to answer?
 - Which question did you find the easiest to answer?
 - Do you believe these gender stereotypes are changing? If yes, which one do you think is changing the quickest?
 - Were you surprised by your reaction to any of the questions? If yes, which one?
 - What are some variables that might influence one's perception of these gender stereotypes?
 - What are some ways that these gender stereotypes could contribute to the oppression of transgendered clients?
- After 15 minutes, bring the discussion back to the larger group and ask participants if they wish to share anything they learned in their discussion with their partner.

PART II - Oppression and Co-occurring Mental Health Issues

Left-handed Video Clip and Discussion Activity

50 minutes

- Materials needed:
 - Is it Okay to be Left-Handed Video on Youtube. The URL address is found in Appendix H.

- Appendix H: Left-handed video clip and summary (in case the video link does not work).
 - Chart paper and pens for group activity.
- Explain to the group that they will watch a short video-clip and then participate in some group work.
- Show the video to the group. This will take approximately two minutes.
- After the group has watched the video, ask participants to close their eyes and imagine themselves as the teenage boy depicted in the film. Request that participants jot down a few notes about how they would feel if they were the boy. This should take approximately five minutes.
- Following this brief individual reflection exercise, divide participants into small groups (three or four).
- State that transgendered individuals face many different forms of oppression including discrimination, neglect, and trauma. This negative treatment can contribute to the development of psychological and emotional problems.
- Ask the small groups to brainstorm and record on their chart paper any potential psychological and emotional difficulties that could be initiated or exacerbated by oppression. Answers could include mental health disorders or specific areas of functioning that could be impaired from such negative treatment. Participants could draw from any of the case studies from day one, the left-handed video and the notes they took on it, as well as any of their own personal and professional experiences. Allow groups approximately 20 minutes to brainstorm any ideas.

- After 20 minutes, begin a discussion with the larger group. In this discussion, ask each of the smaller groups to take turns sharing an idea. This should take approximately 20 minutes.
- If there is additional time, you could ask participants to share some of the emotions they wrote down after watching the left-handed video.

BREAK

15 minutes

Co-occurring Mental Health Lecture

15 minutes

- Materials needed:
 - Lecture slides outlining the co-occurring mental health issues often experienced by the transgendered population.
 - Lecture script.
- Using the slide presentation, present on co-occurring mental health issues that may affect transgendered individuals.

Lecture Script.

- In day one, we discussed the results of the National Transgender Discrimination Survey that interviewed 6,450 American transgendered individuals. This survey along with other studies and the videos shown throughout this workshop demonstrate the oppression transgendered individuals are likely to experience. In the last activity, you were asked to brainstorm mental health issues that may result from this negative treatment. Now, I will share what the research community has discovered in terms of comorbid mental health issues among transgendered individuals.
- Research has shown that gender-based discrimination, victimization, and violence are significantly linked to suicide attempts among transgendered individuals

(Clements-Noelle, Marx, & Katz, 2006; Maguen & Shipherd, 2010). Indeed, transgendered individuals are at a greater risk than the general population for attempting suicide (Clements-Noelle, Marx, & Katz, 2006; Maguen & Shipherd, 2010). The National Transgender Discrimination Survey demonstrated a high suicidal attempt rate with 41% of transgendered participants reporting attempting suicide at some point (Grant et al., 2011). This statistic is especially glaring when one considers the national suicide rate of the general population at the time was only 1.6%.

- Transgendered individuals are also at risk for the development of mental health disorders. According to the DSM-IV TR (2000), those diagnosed with gender identity disorder have an increased risk for relationship difficulties, substance-related disorders, and anxiety disorders.
- No other empirical research articles could be located to determine if transgendered individuals are at greater risk for other mental health issues. However, mental health professionals in the field of transgendered mental health suggest it is important to consider other mental health issues when working with a transgendered client.
- Gail Knudson is the Medical Director of the Transgender Health Program at Vancouver Coastal Health and a professor at the University of British Columbia. She suggests that in addition to depression, suicidal ideation, anxiety, and substance use, mental health professionals should consider depression, somatic problems, eating disorders, personality disorders, and body dysmorphic disorder when working with transgendered clients (Knudson, 2010).
- Given that transgendered individuals are at risk for experiencing psychological, physical, and sexual abuse, they may experience mental health issues that often occur

for victims of trauma. This could include personality disorders, anxiety (including post-traumatic stress disorder and generalized anxiety disorder), and depression.

PART III - The Role of the Counsellor

Counsellor Trait/Skills Activity & Lecture

25 minutes

- Materials needed:
 - Blackboard, whiteboard, or chart paper to record participants' ideas.
 - Lecture slides outlining transgendered clients' perspectives regarding counselling.
 - Lecture script.
- Ask participants to imagine themselves as a transgendered client on their way to their first counselling appointment. Ask the group, "Given all you have learned so far, what traits or skills would you be looking for in a counsellor as a transgendered client?". Record participants' suggestions on a blackboard, whiteboard, or chart paper. This should take approximately 10 minutes.
- Following this brief brainstorming activity, use the slide presentation to present on the counselling traits and skills transgendered clients find the most beneficial.
- During the lecture, try to incorporate the group's suggestions. For example, you could note the similarities and differences between what the group suggested and what empirical research has shown.

Lecture Script.

- As we have learned today, transgendered individuals are at risk for some mental health concerns including substance abuse and suicide attempts. And, with society becoming increasingly accepting of gender diversity, it seems likely that more

transgendered individuals will be coming out. The need for mental health resources appears to be high among the transgendered community.

- Goldberg, Matte, MacMillan, and Hudspith (2003) conducted a survey on 177 transgendered individuals across British Columbia (BC). Eighty-six percent of respondents ($n = 154$) reported requiring counselling at some point. Given these factors, it is possible that we, as mental health professionals, will work with a transgendered client at least once in our careers.

- Because of this possibility, it is important for us to consider traits and skills that may be beneficial when working with transgendered clients. Organizations worldwide have published suggestions for counselling transgendered populations. However, only two empirical studies could be located that examines the counselling experience from the transgendered client's perspective. These will be discussed in this brief lecture.

- Bockting, Robinson, Benner, and Scheltema (2004) conducted a study to compare transgendered clients' and non-transgendered clients' satisfaction with healthcare. Satisfaction with their therapist was a variable included under this broad health-care umbrella. The researchers collected satisfaction ratings from 180 transgendered individuals.

- The results of this study revealed that the majority of transgendered clients felt satisfied with their therapist. Some participants reported that they appreciated when their therapist demonstrated caring, openness, and safety, explored other mental health issues, and focused on self-discovery.

- Participants also mentioned the opportunity to connect with other transgendered individuals in group counselling as being a positive experience. The study found that some transgendered clients did not appreciate when therapists were unclear regarding the prognosis and reversibility of hormone and sex reassignment treatment. Some also felt resentful that a professional needed to act as a gatekeeper in their decision regarding treatment.
- A study by Rachlin (2002) explored transgendered clients' perspectives of therapy. She conducted a survey of 93 transgendered participants concerning their experience of psychotherapy. Participants listed acceptance, flexibility with treatment, respect for their chosen gender identity, and connection to the transgendered community as the most helpful counsellor traits. In addition, counsellors with more experience regarding gender issues were rated more highly.
- These two studies demonstrate that counselling appears to be a positive experience for many transgendered clients. They also provide a basic understanding of the counsellor characteristics that would be effective when working with the transgendered population.
- Providing a safe space and demonstrating warmth, openness, and acceptance appear to be key variables that influence the counselling experience for transgendered individuals. As we will see in the next lecture, the importance of these agreeable counsellor traits are echoed by suggested counselling guidelines published by transgendered organizations world-wide.

- Materials needed:

- Lecture slides outlining the counselling guidelines.
- Lecture Script.
- A copy of Appendix A and Appendix I (One copy for each participant).
- Use the slide presentation to present on the counselling traits and skills transgendered clients find the most beneficial.

Lecture Script.

- There have been three important documents outlining effective ways to counsel transgendered clients.
- In 1979, the World Professional Association for Transgender Health (WPATH, at the time known as the Harry Benjamin International Gender Dysphoria Association - you will recall him from our history lecture during Day One) published a document outlining the Standards of Care for health professionals who work with transgendered clients (Reicherzer, 2008). Since this first edition, the Standards of Care document has been revised six times, with the seventh edition published in 2011 (WPATH, 2012). The report provides flexible guidelines for working with transgendered clients worldwide.
- The authors of the WPATH guidelines state that mental health professionals are responsible for many tasks when working with transgendered clients. Besides assessing clients' gender dysphoria and treating any additional mental health issues, mental health practitioners often act as teachers, educating transgendered clients about gender identity, possible treatment options, and potential medical procedures.
- The authors stress that the goal of psychotherapy should be focused on improving clients' quality of life, exploring gender identity, and helping clients become

comfortable with themselves. It is therefore not the purpose of psychotherapy to attempt to change the person's gender identity.

- The Standards of Care document stresses that mental health practitioners should help transgendered clients explore how stigma has affected or could affect their mental health and psychosocial functioning. The authors do not suggest exactly how to explore the role of stigma with transgendered clients. However, asking clients questions such as, "Have you ever experienced discrimination based on your gender identity? How do you think this has affected you?" could help clients explore the effect of stigma and discrimination.
 - Finally, the authors argue that mental health workers need to become advocates for their transgendered clients by educating other professionals on gender dysphoria and the oppression the transgendered community faces.
 - In 2010, the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (LGBTIC) committee published a document outlining suggested competencies for counsellors who work with transgendered clients. The *American Counseling Association: Competencies for Counseling with Transgendered Clients* (2010) were intended to complement the WPATH Standards of Care.
- These competencies are organized into eight different sections including human growth and development, social and cultural foundations, helping relationships, group work, professional orientation, career and lifestyle developmental competencies, appraisal, and research.
- The competencies integrate multicultural, social justice, and feminist perspectives and are based on a strength-based approach rather than a deficit-based approach.

Similar to the WPATH Standards of Care, the competencies state that mental health practitioners should understand the many ways prejudice and oppression can negatively influence all aspects of transgendered clients' lives and should become social advocates for this population.

- The authors also recommend that counsellors carefully scrutinize their own biases related to gender and request clinical supervision to minimize the impact these personal beliefs may have on the client and the therapeutic relationship. Simple self-reflection exercises are helpful in exploring and understanding one's own prejudices. The gender-role homework assignment you completed for today is an example of a self-reflection activity. Questioning, critically thinking, and being curious about your own beliefs regarding gender and sexuality are also useful in this self-exploration quest. Open-ended exploratory questions such as, "where does this belief come from?", "what is the benefit of this belief?", and "how can I challenge this belief?" can be beneficial when trying to become more open and accepting about gender.
- The WPATH competencies maintain that counsellors need to be aware of the mental health issues that often affect transgendered clients and how these may be the result of oppression. We explored many of these issues earlier today.
- The suggested competencies also stress the importance of creating and maintaining a counselling space that is affirming and welcoming.
- While the WPATH Standards of Care and the ACA competencies provide broad suggestions for working with transgendered clients, there are guidelines available in British Columbia for clinicians that are much more specific. In 2006, experts on

transgendered care worked collaboratively with members of the transgendered community to create the Trans Care Project (Bockting, Knudson, & Goldberg, 2006).

- The purpose of the Trans Care Project (2006) was to provide guidelines and training materials for clinicians in British Columbia who intend to work with individuals of the transgendered community. It consists of seven detailed documents outlining suggestions for both medical and mental health practitioners working with transgendered clients. The topics covered include caring for transgendered adolescents, counselling transgendered adults and their loved ones, caring for clients who have undergone sex reassignment surgery, endocrine therapy for transgendered clients, speech feminization/masculization for transgendered clients, social advocacy for transgendered clients, and primary health care for transgendered clients.
- Because this workshop is geared towards helping transgendered adults, I will only discuss the document titled *Counselling and Mental Health Care of Transgender Adults and Loved Ones*.
- At this point, give each participant a copy of Appendix A and Appendix I.
- As you can see in your first handout, the authors developed a specific process for assessing, treating, and evaluating the progress of transgendered clients (Appendix A). Your second handout provides greater detail about each of the steps and gives a chart of some possible questions you could ask your client about their gender concerns. We will go through each step now.
- During the initial evaluation, the counsellor builds the therapeutic relationship, confirms the client's capacity to make care decisions (i.e., informed consent), discusses the client's expectations and goals of therapy, enquires about and

documents the client's history (e.g., medical, alcohol and drug use, family, sexuality, social, economic, and gender concerns), and gains an initial clinical impression of the client. The authors suggest the use of assessment tools to assist the counsellor in determining the client's general and mental health.

- The second step involves assessing and treating the client's gender concerns. During this stage, the counsellor asks specific questions regarding the client's gender identity, gender expression, sexuality, and supports and resources. As you can see in your handout, the authors provide a chart with specific questions that may be helpful to explore with your client. These questions are divided into six categories: gender identity, gender expression, perceptions of others, sexuality, and support resources. It should be noted that many of these questions are very personal and the counsellor should ensure a strong working alliance and safety has been established before enquiring about gender and sexuality. Asking for the client's permission to ask personal questions could also be beneficial in ensuring safety and maintaining client autonomy.

- An evaluation of Gender Identity Disorder (GID) could also occur at this point. While controversy exists about pathologizing gender diversity, the authors point out that transgendered individuals in British Columbia must be diagnosed with GID to receive funding for surgery from the BC Medical Services Plan (MSP). Thus, the counsellor and client will need to discuss the client's specific gender concerns and goals to determine whether a referral to a psychologist for a GID assessment is necessary. For instance, it would be important to ask clients whether they would like to pursue hormonal or surgical treatment.

- During this second step, the mental health practitioner also determines whether the client displays any indication of obsessive or compulsive characteristics, schizophrenia or delusions about gender, dissociation, Asperger's disorder, or a personality disorder as these particular mental health issues may influence gender identity.
 - The third step involves the development and implementation of a treatment plan for any of the above-mentioned co-occurring mental health issues. If gender concerns still exist following the treatment of any co-occurring mental health issues, the client and counsellor can move onto the fourth step.
 - The fourth step involves the development of a care plan for the client's gender concerns. Bockting et al. (2006) stress the importance of recognizing the diversity among transgendered individuals and understanding that each treatment plan will depend on the client's presenting concerns and goals.
 - During this fourth step, the counsellor helps clients explore their gender identity development, consider the options available for expressing gender identity, decide upon a course of action, and discuss preparation for potential gender identity disclosure to loved ones.
 - If the client would like to receive hormonal treatment or sex reassignment surgery, the counsellor continues to stage five. During this step, the counsellor evaluates and discusses the client's eligibility and readiness for hormonal or surgery options.
- Unfortunately, it is beyond the scope of this workshop to provide sufficient training on how to assess for the client's readiness for hormonal and surgical treatment. In addition, Bockting et al. (2006) state that in order for a client to be considered for

coverage by the BC Medical Services Plan (MSP), either two psychiatrists or one psychiatrist and a psychologist must make recommendations. Mental health clinicians with a Masters degree or PhD in Counselling or Social Work are *not* considered qualified by MSP to assess for hormonal and surgical eligibility. For these reasons, it is recommended that the counsellor refer the client to the appropriate mental health professional in order to be assessed for readiness.

- Bockting et al. (2006) state that transgendered individuals experience stresses just like anyone else, and may be seeking counselling for concerns other than their gender identity. It is important to meet clients where they are at and address their presenting concerns. For instance, if a client seeks counselling to deal with anxiety following a severe car accident, it would probably be inappropriate to ask questions relating to gender identity during the initial interview.

- In *Counselling and Mental Health Care of Transgendered Adults and their Loved Ones*, it is recommended that counsellors assess some mental health issues and areas of functioning that may be especially pertinent to transgendered individuals (Bockting et al., 2006). These areas include body image, grief and loss, social isolation, social skills, spirituality and religion, sexuality, substance use, and current or past physical, emotional, and sexual abuse (Bockting et al., 2006). The co-occurring mental health concerns we discussed earlier, including anxiety and suicidal ideation, should also be assessed.

- Bockting et al. (2006) also provide some general recommendations for working with transgendered clients. To help build rapport, the authors recommend demonstrating trans-sensitive communication. This involves asking clients about their

preferred name and pronouns and then using these accordingly. It is also beneficial if intake forms are also trans-sensitive.

- These documents demonstrate the importance of providing a safe and accepting counselling environment when working with a transgendered client. It is recommended that the counsellor take on many roles including supportive listener, educator, and social activist.

LUNCH 60 minutes

Individual Case Study & Discussion 35 minutes

- Materials needed:
 - Appendix J: Individual Case Study Activity.
 - Appendix K: Client Information Form.
- Explain that this will be an individual activity, followed by a small group discussion. State that the purpose of the activity is to give participants the opportunity to reflect on a clinical case.
- Explain the activity to the group: You are a counsellor who works at an agency that specializes in counselling clients with gender concerns. You have been meeting with Amelia for about three sessions. During these sessions, you have gathered a lot of information about your client and have built a strong relationship. For this activity, read through the intake form and write down your answers to the questions provided below.
- Allow participants approximately 15 minutes to work on their own. Then, divide participants into small groups of two or three participants. Allow them about 20 minutes to discuss their answers and the case.

- After the group discussion, ask if participants have any insights they would like to share with the larger group.

Northern Focus Activity

25 minutes

- Materials needed:
 - Chart paper.
 - Pens or markers.
- State, “Throughout the workshop, we have been examining challenges that face the transgendered population generally. However, transgendered individuals in Northern BC face unique challenges in comparison to their Lower Mainland counterparts. The purpose of this activity is to explore some of the unique challenges faced by transgendered individuals who reside in Northern British Columbia”.
- Divide participants into two groups. Ask participants to spend the next 15 minutes brainstorming challenges that transgendered individuals in the north may face. Ask them to record their answers on the chart paper. After this small group discussion, have each group share one or two ideas with the larger group. This should take approximately 10 minutes.
- Ensure that the following points are covered in this larger group discussion:
 - Lack of resources in Northern BC for the transgendered population which could lead to individuals feeling lonely and unsupported.
 - Lack of professionals trained on transgendered related issues and concerns.
 - Lack of privacy. Living in smaller communities may feel like “living in a fish bowl” and could make coming out as transgendered or accessing resources embarrassing or shameful.

- Due to lack of exposure to the transgendered community, residents in Northern BC may be less accepting than residents in the Lower Mainland. This could result in greater oppression of transgendered individuals.

BREAK 15 minutes

Counselling Role-Play and Debrief 65 minutes

- Materials needed:
 - Appendix L: Role-plays.
- Explain that the purpose of this role-play activity is to give participants the opportunity to practice their counselling skills when working with a transgendered client.
- Ask participants, "Given what you have learned today from the lectures and our group discussions, what are some things to be mindful of when working with a transgendered client?" Allow participants no more than 10 minutes to call out some ideas.
- After this brief brainstorming exercise, divide participants into pairs. Explain that for the role-play, one participant will act as the client and one participant will act as a counsellor. Each participant will have the opportunity to act in each role. If there are an odd number of participants, a group of three may be used with one person acting as an observer.
- Recommend that pairs face their chairs towards each other at a comfortable distance.
- After the group has been divided into pairs, ask the participants who are playing the role of the client to step outside. Once the clients are isolated from the counsellors,

give each client a copy of the role-play script and read the script out loud to the group.

- Encourage participants to try to truly feel what it would be like to be the client described in the role-play. This will make the role-play more believable and realistic. Encourage participants to be creative and to add in information if they wish.
- Ask participants if they have any questions. Explain that the role-play should take approximately 10 minutes.
- The participants will reconvene with their partners and begin the role-play. Allow participants to engage in the role-play for approximately 20 minutes.
- After 20 minutes have elapsed, stop the participants and ask the client to give the counsellor some feedback about their performance. This should take approximately five minutes.
- After allowing time for feedback, ask participants to switch roles. The new clients will be asked to step outside to get their role-play script.
- Give the new clients their role-play descriptions, read the role-play out loud, and answer any questions. As before, this process should take approximately 10 minutes.
- The participants will reconvene with their partners and begin the second role-play. Allow approximately 20 minutes for the role-play and five minutes for feedback.

Homework

10 minutes

- Materials needed:
 - Appendix M: Coming out as Transgendered: Homework Assignment. One copy for each participant.

- Explain that the purpose of this homework assignment is for participants to get in touch with their own feelings regarding transgendered individuals.
- Explain that the assignment consists of ten statements about someone in your life coming out as transgendered. Like the first homework assignment, a five Point Likert scale follows each statement. Remind participants that there are no right or wrong answers. Encourage participants to answer each question according to their initial gut feeling.
- After explaining the assignment instructions, give each participant a copy of the Coming out as Transgendered: Homework Assignment. Ask participants if they have any questions regarding the homework assignment.

Closing

10 minutes

- Materials needed: None.
- As in the first day, ask each participant to share one thing they learned during the day that will be useful in their current practice or future work with clients.

Day Three Outline

Objectives of Day Three

- To educate participants about the coming-out process of transgendered individuals.
- To explore the experience of transgendered individuals' family members and loved ones.
- To provide an opportunity for participants to practice their counselling skills.
- To discuss developmental considerations that may be important when working with transgendered adults.
- To provide information about the various hormonal and surgical treatment options available for individuals experiencing gender dysphoria.
- To provide participants with resources for further research and exploration of transgendered issues.
- To provide closure and allow participants an opportunity to evaluate the workshop.

Day Three Topic Outline

PART I	Introduction	10 minutes
	Icebreaker	25 minutes
Introduction to Day Three		
PART II	Coming-Out Role-play & Debrief	30 minutes
	Coming-Out Lecture	15 minutes
Coming Out		
BREAK		15 minutes
PART III	Discussion of Homework	20 minutes
	Family Video Clip & Activity	30 minutes
Family Issues	Family Lecture	25 minutes
LUNCH		60 minutes

PART III (Continued)	Counselling Role-play & Debrief	50 minutes
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Family Issues

PART IV	Developmental Considerations	15 minutes
	Lecture	

Developmental Considerations	Developmental Video Clip and Discussion	30 minutes
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PART V

Hormonal and Surgical Treatment	Hormonal & Surgical Treatment	15 minutes
	Lecture and Discussion	

BREAK		15 minutes
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Part VI	Resource Sharing	10 minutes
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	Review Game	35 minutes
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Closing	Closing	10 minutes
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	Evaluation	10 minutes
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Preparation for Day Three

- Prepare any lecture slides.
- Chart paper and pens.
- Scotch tape and coin for Review Game.
- Family video clip (Appendix O).
- Child and Parent video clip (Appendix Q).
- Appendices M – W.

Day Three Description

PART I - Introduction to Day Three

Introduction

10 minutes

- Materials needed: None.
- Begin day three by welcoming participants back. State that the homework assignment will be discussed later on in the day and ask participants if they have any other questions from day two.
- Once any questions are answered, explain that the purpose of day three. State, “In this final session, we will discuss the coming-out process of transgendered individuals. We will also explore the experience of transgendered individuals’ loved ones and discuss various hormonal and surgical treatment options”.

Icebreaker

25 minutes

- Materials needed:
 - Appendix N - Circle Icebreaker Statements.
- Have participants stand in a circle. Tell participants, “I will read a statement. If the statement applies to you, jump into the circle. If it does not apply to you, stay where you are and do not jump into the circle. For instance, I will read something like, “My favorite season is spring”. If this applies to you, jump into the circle. If it doesn’t apply to you, stay where you are”.
- Read each statement. When participants are in the middle of the circle, ask each person a question. For instance, if they jump in for “my favorite season is spring”, ask them why spring is their favorite season. Some ideas of a follow-up question for each statement are provided in the Appendix N.

- The statements in this icebreaker are divided into “warm-up” statements (to help ease participants into the activity) and “transgender-focused” statements (to provide participants with an opportunity to reflect on their learnings regarding transgenderism).

PART II - Coming Out

Coming-out Role-Play and Debrief

30 minutes

- Materials needed:

Appendix O: Coming-out role-plays.

- Divide participants into pairs.
- Explain that one participant will play a transgendered individual and the other participant will play a family member. Ask participants to decide together who will play each role.
- Ask participants who are playing the role of the transgendered individual to step outside. Once these participants are isolated from the rest of the group, give each person a copy of their role-play and read the script out loud to the group.
- Encourage participants to try to truly feel what it would be like to be the client described in the role-play. This will make the role-play more believable and realistic. Encourage participants to be creative and to add information if they wish.
- Ask participants if they have any questions. Explaining the role-play should take approximately five minutes.
- Ask participants who are playing the role of the family member to step outside. Give each person a copy of their role-play, read the script out loud, and answer any

questions. As with the previous group, encourage participants to try to step into their role and be creative. This should take approximately five minutes.

- The participants will reconvene with their partners and begin the role-play. Allow participants to engage in the role-play for approximately 10 minutes.
- After approximately 10 minutes, stop the participants' role-play. Have partners engage in a discussion about the role-play. Here are a few questions that may help guide the discussion:

- What was your immediate emotional reaction when your partner shared their gender identity? How did you react?
- How did you feel as the transgendered individual coming out to your partner?
- How do you imagine most people would react if their partner came out to them as transgendered?
- How do you think couples would work through this kind of disclosure and subsequent changes? How might the disclosure affect the relationship?

Coming-out Lecture

15 minutes

- Materials needed:
 - Slides outlining the coming-out process for transgendered individuals.
 - Lecture Script.
- Using the slide presentation, the facilitator will present on the coming-out process for transgendered individuals.

Lecture Script.

- Historically, the term “coming out” has referred to the declaration of one’s gay, lesbian, or bisexual orientation. The transgendered community has adopted this phrase to refer to the declaration of their gender identity.
- Coming out as transgendered differs from the conventional act because it is usually more obvious to outsiders. As transgendered individuals attempt to pass as their preferred gender, they will likely wear clothing typical of that gender. The way they dress and the physical changes that occur due to hormonal medications and surgery often “force [transgendered individuals] out of the closet” (Gagne et al., 1997, p. 482). Other people may wonder whether the transgendered individual is male or female. Indeed, transgendered individuals report being asked intrusive questions by others regarding their bodies and gender.
- There doesn’t seem to be much research examining the coming-out experiences of transgendered individuals. In one study, Gagne et al. (1997) completed interviews with 65 male-to-female transgendered participants. Their findings revealed that before coming out to family, friends, and society, transgendered individuals must first come out to themselves. Coming out to oneself often occurred after a long, internal struggle of searching for their true identity. Many felt ashamed, guilty, and anxious about their identification with the female gender. The majority of participants reported feeling extreme pressure to conform to male gender roles and often wondered if their desire to deviate from these roles meant they were homosexual.
- The discovery that there were terms to describe how they were feeling and that there were others who felt similar helped participants resolve their gender-identity conflict (Gagne et al., 1997). Inclusion within a subculture of individuals (i.e., Lesbian, gay,

bisexual, and transgendered [LGBT] community) who had also experienced the same kind of confusion, guilt, and stigma fostered a sense of companionship and safety for individuals in transition.

- Seeing transgendered individuals featured in magazines, articles, and on television normalized the experience of gender confusion and demonstrated to participants that there are others that feel the same way.

- Simply learning about the possibility of sex reassignment surgery helped some participants accept their gender identity because they realized that change was possible. Finding others who felt the same about their gender and recognizing that a transition could happen were important factors in accepting their preferred gender identity and decision to come out to others.

- While coming out to oneself is important in establishing identity, validation from the transgendered individual's family, friends, and community appears to be key for affirming one's gender identity (Gagne et al., 1997). In Gagne's et al. (1997) study, the majority of participants mentioned feeling intimidated and anxious about coming out to their family. First, they displayed concern regarding their treatment by others. This is a valid concern given the amount of violence and discrimination faced by transgendered individuals. Second, participants reported feeling worried about how significant others would manage with the disclosure. These findings demonstrate the anxiety, stress, and intimidation transgendered individuals feel when considering disclosure to loved ones.

- Transgendered individuals who are accepted by their family members appear to experience more favorable outcomes than those who are rejected by their family, including lower rates of suicide, homelessness, and involvement in sex work.
- Coming out to oneself, family, and friends as transgendered can be daunting and anxiety-provoking. Counsellors working with a transgendered individual will likely need to support their client through the coming-out process. It is important for counsellors and clients to understand that coming out is not a one-time occurrence but rather a lifelong process that involves both acceptance from oneself and others.
- Some mental health professionals suggest counsellors validate their clients' fears about coming out to loved ones but encourage them to do it anyway. The WPATH Standards of Care also recommend helping one's client develop a plan for coming out to loved ones and discuss the possible consequences of disclosure.

BREAK

15 minutes

PART III - Family Issues

Discussion of Homework

20 minutes

- Materials needed:
 - A copy of Appendix M - Coming out as Transgendered - Homework Assignment.
- Divide participants into pairs. Ask them to share their answers and discuss the homework assignment together.
- The following questions may be used to guide the discussion:
 - Which statement did you find the most uncomfortable? Why?
 - Which statement did you find the least uncomfortable? Why?

- How would your reaction differ depending on who came out as transgendered?
- Were you surprised by your reaction to any of the questions? If yes, which one?

Family Video and Activity

30 minutes

- Materials needed:
 - Video clip from YouTube. The URL address is found in Appendix P.
 - Appendix P – Family video clip and summary (in case the video clip does not work).
 - Chart paper and pens.
- Show the video to the group. Following the video clip, divide participants into three groups.
- Explain the activity, “For this activity, each group will represent a family member. Group one; imagine you are the partner of a transgendered individual. Group two; imagine you are the parent of a transgendered individual. Group three; imagine you are the child of a transgendered individual. In the video, Justin describes his parents going through “their own process”. In your small group, discuss what process you think you would go through if your loved one came out to you as transgendered. What questions would you want to ask your loved one? What concerns would you have? What do you think would be helpful for you in learning to accept your loved one’s gender identity? What do you think would be challenging?”
- Write the discussion questions stated above on a whiteboard or blackboard so participants can see them.

- Allow participants approximately 20 minutes for the discussion. After 20 minutes, ask the groups to share one thing they discussed with the larger group.

Family Lecture

25 minutes

- Materials needed:
 - Lecture slides outlining the literature on the experiences of family members and loved ones of transgendered individuals.
 - Lecture script.
- Using the slide presentation, present on the experiences of family members and loved of transgendered individuals.

Lecture Script.

- As we explored in that last activity, loved ones of transgendered individuals appear to go through their own process. Literature has been written on this process.
- Emerson and Rosenfeld (1996) argue that when transgendered individuals disclose their gender identity, their family members progress through several specific stages of adjustment. The authors describe these steps as similar to the stages of grief outlined by Kubler-Ross (1969).
- During the first stage, family members may experience denial and shock. They may claim that their transgendered relative is simply going through a phase and will grow out of it. There is hope that the transgendered individual will not continue with the transition.
- During the second stage, loved ones may experience anger and frustration (Emerson & Rosenfeld, 1996). Spouses may feel furious and betrayed by their partners for putting them through such a confusing and uncomfortable experience. These angry

feelings are often coupled with feelings of shame and concerns of potential rejection and stigmatization from other family members, friends, and society (Ellis & Erikson, 2002).

- During the third stage, family members bargain with the transgendered relative (Emerson & Rosenfeld, 1996). They may offer incentives for abandoning the transition or state that they will withdraw their support, either financial or emotional if transgendered relatives continue with the transition. For example, partners may threaten to end the relationship if the transgendered individual does not cease the transition. Family members at this stage possess hope that their transgendered relative will not continue with a planned gender transition.
- The fourth stage of adjustment is characterized by depression and grief (Emerson & Rosenfeld, 1996). By recognizing the permanency of their loved one's transition, family members may experience an extreme sense of loss and unhappiness (Zamboni, 2006). For instance, spouses may feel that the partner they initially fell in love with has died and they must grieve this loss. Family members' depression may manifest as somatic complaints such as headaches and upset stomachs (Emerson & Rosenfeld, 1996).
- The acceptance stage comes last as family members no longer attempt to change their transgendered relative or dwell on how things could be different. While they still experience a deep sense of loss, family members begin to recognize how living as one's preferred gender has positively influenced their loved one. They may become concerned for their transgendered relative's wellbeing. For instance, family members

may worry about their loved one being discriminated against and the effects that surgery and hormonal treatment will have on the individual's body.

- The authors emphasize that like Kubler-Ross's (1969) stages of grief, people do not progress through the above stages in a clear-cut, linear fashion (Emerson & Rosenfeld, 1996). Some people may stay in the denial stage and never progress any further, others may skip stages, and some individuals may regress to earlier steps.

Individuals are unique and diverse in how they respond to their loved one's revelation and these stages are meant only as a guideline.

- Bockting et al. (2006) recommend that counsellors need to help their clients understand that their families may need time to adjust to their disclosures.

Nonetheless, coming out to one's family is an important task and can result in improved relationships. Indeed, the majority of participants (61%) in the National Transgender Discrimination Survey reported improved relationships following disclosure of their gender identity to their families (Grant et al., 2011). Further, less than one quarter of the participants in Gagne et al.'s (1997) study reported a negative experience during their first disclosure.

- Indeed, family members of transgendered individuals often require some time to adjust to the news of their loved one's gender identity. A smoother coming-out process seems more likely if transgendered individuals are sensitive and mindful to how their gender disclosure could affect their loved ones.

- **Partners.** Three studies could be located that examined the experiences of the partners of transgendered individuals. Partners of transgendered clients reported feeling confused about their own sexual orientation (Algeria, 2010; Chase, 2011;

Joslin-Roher & Wheeler, 2009), worried about not being accepted by their friends and family (Algeria, 2010), and concerned for their loved one's welfare (Joslin-Roher & Wheeler, 2009). Participants also stated that they felt hostility from other people and lost friends and family following their partner's gender-identity disclosure (Chase, 2011; Joslin-Roher & Wheeler, 2009).

- In a 2009 study, participants described how they adopted a “caregiver” role for their transgendered partner (Joslin-Roher & Wheeler). Perhaps the most notable finding from the literature is that partners often felt neglected and unsupported once their partner's transition had begun (Algeria, 2010; Chase, 2011; Joslin-Roher & Wheeler, 2009). Some mentioned that their needs became less important than their partner's needs and that the transition took over their whole life (Joslin-Roher & Wheeler, 2009).

- It should be noted that these three studies examined the perspectives of lesbian female or heterosexual female partners. Research that explored the experiences of gay male or heterosexual male partners of transgendered individuals could not be located. Therefore, the results from this research cannot necessarily be generalized to other populations.

- Nonetheless, the research demonstrates that partners may struggle with their own sense of loss, their sexual orientation identity, and the loss of support from a partner now all-encompassed with their gender exploration and transition. A partner's transgender identity and choice to transition may result in relationship dissolution. In the National Transgender Discrimination Survey (Grant et al., 2011), 55% of

transgendered individuals who chose to transition ended their relationship with their partner.

Children. There appears to be very little research examining the experiences of children who have a transgendered parent. One reason for this lack of research may be that transgendered individuals are less likely to have children than the general population. For instance, only 38% of participants in the National Transgender Discrimination Survey reported having children, compared to 64% of the general population at that time (Grant et al., 2009). Nonetheless, how a parent's gender identity disclosure and/or transition affects the children is an important avenue to explore.

- White and Ettner (2004) mailed questionnaires to therapists who work with individuals experiencing gender dysphoria. The questionnaire enquired specifically about transgendered clients with children. It assessed how transgendered clients disclosed their gender identity to their child or children and the nature of the parent-child relationship. Only 10 therapists completed the survey; however, altogether they had counselled 4,768 transgendered clients.
- Most therapists felt strongly that clients should disclose their gender identity to their children and that non-disclosure would be more harmful to the children. If the transgendered client's child was a teenager, some therapists recommended that the disclosure and gender transition of the client should wait until after the child became an adult. Indeed, therapists rated adolescents as having the most difficulty adjusting to their parent's gender identity disclosure and transition and preschool children as having the easiest time adjusting.

- Therapists collectively agreed that familial factors affected children more than the gender transition. Sudden separation from either parent, a spouse who was extremely opposed to the transition, and parental conflict regarding the transition were thought to be risk factors for the child's poor adaptation to their parent's transition. On the other hand, close emotional ties to both parents, cooperation between parents, extended family support for the transitioning parent, and continued contact between parents were thought to be protective in helping children adjust to their parent's transition.
- To further understand how children adjust to their parent's transition, White and Ettner (2006) interviewed 27 transgendered parents of 55 children. In this study, children who experienced their parent's transition at a younger age tended to have a healthier and less-antagonistic relationship with their transgendered parent. A positive relationship between parents also predicted a better relationship between the child and transgendered parent. Most children who had had a positive relationship with their transgendered parent before the transition experienced improvement within the relationship.
- These studies demonstrate that a healthy relationship between both parents can help children adjust to their parent's gender transition. White and Ettner (2004) suggest that counsellors assist parents in developing a collaborative relationship. Further, they recommend working with both parents and to educate the non-transitioning parent about gender identity disorder. The authors also mention that transitioning parents may feel incompetent as a parent and these feelings should be addressed in therapy. These studies used outside therapists and parents to understand children's adjustment

and did not include children directly. Clearly more research is required to better understand the experience of children with a transgendered parent.

LUNCH 60 minutes

Counselling Role-play and Debrief 50 minutes

- Materials needed:

- Appendix Q: Role-plays.

- Explain that the purpose of this role-play activity is to give participants the opportunity to practice their counselling skills when working with a transgendered client.

- Divide participants into pairs. Explain that for the role-play, one participant will act as the client and one participant will act as a counsellor. Each participant will have the opportunity to act in each role. If there are an odd number of participants, a group of three may be used with one person acting as an observer.

- Recommend that pairs face their chairs towards each other at a comfortable distance.

- After the group has been divided into pairs, ask the participants who are playing the role of the client to step outside. Once the clients are isolated from the counsellors, give each client a copy of the role-play script and read the script out loud to the group.

- Encourage participants to try to truly feel what it would be like to be the client described in the role-play. This will make the role-play more believable and realistic. Encourage participants to be creative and to add in information if they wish.

- Ask participants if they have any questions. Explaining the role-play should take approximately five minutes.
- The participants will reconvene with their partners and begin the role-play. Allow participants to engage in the role-play for approximately 15 minutes.
- After 15 minutes have elapsed, stop the participants and ask the client to give the counsellor some feedback about their performance. This should take approximately five minutes.
- After allowing time for feedback, ask participants to switch roles. The new clients will be asked to step outside to get their role-play script.
- Give the new clients their role-play descriptions, read the role-play out loud, and answer any questions. As before, this process should take approximately five minutes.
- The participants will reconvene with their partners and begin the second role-play. Allow approximately 15 minutes for the role-play and five minutes for feedback.

PART IV - Developmental Considerations

Developmental Considerations Lecture

15 minutes

- Materials needed:
 - Slides outlining the developmental considerations.
 - Lecture script.

Lecture Script.

- The focus of this workshop is on working with transgendered adults. However, because adults will have progressed through childhood and adolescence, it is important to consider unique factors that may affect these younger age groups. This

lecture will provide a very brief review of issues unique to child and adolescent transgendered mental health.

- When babies are born in Western society, many are dressed in either pink or blue depending on their sex. Indeed, gender socialization begins at birth and continues throughout one's life (Ryle, 2012). Children appear to be aware of gender and gender roles at a very young age. Infants as young as 18 months old begin using gender labels such as "boy" and "girl" and children begin to prefer gender-type play between 17 and 21 months (Zosuls et al., 2009).
- However, there are some children who transcend these socially constructed gender norms. Transgendered individuals often recall feeling different from other children at a young age. In a study by Grossman, D'Augelli, Howell, and Hubbard (2005), 31 male-to-female and 24 female-to-male transgendered adolescents participated in an interview and completed a questionnaire regarding their gender development. The average age reported for "feeling different from others" was 7.5 years. It appears that many transgendered individuals begin the struggle of being different from others at a young age. However, it should be noted that not *all* transgendered people recognize their gender variance in childhood (Menvielle, 2009). Individuals are unique and carve out their own path towards realizing and expressing their gender identity.
- In the National Transgender Discrimination Survey (2011), only 13% of the sample began their gender transition before the age of 18. Nonetheless, as both social and legal acceptance of the transgendered population grows, it is likely that more transgendered individuals will come out or transition at a younger age (Minter, 2012). The idea of beginning a gender transition during childhood and adolescence is

controversial. Some individuals argue that children are still unaware of their gender identity and that their gender dysphoria could simply be a phase.

- Zucker (2005) completed a summary of the follow-up studies on gender dysphoric male children. The percentage of children still experiencing gender dysphoria in adolescence ranged from 2% to 20%. A study conducted on female children with gender dysphoria revealed that only 12% of the sample still felt gender dysphoric in adolescence (Drummond, Bradley, Peterson-Badali, & Zucker, 2008). These studies demonstrate that gender dysphoria in childhood may not necessarily persist into adolescence.
- However, it appears that adolescents are more stable in their gender identity than children. In a follow-up study of 70 gender dysphoric adolescents, all participants chose to continue with sex reassignment surgery (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010). This study suggests that gender identity remains stable from adolescence and into adulthood.
- Puberty suppression is a relatively new medical treatment that can relieve gender dysphoria, allow children more time to discover their preferred gender identity, and suppress the development of sexual characteristics that will be difficult to reverse if the individual does choose to undergo sex reassignment surgery (de Vries, Steensma, Doreleijers, & Cohen-Kettenis, 2010; WPATH, 2012). In De Vries et al.'s (2010) study, depressive symptoms and behavioural problems decreased, while general functioning increased among participants after beginning puberty suppression. This demonstrates that it may be a viable option for gender dysphoric youth. It should also be noted that puberty suppression is an entirely reversible treatment option (WPATH,

2012).

- Transgendered children and youth appear to experience much of the same oppression faced by the transgendered adult population. Those who identify as transgendered during primary and secondary school years experience high rates of harassment and assault.
- In the National Transgender Discrimination Survey (2011), 78% of those who came out as transgendered in grades kindergarten to 12 reported experiencing harassment from either other students or school staff. In addition, 35% of this group stated they were physically assaulted and 12% asserted they were sexually assaulted while at school. These findings demonstrate that transgendered children and adolescents are likely to be victims of bullying and assault from both other students and staff. It is likely that this mistreatment at a young age influences transgendered individuals' psychological, emotional, and social functioning as an adult.

Developmental Video Clip and Discussion

30 minutes

- Materials needed:
 - Video clip from YouTube. The URL address is found in Appendix R.
 - Appendix R: Developmental Video Clip Link and Summary (in case the video link does not work).
- Show the video to the group and lead a larger group discussion. The group discussion should take approximately 20 minutes. The following questions could be used to guide the discussion:
 - Hayley's father is concerned his child may never find love. What are some other concerns parents may have about their transgendered child?

- When do you believe people are truly aware of their gender identity?
- How do you believe you would respond as a parent in their situation?

PART V - Hormonal and Surgical Treatment Options

Hormonal & Surgical Treatment Lecture

15 minutes

- Materials needed:
 - Slides outlining the various hormonal and surgical treatment options.
 - Lecture script.
 - Appendix S: Hormonal and Surgical treatment options.

Lecture Script.

- While mental health counselling can be beneficial, there are other treatment options available to assist individuals struggling with gender dysphoria. It is likely that transgendered clients will request some form of medical treatment. In the National Transgender Discrimination Survey, 62% of participants had received hormonal therapy and 23% hoped to receive it in the future (Grant et al., 2011).
- Therefore, it is important that counsellors have an understanding about the hormonal and surgical options available so that they can better assist their client in making an informed choice. The ACA competencies (2010) (which we discussed in the second day of the workshop) recommend that mental health practitioners become familiar with transgendered medical health care (e.g., hormone therapy, sex reassignment surgery, where and how to access treatment). The WPATH guidelines (2012) state that if clients choose to continue with feminizing or masculinizing treatments, it is the mental health practitioner's responsibility to assess clients'

eligibility for hormonal treatment and/or sex reassignment surgery, prepare them for what to expect from the treatment, and refer them to a qualified practitioner.

- It should be noted that mental health counsellors are not expected to act as experts regarding endocrine therapy or surgical procedures. Mental health counsellors can provide basic information regarding treatment options; however, referral for additional care is mandatory.
- This brief lecture will provide basic information about the hormonal and surgical options available.
- Hand out each participant a copy of *Appendix S: Hormonal and Surgical Treatment Options*. This handout provides additional information regarding treatment that will not be covered in the lecture, including possible side effects.
- Medication to feminize or masculinize an individual can be prescribed by a physician, endocrinologist, or a nurse practitioner (Dahl et al., 2006).
- To feminize a biologically male body, the individual usually takes a combination of estrogen and androgen antagonists (Dahl et al., 2006). When taking these hormones, the individual will begin to notice bodily changes including softer skin, fat redistribution, and a decrease in muscle mass. After two to three months, breasts begin to develop and continue to do so for up to two years (Levy, Crown, & Reid, 2003). Most clients do not achieve their desired breast size and may wish to consider breast augmentation surgery. While most feminizing hormonal treatments are reversible, it should be noted that breast growth is not (Dahl et al., 2006). Your handout lists some possible side effects of taking feminizing hormones.

- To masculinize a biologically female body, the individual usually takes testosterone.

When taking these hormones, the individual will begin to notice bodily changes including increased muscle mass and upper body strength, weight gain, and oilier skin. Many of the changes from masculinizing hormones are reversible; however, it should be noted that voice deepening, baldness, and development of facial hair are not (Dahl et al., 2006). Your handout lists some of the possible side effects of taking masculinizing hormones.

- Your handout lists several different surgical procedures available for feminizing the male body, allowing male-to-female transgendered individuals to live more fully as women.

- Breast augmentation surgery is performed by a plastic surgeon and involves inserting silicone or saline-filled implants under the breast (Bowman & Goldberg, 2006; Kanhai, Hage, Asscheman, & Mulder, 1999). It is typically performed at least 18 months after the male-to-female individual has started hormone treatment to allow for maximum development of the breast before surgery (Bowman & Goldberg, 2006). Because the anatomy of a biological male chest differs from a biological female's chest, it is unlikely that breast implants will perfectly simulate an adult woman's breasts (Bowman & Goldberg, 2006; Kanhai et al., 1999).

- Vaginoplasty is a procedure performed by a plastic surgeon and involves transforming the male genitalia into a vagina, labia, and clitoris (Bowman & Goldberg, 2006). The client must ensure daily dilation of the newly constructed vagina to avoid vaginal closure (Bowman & Goldberg, 2006).

- Some individuals may decide to receive a penectomy instead of the full vaginoplasty. During this procedure, a small depression is created that does not require daily dilation (Bowman & Goldberg, 2006).
- Some individuals may also choose to receive facial reconstruction surgery to create a more feminine face.
- There are surgeries also available for female-to-male transgendered individuals. Some female-to-male clients may request surgical removal of the uterus and ovaries to reduce gender dysphoria (Bowman & Goldberg, 2006). Removal of these organs results in the cessation of menstruation and may be a viable option for individuals who are unable to handle high doses of testosterone (Bowman & Goldberg, 2006). These surgeries also eliminate any concerns regarding the development of uterine or ovarian cancer and remove the need for pap tests (Bowman & Goldberg, 2006).
- Genital reconstruction is also available. Phalloplasty is a long and complex surgical procedure that involves the creation of a penis that is capable of sexual intercourse (Bowman & Goldberg, 2006; Gilbert, Schlossberg, & Jordan, 1995). Using tissue from the forearm, the surgeon forms a tube that will act as the urethra. This tube is rolled inside another tube of tissue to form the penis. This newly formed organ is capable of transmitting urine and can achieve erection by inserting an erectile prosthesis. Erogenous sensation remains because the clitoris is not removed (Bowman & Goldberg, 2006; Gilbert, Schlossberg, & Jordan, 1995).
- Female-to-male transgendered individuals may also wish to receive a scrotoplasty, the creation of a scrotum using tissue from the labia (Bowman & Goldberg, 2006).

Testicular implants can be inserted into the newly created scrotum (Hage, Bouman, & Bloem, 1992).

- Metaidoioplasty offers a genital reconstruction option that is less intensive, complicated, and risky than the phalloplasty (Bowman & Goldberg, 2006; Perovic & Djordjevic, 2003). In this procedure, tissue from the labia is wrapped around the enlarged clitoris to form a small penis (Bowman & Goldberg, 2006; Perovic & Djordjevic, 2003). Although the phallus is not large enough for sexual penetration, it retains more sensitivity to sexual stimulation than in the phalloplasty (Bowman & Goldberg, 2006; Perovic & Djordjevic, 2003).

- Individuals may also wish to receive facial reconstruction surgery to create a more masculine face.

- Dissatisfaction with the result is a risk of all the surgical options available. Given that sex reassignment surgery is irreversible, concerns regarding postoperative regret are inevitable.

- Michel, Anseau, Legros, Pitchot, and Mormont (2002) conducted a review of the literature regarding transgendered individuals' satisfaction following sexual reassignment surgery. The vast majority (more than 90%) of transgendered participants stated that they were satisfied with the surgical results and only 10% reported unsatisfactory results.

- Regret following surgery was typically felt by individuals immediately after the operation but tended to diminish after one year. Participants' reasons for regret often related to pain and complications from the surgery, disappointment with the results, loss of a job or partner, and/or familial disputes.

- It appears that long-term regret following sex reassignment surgery is rare. Less than 1% of female-to-male transgendered individuals and 1% - 1.5% of male-to-female transgendered clients report long-term regret. Those who reported long-term regret were misdiagnosed (e.g., were experiencing psychosis instead of gender dysphoria), did not receive prolonged assessment for their gender identity before surgery, or did not experience adequate surgical results (i.e., not aesthetically pleasing or functional).
- So, although some individuals feel regret following sex reassignment surgery, it is a relatively rare phenomenon. It seems that if clients are properly diagnosed and are well-informed regarding the process and results of sex reassignment surgery that regret following surgery is less likely to occur.
- Although counsellors do not need to be experts regarding sex reassignment surgery, it is important that they have a basic understanding of the procedures and side effects to help inform the client.

BREAK

15 minutes

PART VI – Closing

Resource Sharing

10 minutes

- Materials needed:
 - Appendix T: Resources.
- Give each participant a copy of the resource list. State that this list will provide them with some resources if they are interested in researching transgenderism further.

Review Game

35 minutes

- Materials needed:

- Appendix U: Review Game: Questions and Answers.
- Appendix V: Review Game Board Set-up.
- 25 question cards with the dollar amount written or typed on one side, and the corresponding question and answers on the other side (these are not supplied in this project and should be prepared prior to day three. The questions are available in Appendix U).
- Scotch tape to adhere the questions cards to a wall or blackboard.
- Coin for the coin toss.
- Pens or chalk or the whiteboard/blackboard to record the team's score.
- Preparation:
 - This game requires some preparation. The category and question and answer cards should be prepared prior to day three. These cards should be arranged according to Appendix V. The cards can be taped onto a blackboard or whiteboard, with the question side down.
 - Divide participants into two groups (Group A and Group B) and explain the purpose and rules of the game.
 - State, "The purpose of the game is to review what you have learned during the last three days. Each team will take turns choosing a question on the review game board. I will read the question and the three answers. If the team correctly answers the question, they receive the points allocated to the question and can choose another question. If the team incorrectly answers the question, they lose their turn and the opposing team is given a chance to steal. If the opposing team answers the question correctly, they receive the points allocated to the question and can choose another

question. If they answer it incorrectly, they do not receive the points allocated to the question but can still choose another question. We will determine which team goes first by flipping a coin”.

- After giving these instructions and answering any questions or concerns about the game, have a participant from each team participant in a coin toss to determine which team will go first.
- Next, act as a leader for the game, reading the questions out loud, ensuring each team abides by the outlined rules, and keeping track of each team’s score on the blackboard.

Closing

10 minutes

- Materials needed: None.
- Ask each participant to share one thing they learned during the day that will be useful in their current practice or future work with clients.

Evaluation

10 minutes

- Materials needed:
 - Appendix W: Workshop Evaluation Form.
- The purpose of this activity is to allow participants the opportunity to provide feedback on the workshop. This will provide valuable information on the strengths of the workshop and how to improve it for the next facilitation.

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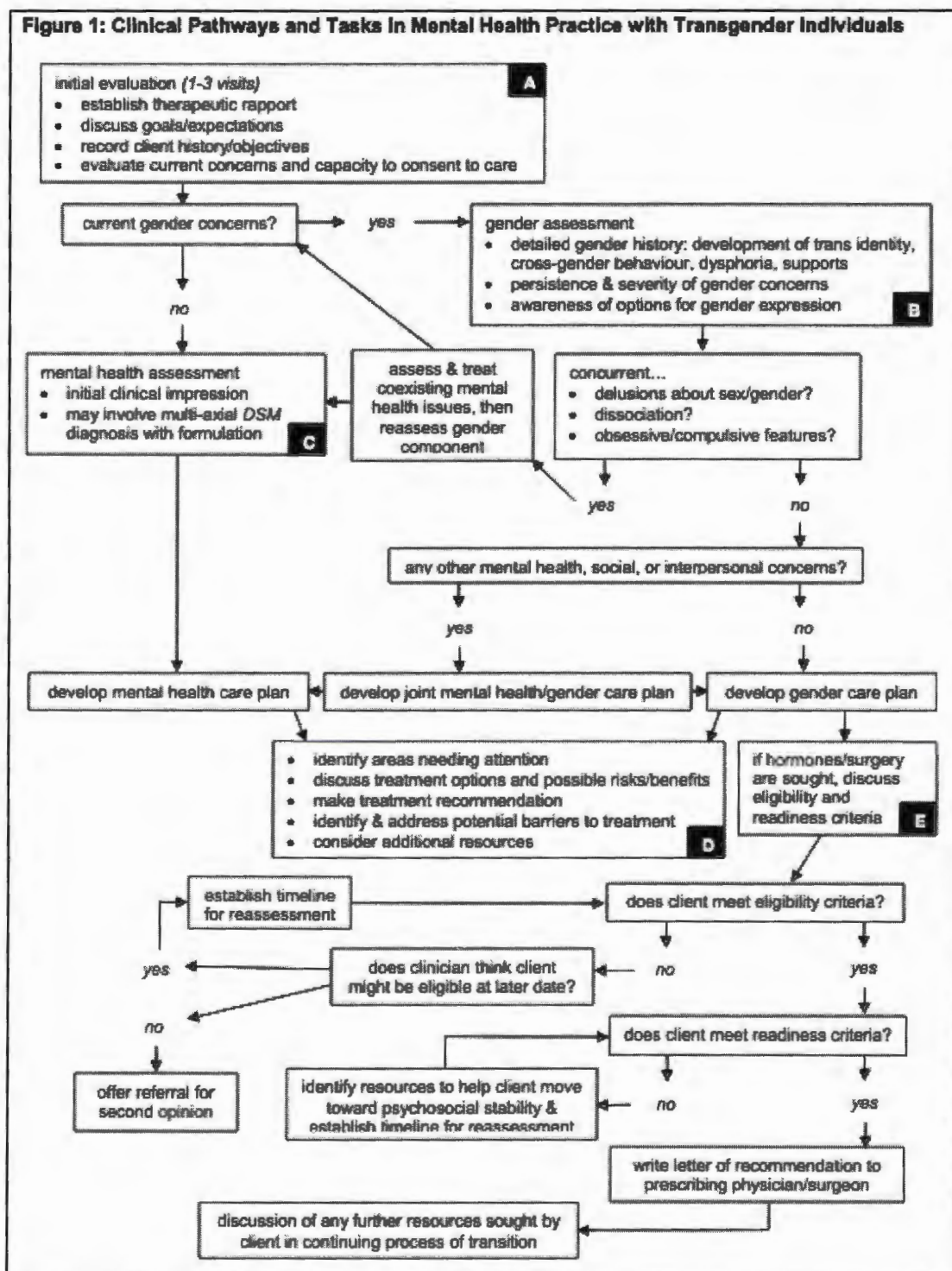
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Appendix A

Process for Assessing Transgendered Clients

Reference: Bockting, W., Knudson, G., & Goldberg, J. (2006). Counselling and mental health care of transgender adults and loved ones. *Vancouver Coastal Health Authority*. Retrieved from: <http://transhealth.vch.ca/>

Figure 1: Clinical Pathways and Tasks in Mental Health Practice with Transgender Individuals



Appendix B

Clarification of Terms

Gender identity: One's inherent "sense of being male (a boy or a man), female (a girl or a woman), or alternative gender" (WPATH, 2012, p. 96).

Sexual orientation: "An enduring pattern of emotional, romantic, and/or sexual attractions to men, women, or both sexes" (American Psychological Association, 2010, para. one).

Gender dysphoria: "Discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assigned at birth" (WPATH, 2012, p. 5).

Drag kings/queens: Performers who dress in gender non-conforming clothing.

Transvestites: Individuals who dress as the opposite gender for sexual pleasure.

Androgynous: Individuals with both masculine and feminine characteristics.

Two-spirit: Among some Aboriginal communities, individuals who take on the roles of the opposite gender.

Transsexual: Individuals who identify with the opposite gender and wish to change their assigned gender.

Transgender: Typically refers to individuals who either identify with a different gender than their assigned gender or transcend societal norms of gender expression. May include any of the terms discussed above and others.

***Note:** All of the terms on this handout are considered broad and flexible. Terminology is constantly changing and evolving.

Appendix C

Media Activity Articles

Article 1 - Transgender Man Denied Cancer Diagnosis and Care

Reference:

James, S. D. (2012, August 8). Trans man denied cancer treatment; now Feds say its illegal. *ABC News*. Retrieved from: <http://abcnews.go.com/Health/transgender-bias-now-banned-federal-law/story?id=16949817>

Article 2 - Transgender Father Says Breastfeeding Support Group Rules Unfairly bar him From Becoming a Leader

Reference:

Ligaya, A. (2012, August 20). Transgender father says breastfeeding support group rules unfairly bar him from becoming a leader. *The National Post*. Retrieved from: <http://news.nationalpost.com/2012/08/20/transgender-father-says-breastfeeding-support-group-rules-unfairly-bar-him-from-becoming-a-leader/>

Article 3 - Article 3 - Transgender Pilots Cleared for Takeoff as FAA Changes Rule

Reference:

James, S. D. (2012, August 18). Transgender pilots cleared for takeoff as FAA changes rule. *ABC News*. Retrieved from: <http://abcnews.go.com/Health/faa-psychological-exam-policy-transgender-pilots/story?id=17030092>

Appendix D

Diagnostic Criteria of Gender Identity Disorder

In adolescents and adults, the disturbance is manifested by symptoms such as a stated desire to be the other sex, frequent passing as the other sex, desire to live or be treated as the other sex, or the conviction that he or she has the typical feelings and reactions of the other sex.

Persistent discomfort with his or her sex or sense of inappropriateness in the gender role of that sex.

In children, the disturbance is manifested by any of the following: in boys, assertion that his penis or testes are disgusting or will disappear or assertion that it would be better not to have a penis, or aversion toward rough-and tumble play and rejection of male stereotypical toys, games, and activities; in girls, rejection of urinating in a sitting position, assertion that she has or will grow a penis, or assertion that she does not want to grow breasts or menstruate, or marked aversion toward normative feminine clothing.

In adolescents and adults, the disturbance is manifested by symptoms such as pre-occupation with getting rid of primary and secondary sex characteristics (e.g., request for hormones, surgery, or other procedures to physically alter sexual characteristics to simulate the other sex) or belief that he or she was born the wrong sex.

The disturbance is not concurrent with a physical intersex condition.

The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Code based on current age:

- 302.6 Gender Identity Disorder in Children
- 302.85 Gender Identity Disorder in Adolescents or Adults

Specify if (for sexually mature individuals):

- Sexually Attracted to Males
- Sexually Attracted to Females
- Sexually Attracted to Both
- Sexually Attracted to Neither

Reference: American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders revised* (4th ed.). Washington, DC: Author.

Appendix E

Video Links and Summaries

Video 1 - Diane Schroer

Video length: 4:20

URL: http://www.youtube.com/watch?v=UEPsK_axRqo

Summary:

Diane Schroer was known as David Schroer for most of her life. She was raised in Chicago in what she describes as a normal family. However, she often felt different and didn't understand why she wasn't a girl. Diane recounts being aware that this feeling was something that shouldn't be talked about. When she was a young man, she joined the army. She found it was a way to keep her distracted from her unexplainable thoughts. After 25 years, she was retired as a colonel in Special Forces. After her retirement, she decided to begin her transition. While Diane's family and colleagues was supportive of her decision, she did not experience the same acceptance from her country. She applied for a job as an International Terrorism Analyst and was chosen. However, after sharing that she would begin work as a woman, the offer was revoked. She felt disappointed, angry, and confused about the decision.

*Side note: On September 19, 2008, the Library of Congress was found guilty of illegally discriminating against Schroer.

Video 2 - Laverne Cox

Video length: 4:01

URL: <http://www.youtube.com/watch?v=6B6abyTQMIA>

Summary:

Laverne is a male-to-female transgendered individual. In this video, she recalls being bullied as a child. Her Mom would often blame her for her bullying and mistreatment by other children. She recalls feeling confused about being told that she was a boy when she felt like a girl. Her Mom was not supportive of her gender identity and she felt shame for how she was thinking and feeling. She joined a dance class which she states "saved her life", although she did try to commit suicide once when she was 11 years old. Laverne remembers feeling very unsafe as a child, particularly because she felt unsupported. As an adult, she has felt unsafe but has a lot more supports than when she was a child. Laverne had a conversation with her Mom where her Mom apologized for not being supportive during her bullying as a child.

Video 3: Noran Wolf

Video length: 3:36

URL: <http://www.youtube.com/watch?v=I7g0sawovxY>

Summary:

Noran knew since the age 5 or 6 that she was different from others. Her wife caught her shaving in "places only women shave". After this shaving incident, their relationship disintegrated. Noran states that she has struggled with depression her whole life and has often felt like a freak. She remembers being so low at one point that she almost killed herself by using a gun. It was at this point that she decided to begin living life as a woman. Noran

decided that it is not her fault if people choose to reject her based on her gender transition. She said that although the rejection hurts, she has been “happier than in her entire life” now that she can live as a woman.

Video 4: Dru Levasseur

Video length: 2:42

URL: <http://www.youtube.com/watch?v=gpMn3OxY6iw>

Summary:

Dru realized he was transgendered when he was around 27 years old. He recalls a time when he experienced discrimination. The night of his best friend's death, Dru went to a gay bar to be with friends. It was this night that he decided to use the men's bathroom for the first time. However, as he headed into the bathroom, a bouncer followed him in and asked to see his id. He showed his id which indicated his female gender and was subsequently kicked out of the bathroom. Dru recalls feeling ashamed and embarrassed. After this incident, he decided to file a human rights complaint against the owners of the gay bar. The lesbians who owned the bar stated that “we don't have to do anything for those people”. It was at this point that Dru realized his support system of 10 - 12 years was no longer supportive. Because of this lack of support, he started a subsystem of the PRIDE centre for transgendered individuals. Five years later, he finally received an apology from the gay bar that had mistreated him.

Video 5: Tony Ferraiolo

Video length: 2:23

URL: <http://www.youtube.com/watch?v=Jw87V7sy5lY>

Summary:

Tony reports being abused by his father for not acting like the daughter that he wanted. When he was in grade 6, the teacher asked him what he wanted to be when he grows up and Tony replied, “a boy”. He was teased about that answer for the rest of his school career. Because of the bullying, Tony isolated himself and turned to drugs and cutting as ways to cope. Things became better once he identified as a lesbian; however, he reports that he still didn't feel “quite right”. After watching a documentary on transgendered people, Tony came to realize that he was transgendered. He began his transition and states that his life totally changed. He became a transgender activist specifically working with transgendered youth.

Total video time: 16 minutes and 2 seconds

Appendix F

Video Case Study Discussion Worksheet

Part I - Case Study Worksheet

Video	Did the individual mention any form of mistreatment? If yes, what?	Did the individual mention any mental health concerns? If yes, what?	What feelings came up for you when watching this video?
Video 1: Diane Schroer			
Video 2: Laverne Cox			

Video	Did the individual mention any form of mistreatment? If yes, what?	Did the individual mention any mental health concerns? If yes, what?	What feelings came up for you when watching this video?
Video 3: Noran Wolf			
Video 4: Dru Lavasseur			

Video	Did the individual mention any form of mistreatment? If yes, what?	Did the individual mention any mental health concerns? If yes, what?	What feelings came up for you when watching this video?
Video 5: Tony Ferraiolo			

Part II - Group Discussion Questions

1. Which case study stood out the most for you? Why?
2. Did you find anything in these videos surprising? If yes, what?
3. In your group, try to imagine each individual in the case studies as gay instead of transgendered. Do you think things would have been different for these individuals if they were gay instead of transgendered? Would they have been treated differently? If yes, in what ways would they have been treated differently?
4. Share with your group some feelings that came up for you while watching the videos.
5. In the lecture on oppression, one study examined "micro-aggressions" among transgendered individuals. Microaggressions refer to "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups" (Nadal, 2008, p. 23). Did any of the participants discuss experiencing this kind of aggression? Have you or someone you know experienced this kind of aggression?

Appendix G

Gender Roles: Homework Assignment

Instructions: Please complete all the questions on this form according to how *you* feel. Try to answer them using your initial gut feeling.

1. It would be strange for me to see a man wearing a dress.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

2. I would feel more comfortable talking about my feelings with a woman than with a man.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

3. If I were to have surgery, I would feel more comfortable with a male brain surgeon than a female brain surgeon.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

4. Gender roles have influenced my career choice.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

5. I am less intimidated by women in the workplace than by men.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

6. I would feel more comfortable having a male rather than a female pilot fly my plane to Europe.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

7. If a boy's favorite colour is pink, he will get teased.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

8. I would be hesitant to vote for a female Prime Minister.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

9. I think that women should have precedence over men for parental leave.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

10. I find it strange when men wear nail polish.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

11. I would be more comfortable watching a woman cry than a man cry.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

Appendix H

Left-Handed Video Clip and Summary

Video: Is it Okay to be Left-Handed?

URL: <http://www.youtube.com/watch?v=XM2J7nOp3nU>

Video length: 2:01.

The video begins with a teenage boy eating cereal and watching television. He is holding the spoon in his left hand. His Mom walks into the kitchen and asks him, "Oi! What are you doing?". The scene switches and the teenage boy is now in the bathroom brushing his teeth with his younger brother. He is using his left-hand to hold his toothbrush. He hears his Dad ask, "Are you boys ready yet?" and quickly switches his toothbrush into his right hand before his Dad gets to the bathroom. The scene changes and now the teenage boy is walking to school. He sees and hears a group of other teenage boys teasing another boy. They are calling him a freak. As he gets closer, they stop teasing the other boy and now direct it at him. They call him a freak and tell him to keep walking. The scene switches again. The teenage boy is opening his locker at school. Inside he finds a note that says "LEFT-HANDED FREAK!!". The scene changes again. Now the boy is in his classroom taking notes with his right hand while his teacher walks around the classroom and lectures. As the teacher passes by his desk, he says to the boy, "it needs to be neater than that!" A teenage girl across the aisle notices the interaction and is looking at him curiously. The scene switches to the teenage boy having dinner with his family. The boy takes a drink of water using his left hand. His Dad turns to the boy's Mom and says, "He's doing it again" and then asks his son, "Why can't you just be normal?" The scene changes again. The teenage boy is on his computer. On what appears to be his Facebook page, someone has posted "Everyone knows you're a LEFT HANDED FREAK now!!" The boy lets out a big sigh and shuts his laptop. The scene changes again. The teenage boy is now in shop class. A group of four boys comes over yelling, "Leftie! Leftie!". They start to poke and prod at him. They take his left hand and force it onto the workbench. One of the bullies takes a sledgehammer and threatens to smash the left-handed boy's hand. The boys are all yelling "Freak!" at him. The teacher walks in before they are able to hit his hand with the hammer. The boys yell at him, "You're lucky! You're lucky!" The scene switches again. The boy is walking down the steps of the school, and the same girl who noticed him in class previously walks by him and says, "Hey, you shouldn't worry what people think. You should just be yourself. Okay, well, see ya." The scene switches again. Now the boy is at home. He is in the hallway outside of the living room and can hear his parents talking. He sneaks up to the doorway and overhears his Mom say to his Dad, "This left-hand being his main...maybe it's just a phase". At the same time, the narrator of the video says "Imagine being made to feel like crap, just for being yourself. It's the same for gay, lesbian, bi, trans, and intersex people. The things we say and do cause anxiety and depression". The scene switches to the same teenage boy and shows him in his bedroom. He looks anxious and sad. He punches his bedroom wall. The video screen then goes black and three words come on the screen, "Stop. Think. Respect."

Appendix I

Evaluating the Progress of Transgendered Clients

Bockting et al. (2006):

Step 1: Initial Evaluation (A)

Building rapport

Establishing the therapeutic alliance

Discuss goals and expectations

Document client's history and present concerns

Bockting et al. (2006) recommend exploring the following areas:

Medical History - Physical/Mental health concerns, medications etc.

Alcohol & Drug use - Which substances, how often, and how much.

Family - Relationships with family members.

Sexuality - Sexual orientation, romantic involvement, sexual abuse/assault.

Social - Social supports, work/volunteer/school, community involvement.

Economic - Financial stresses, work concerns, housing concerns.

Gender Concerns - Client's gender identity, thoughts about hormonal/surgical treatment etc.

Step 2: Gender Assessment (B)

- Assessing and treating the client's gender concerns.
- The following table is borrowed directly from *Counselling and Mental Health Care of Transgendered Adults and Loved Ones*.

Table 4: Potential Areas of Inquiry in Gender Evaluation

Gender identity

- How would you describe your gender identity?
- How did you come to recognize that your experience of gender is different than most individuals?
- Were there any life events that you feel were significant in influencing your gender identity?
- Have there been changes to your gender identity over time?
- What do you remember feeling about your gender as a child? What was puberty/adolescence like?
- How do you feel about your gender now? Do you have any questions/concerns about your gender?
- How does your gender identity impact how you feel about work, relationships, family, or other aspects of your life?

Gender expression

- Are there any activities you did as a child or that you do now as an adult that you think of as being cross-gendered? If so, how have these been viewed by your family and others in your life?
- Did you prefer to be around individuals of any particular gender as a child? Is this different than your preferences now?
- Have you ever cross-dressed? If so, what was that experience like for you? If not, what do you imagine it would be like?
- If you could change your external appearance in any way you wanted to more closely match your sense of who you are, what would this look like in terms of your gender?
- Have you ever taken feminizing/masculinizing hormones or had feminizing/masculinizing surgery? What was that like for you?

Perceptions of others

- How do you think others perceived your gender when you were a child? How do you think others perceive your gender now?
- How do you want to be perceived in terms of your gender?
- How important is it to you that there be a fit between how you feel about your gender and how others perceive you?

Sexuality

- How does gender play out in your sexual desires or fantasies? Does it impact the kinds of sexual activities you do (on your own or with others) or wish you could do?
- What is a typical sexual fantasy for you?
- Do your sexual fantasies involve other men, women, or trans people, or do you mainly fantasize about yourself? If you are in your fantasies, do you imagine yourself to be female, male, or transgender?
- What are your feelings about the parts of your body that are often associated with sexuality (e.g., genitals, chest/breasts)?

- Support resources
- Do the people in your life know that you are transgender? If so, what was it like to tell them? If not, how do you feel about them not knowing?
 - Have you had any contact with other transgender individuals? What was that like for you?
 - What do you see your relationship being to the transgender community now? What would you like it to be in the future?
 - Have you used the internet to access support and information about being transgender? What have you learned? In what ways was it helpful or not helpful for you?

- Also assess client for:
 - Obsessive or compulsive characteristics
 - Schizophrenia or delusions about gender
 - Dissociation
 - Asperger's disorder
 - Personality disorder

Step 3: Mental Health Assessment (C)

- Treatment for any co-occurring mental health concerns.
- If there are still gender concerns following this treatment, move on to step four.

Step 4: Develop Mental Care Plan (D)

- Discuss potential treatment options, risks/benefits, and barriers.

Step 5: Discuss Eligibility and Readiness Criteria for Hormonal or Surgery Treatment (E)

- Beyond the scope of this workshop.
- If you do not have specific training in assessing readiness for hormonal and surgical treatment and are not a psychiatrist or psychologist approved by MSP, consider referring to a qualified mental health practitioner for the client's eligibility assessment.

See *Counselling and Mental Health Care of Transgendered Adults and Loved Ones* for greater details and information about these steps.

Bockting, W., Knudson, G., & Goldberg, J. (2006). Counselling and mental health care of transgender adults and loved ones. *Vancouver Coastal Health*. Retrieved from: <http://transhealth.vch.ca/resources/library/tcpdocs/guidelines-mentalhealth.pdf>

Appendix J

Individual Case Study Activity

You are a counsellor who works at an agency that specializes in counselling clients with gender concerns. You have been meeting with Amelia for about three sessions. During these sessions, you have gathered a lot of information about your client and have built a strong relationship.

For this activity, read through the client information form and write down your answers to the questions provided below. Discuss these questions in your small groups.

1. Amelia's goal is to work on stopping her panic attacks. What other mental health concerns do you think would be beneficial to explore?
2. What other information do you think would be important to gather from Amelia?
3. How would you improve the client information form?

Appendix K

Client Information Form

Demographic Information

Name: <i>Amelia Jones</i>	Date: <i>February, 27 2013</i>
Date of Birth: <i>January 3, 1992</i>	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input checked="" type="checkbox"/> (Please specify): <i>Transgender</i> Preferred pronoun: <i>She/Her</i>
Age: <i>21</i>	Home town: <i>Mackenzie, BC</i>
Home Phone: <i>250 - 640 - 5555</i>	Is it okay to leave a message at this number? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Work Phone: <i>250 - 552 - 5555</i>	Is it okay to leave a message at this number? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
Email: <i>Amelia.Jones347@gmail.com</i>	Is it okay to email you? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
Mailing Address: <i>14 - 4535 Ospika Dr.</i> <i>Prince George, B.C.</i> <i>V2M 4T7</i>	

Employment/Education Information

Employment? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	Employer: <i>MacDonalds</i>
	Current Position: <i>Line Cook</i>
Financial Concerns? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>Job doesn't pay enough, hard to pay rent. Wants to find a better job.</i>	
Education? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> <i>UNBC</i>	

Family/Social Support

Relationship Status: <i>Single</i>	Household members: <i>Self and two roommates</i>
Children? <i>No</i>	
Social supports? <i>Sister, Mom, Roommates, UNBC PRIDE</i>	

Physical Health

Current Medications: *Paxil - for depression*

Mental Disorder Diagnosis? Yes ☒ No ☐

Please specify: *Major Depressive Disorder*

Other health concerns? *Panic Attacks*

Substance Use

Substance use?

Drinks occasionally, more often and heavily on weekends. Uses marijuana on weekends.

Mental Health

Physical Abuse? Yes ☒ No ☐

Sexual Abuse? Yes ☐ No ☒

Emotional Abuse? Yes ☒ No ☐

Suicide attempts? Yes ☒ No ☐

5 years ago, pills, Mom found her and brought her to hospital

Current suicidal thoughts? Yes ☐ No ☒

Gender Identity and Sexuality

Gender identity?

Transgender - Male - to - Female

Come out? Yes ☒ No ☐ To whom?

Sister - good, very supportive, Mom - good, supportive, felt confused at first; Dad - has stopped talking to her since she shared her gender identity with him, hasn't shared with roommates yet

Considered hormonal treatment? Yes ☒ No ☐

Considered surgical treatment? Yes ☒ No ☐

Sexual orientation? *Heterosexual - attracted to men*

Presenting Problem**Presenting problem:**

Anxiety at work - panic attacks during and before shifts, feels terrified when attacks happened, worried about money because she has missed several work shifts. Would also like to explore gender identity more and make decision regarding hormonal and surgical treatment

Goal(s) for counselling:

Stop the panic attacks

Blank Client Information Form

Name:	Date:
Date of Birth:	Gender: Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> (Please specify): Preferred pronoun:
Age:	Home town:
Home Phone:	Is it okay to leave a message at this number? Yes <input type="checkbox"/> No <input type="checkbox"/>
Work Phone:	Is it okay to leave a message at this number? Yes <input type="checkbox"/> No <input type="checkbox"/>
Email:	Is it okay to email you? Yes <input type="checkbox"/> No <input type="checkbox"/>
Mailing Address:	

Employment/Education Information

Employment? Yes <input type="checkbox"/> No <input type="checkbox"/>	Employer:
	Current Position:
Financial Concerns? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Education? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Family/Social Support

Relationship Status:	Household members:
Children?	
Social supports?	

Physical Health

Current Medications:
Mental Disorder Diagnosis? Yes <input type="checkbox"/> No <input type="checkbox"/>
Please specify:
Other health concerns?

Substance Use

Substance use?

Mental Health

Physical Abuse? Yes <input type="checkbox"/> No <input type="checkbox"/>	Sexual Abuse? Yes <input type="checkbox"/> No <input type="checkbox"/>
Emotional Abuse? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Suicide attempts? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Current suicidal thoughts? Yes <input type="checkbox"/> No <input type="checkbox"/>	

Gender Identity and Sexuality

Gender identity?
Come out? Yes <input type="checkbox"/> No <input type="checkbox"/> To whom?
Considered hormonal treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>
Considered surgical treatment? Yes <input type="checkbox"/> No <input type="checkbox"/>
Sexual orientation?

Presenting Problem

Presenting problem:

Goal(s) for counselling:

Appendix L

Role-Plays

Role-play #1

You are a transgendered individual who has just begun the transition from one gender to another. You have recently changed your dressing style to match your preferred gender and have begun taking steps to live fully in your new life. The other day while shopping at the mall, you decided to use the opposite bathroom for the first time. This was a big step for you and took courage. You felt very anxious but excited about making such a large change. Unfortunately, during this first attempt someone became very upset and told you that you were in the wrong bathroom. They threatened to call security and you ran out of the bathroom in tears. You are feeling embarrassed and frustrated, and are afraid to try again. You are coming to counselling to deal with the anxiety that you now feel about going out in public.

Role-Play #2

You are a transgendered individual working as a server in a restaurant with a gender specific dress code. You have a good relationship with your boss and have decided to tell your boss about your transition. Your boss is trustworthy and you have worked together for a couple years. After sharing the news, your boss seems to take it well. However, the next day when you arrive in the opposite gender's uniform your boss approaches you and tells you to go home and change. You leave the restaurant feeling angry and ashamed, and you have not returned to work since. You don't feel like you can go back because you feel betrayed and disrespected. However, you are also unsure about applying for other jobs because you believe you won't get hired.

Appendix M

Coming out as Transgendered: Homework Assignment

Instructions: Please complete all the questions on this form according to how *you* feel. Try to answer them using your initial gut feeling.

1. I would feel uncomfortable if my neighbour came out to me as transgendered.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

2. I would feel uncomfortable if my coworker came out to me as transgendered.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

3. I would feel uncomfortable if my best friend came out to me as transgendered.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

4. I would feel uncomfortable if my friend's romantic partner came out to me as transgendered.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

5. I would feel uncomfortable if my grandparent came out to me as transgendered.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

6. I would feel uncomfortable if my cousin came out to me as transgendered.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

7. I would feel uncomfortable if my sibling came out to me as transgendered.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

8. I would feel uncomfortable if my parent came out to me as transgendered.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

9. I would feel uncomfortable if my child came out to me as transgendered.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

10. I would feel uncomfortable if my romantic partner came out to me as transgendered.

Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	2	3	4	5

Appendix N

Icebreaker Statements

Warm-up Statements

1. I have travelled to another continent.
Potential follow-up question: Where have you travelled?
2. My favorite season is summer.
Potential follow-up question: Why?
3. I play a musical instrument.
Potential follow-up question: Which instrument do you play?
4. I exercise more than 3 days a week.
Potential follow-up question: What kind of exercise do you enjoy?
5. I enjoy winter sports.
Potential follow-up question: Which winter sports do you enjoy?

Transgendered Focused Statements

6. I have had previous training or education on transgendered related issues.
Potential follow-up question: What kind of training have you had?
7. So far in the workshop, I have learned something interesting.
Potential follow-up question: What is one interesting thing you have learned?
8. There is still something about working with transgendered clients that I am hoping to learn.
Potential follow-up question: What is it that you are hoping to learn more about?
9. I believe that working with transgendered clients will be challenging.
Potential follow-up question: What do you think will be the most challenging thing for you?
10. I am looking forward to working with a transgendered client.
Potential follow-up question: What are you looking forward to?

Appendix O

Coming-out Role-Plays

Partner One Role (Transgendered individual)

You have recently begun secretly exploring your new identity as transgendered. You have joined a few online discussion boards and have begun reading about transgenderism. When you are alone, you have been experimenting with different clothing. You have been in a serious relationship with your common law partner for seven years and you haven't shared your gender dysphoria and new identity. You are feeling excited about the possibility of beginning hormonal treatment and exploring your gender identity further, but are feeling very worried about coming out to your partner as transgendered. You don't want to hurt your partner but are feeling unsure about how your disclosure will be received. You know you need to disclose soon because you are feeling eager to begin your transition. For this role-play, you decide to tell your partner about your gender identity and desire to transition. You have approached your partner and stated that you need to talk.

Partner Two Role (Family member)

You have been in a serious relationship with your common-law partner for seven years. You and your partner are in love with each other but you have noticed a change in your partner's behaviour. Your partner has been spending more time alone and has seemed distracted. You are feeling concerned, but whenever you ask if something is wrong, your partner says, "I'm fine". For this role-play, your partner has just approached you and said to you, "We need to talk".

Appendix P

Family Video Clip Link and Summary

Video: Justin Adkins

Video length: 2:11

URL: <http://www.youtube.com/watch?v=P8wdQzAvNJk>

Summary:

Justin states that he came out as a trans person in college, although he had not yet began his full transition. He states that he navigates the world by “being a really nice guy” and allowing people to ask him questions and be curious. Justin describes a recent visit from his parents. Although his Mom sees him every six months or so, his Dad had not seen him in quite a while. He describes it being good for his Dad to see him in his own environment and that other people accept he and his gender identity. Justin states that this particular visit was the best him and his Dad have ever got along. He believes that this is partially because he allowed his parents to “transition with [him]” and because he was aware of their own process in understanding and adapting to his gender identity. Justin encouraged his parents to ask him questions about his gender identity and transition, and did not get upset if his parents used the wrong name or pronouns. Justin describes how being patient and understanding towards his parents was helpful because they came to accept him on their own rather than being pressured to do so.

Appendix Q

Role-Plays

Role-play #1

You have been with your current common-law partner for three years. Recently, you have begun exploring your gender identity and now identify as transgender. You have begun experimenting with the opposite gender clothing in private and have come out as transgender to a few online friends. However, you have yet to share your preferred gender identity with your partner. Keeping this large part of your life from them has been difficult for you because the two of you are very close. You would like to begin living full-time as your true gender; however, you are feeling concerned about how your partner will react to your disclosure. You would like the relationship to continue. You are coming to counselling because you would like to share these anxieties with someone and receive some advice on the best way to come out to your partner.

Role-play #2

You are a divorced individual who recently came out as transgendered to your adult daughter. Because you have a close relationship with her, you believed she would react favorably and be supportive of you. However, when you shared the news of your gender identity with your daughter, she was angry. She stated that she will never talk to you again and is ashamed to be your child. She called you disgusting and walked out. This incident has left you feeling rejected, humiliated, and miserable. You are also feeling worried because you still haven't had the chance to share your gender identity with your adult son. You are concerned that your daughter may have spoken to him already. You are coming to counselling because you are feeling lonely and upset about her reaction and would like some support on how to share the news with your son.

Appendix R

Developmental Video Clip and Summary**Video: Our America with Lisa Ling - Transgender Child: A Parent's Difficult Choice - Oprah Winfrey Network**

Video length: 5:36

URL: <http://www.youtube.com/watch?v=S5P9kUz0yO0>**Summary:**

The video describes a family who noticed their son began acting feminine at a very young age. They describe him as choosing girl toys, depicting himself as a girl in drawings, and wanting to wear feminine clothing. The parents describe a situation where their son got into an argument with other boys at school about gender, stating that she was not a boy but a girl. She started to refer to herself as Hayley instead of Harry. The parents met with many therapists who described Hayley as transgendered. Her parents describe the difficulty and pain associated with hearing that their child may be transgendered. Her Dad describes it "like a dagger in my stomach" and feeling incredibly angry. He describes his child being transgendered as being in direct opposition with his religious beliefs and that he used to hold far different views regarding gender and sexuality. He describes feeling embarrassed and continuing to believe that his child's gender expression was merely a phase. However, he now believes that Hayley's gender identity is not a phase and that she is a girl. Hayley's parents made a choice to support their child and her gender identity to help her lead a better life. When asked about how they would respond to people who say, "you're encouraging a boy to act as someone they're not" the parents reply that they didn't wish this upon their child and that they can't force their child to be someone who they are not. Hayley's parents believe that by accepting her as who she is they are raising a child who will live without shame and secrecy. Her parents recognize that although other children are accepting of Hayley now, this will likely not always be the case. As puberty begins, she will be faced with more challenges. Her Dad becomes emotional when he expresses concerns about his child not being able to find love in her life because of her gender identity.

Throughout the video, the commentator comments on transgenderism more generally. She points to the controversy regarding at what age people are aware of their gender identity. She also states that there are only theories about what causes transgenderism and that some believe it can occur prenatally. The commentator also states that it appears that many transgendered individuals are aware of their gender identity at a young age. She states that being transgendered can be difficult and that many transgendered individuals grow up "hating their bodies" and may experience depression, drug abuse, and suicide.

Appendix S

Treatment Options**Hormonal Treatment Options**

Treatment Option	Physical/Psychological Changes	Potential Side Effects
Hormonal Treatment (Feminizing)	Fat redistribution Muscle mass/upper body strength will decrease Skin will soften Body/facial hair becomes finer Breasts develop Decreased libido	Blood clots Gallstones Breast cancer Depression Benign tumours of the pituitary gland
Hormonal Treatment (Masculinizing)	Fat redistribution Increased muscle mass/upper body strength Weight gain Oilier skin Voice deepening Breast atrophy Body/facial hair becomes coarser	Acne Sleep apnea Elevated liver enzymes Ovarian cancer Decreased insulin sensitivity Increased red blood cell count Poor lipid profile Heart attack/stroke

Surgical Treatment Options

Treatment Option	Description	Risks/Side effects
Feminizing: Augmentation mammaplasty (Breast augmentation)	Silicone or saline-filled implants are inserted under the breast	May not perfectly simulate a female chest Dissatisfaction with result

Feminizing: Vaginoplasty	Transforms the male genitalia into a vagina, labia, and clitoris	Post-operative bleeding Infection Tissue death Decreased sensation Narrowing of the urethra or vagina Scarring Intravaginal hair growth Requires daily dilation Dissatisfaction with result
Feminizing: Penectomy	Removal of the penis, creation of a small indent	Post-operative bleeding Infection Tissue death Decreased sensation Dissatisfaction with result
Feminizing: Facial Surgery	Rhinoplasty Forehead surgery Chin reduction Jaw reduction Lip augmentation	Nerve damage Infection Dissatisfaction with result
Masculinizing: Subcutaneous mastectomy	Creates a chest that resembles the male form Removes breasts, reduces nipple size, and removes the crease beneath the breast	Post-operative bleeding Infection Scarring Loss of a nipple Asymmetrical appearance Dissatisfaction with result
Masculinizing: Hysterectomy, oophorectomy, and vaginectomy	Removal of the uterus and ovaries	Post-operative bleeding Infection Scarring Dissatisfaction with result
Masculinizing: Phalloplasty	Creation of a penis using a skin graft from the person's arm	Post-operative bleeding Infection Scarring Losing sensation and function in the donor arm Tissues in the newly created phallus may die or be rejected by the body Dissatisfaction with result

Masculinizing: Metaidoioplasty	Less intensive and risky than phalloplasty Creation of a smaller phallus using vaginal tissue	Post-operative bleeding Infection Scarring Dissatisfaction with result
Masculinizing: Facial Surgery	Rhinoplasty Chin/Jaw implantation	Nerve damage Infection Dissatisfaction with result

Appendix T

Resources

1. American Counselling Association

This website provides access to the ACA Competencies document.

<http://www.counseling.org/resources/>

2. American Psychological Association

This link leads to a page that contains answers to questions regarding transgendered individuals and gender identity. A great resource for those beginning to learn about transgenderism.

<http://www.apa.org/topics/sexuality/transgender.aspx>

3. I'm from DriftWood.

A non-profit organization that aims to share LGBT life stories. Allows individuals to submit their own videos. Some of these videos were used in this workshop.

<http://www.imfromdriftwood.com/>

4. National Transgender Discrimination Survey

This link provides a free copy of the preliminary findings of the National Transgender Discrimination Survey. Keep in mind that these are American statistics only and should be generalized to the Canadian transgender population with caution.

http://www.thetaskforce.org/downloads/reports/fact_sheets/transsurvey_prelim_findings.pdf

5. QueerBC

A website that provides links to many other support webpages across British Columbia.

<http://www.queerbc.com/>

6. The World Professional Association for Transgender Health (WPATH)

Originally named for Harry Benjamin, WPATH is a professional organization that focuses on treating gender identity concerns. You can also obtain a free copy of the WPATH Standards of Care from this website.

<http://www.wpath.org/>

7. The Northern Pride Centre Society

Provides a safe place and counselling services for LGBT individuals. Also provides access to other online resources.

<http://www.northernpridecentre.com/#!>

8. Trans Alliance Society

A non-profit organization that provides transgender support, education, and advocacy.

<http://www.transalliancesociety.org/index.html>

9. Transgender Basics Video

A 20 minute educational film about the basics of transgenderism and gender identity.

<http://www.gaycenter.org/transgenderbasics>

10. Vancouver Coastal Health - Transgender Health Program

This website provides support and information for individuals interested in transgender health. It includes information on support groups available in the Lower Mainland and also provides useful education materials. Some of the documents available for transgendered individuals include: Trans People and Cancer, Changing Speech, Getting Surgery, Getting Hormones, and Trans People and Vaccinations. The website also provides access to clinical protocol guidelines for transgender care including "Counselling and Mental Health Care of Transgender Adults and Loved Ones" (as discussed in detail in the workshop).

<http://transhealth.vch.ca/>

Appendix U

Review Game - Questions and Answers

Game Questions and Answers

- The bolded answer indicates the correct response.

Background/History

1. (For \$100) Which event in 1952 sparked wide-spread interest in gender identity and sex reassignment surgery in the United States?
 - a. **An American transgendered individual received sex reassignment surgery in Denmark.**
 - b. The first gender clinic opened in the United States.
 - c. The beginning of the feminist movement.
2. (For \$200) In which decade did gender as a dichotomy begin to be challenged?
 - a. 1930s.
 - b. 1980s.**
 - c. 1970s.
3. (For \$300) In which year did English surgeons perform the first sex reassignment surgery?
 - a. 1980.
 - b. 1947.
 - c. 1931**
4. (For \$400) Which individual is credited with coining the term “transgenderist”?
 - a. Virginia Prince.**
 - b. Harry Benjamin.
 - c. Carl Rogers.
5. (For \$500) Which individual is credited with coining the term “psychopathic transsexual”?
 - a. Harry Benjamin.
 - b. David Cauldwell.**
 - c. Christine Jorgensen.

Oppression/Co-occurring Mental Health Issues

1. (For \$100) The National Transgender Discrimination Survey polled 6, 450 American transgendered individuals. What percentage of these participants reported experiencing mistreatment while at work?
 - a. 55%.
 - b. 89%.
 - c. 97%**

2. (For \$200) A 2012 qualitative study found that transgendered participants often reported experiencing microaggressions. What is a microaggression?
 - a. Physical assaults that do not cause bodily harm.
 - b. Covert, commonplace words or actions that convey negative slights or insults.**
 - c. Aggressions that only the offender party would notice.

3. (For \$300) The DSM-IV TR (2000) states that transgendered individuals are at risk for certain mental health concerns. Which of the following mental health concern is *NOT* one that the DSM-IV TR (2000) lists?
 - a. Schizophrenia.**
 - b. Anxiety disorders.
 - c. Substance-related disorders.

4. (For \$400) Which percentage of transgendered participants in the National Transgender Discrimination Survey had attempted suicide?
 - a. 41%**
 - b. 65%
 - c. 21%

5. (For \$500) Which other mental health concerns do you think could be important to consider when working with a transgendered client?
 - a. Down's Syndrome.
 - b. Body Dysmorphic Disorder.**
 - c. Attention Deficit Hyperactivity Disorder (ADHD).

Role of the Counsellor

1. (For \$100) Which task does the World Professional Association for Transgender Health (WPATH) believe is *NOT* the responsibility of the counsellor?
 - a. To act as an educator about gender identity and possible treatment options.
 - b. To try to change the person's gender identity.**
 - c. To help clients become comfortable with themselves.

2. (For \$200) What does the *American Counseling Association: Competencies for Counseling with Transgendered Clients* believe is an important self-exploration task for counsellors planning on working with transgendered clients?
 - a. To understand one's own biases regarding gender.**
 - b. To understand one's own biases regarding sexuality.
 - c. To explore and question one's own gender identity and sexuality.

3. (For \$300) Controversy exists regarding the diagnosis of Gender Identity Disorder. However, the authors of *Counselling and Mental Health Care of Transgender Adults and Loved Ones* believe this diagnosis can be beneficial for some transgendered clients. What is their reason for this belief?
 - a. It can help the client better understand their thoughts and feelings.

- b. It can help validate the client's experience.
- c. Transgendered individuals in BC must be diagnosed with GID to receive funding from MSP for surgery.**

4. (For \$400) Which of the following counsellor traits did transgendered individuals *NOT* state as being important for their counselling experience?

- a. Experience working as a counsellor.**
- b. Respect for their gender identity.
- c. Experience regarding gender issues.

5. (For \$500) The *Counselling and Mental Health Care of Transgender Adults and Loved Ones* document provides a process for assessing, treating, and evaluating the progress of transgendered clients. What occurs in stage three of this process?

- a. The development and implementation of a treatment plan for any co-occurring mental health issues.**
- b. The development of a care plan to treat the client's gender concerns.
- c. An evaluation of gender identity disorder.

Family and Loved Ones

1. (For \$100) Family members and loved ones of transgendered individuals also go through a period of adjustment. What is something that the transgendered individual can do to help facilitate this transition?

- a. Be patient and understanding of their family member's need for time.**
- b. Demand loved ones use the proper pronoun and new name.
- c. Expose loved ones to transgendered culture as much as possible.

2. (For \$200) Research demonstrates that partners of transgendered individuals report many problems following their partner's disclosure of their preferred gender identity. Which of the following is *NOT* one of the problems reported by partners of transgendered individuals?

- a. Lack of acceptance from family and friends.
- b. Confusion regarding their own sexuality.
- c. Increased alcohol and drug use.**

3. (For \$300) Transgendered individuals may have children. Which age group do some therapists believe would have the most difficult time adjusting to their parent's gender identity disclosure?

- a. Preschool years (ages 2-4).
- b. Adolescence (ages 13 - 17).**
- c. Childhood years (ages 5 - 12)

4. (For \$400) The research on partners of transgendered individuals provides some interesting data regarding their experience. However, the studies that have been conducted have some major flaws. Which of the following is one of these concerns?

- a. The research only examined the experience of female partners.**
- b. The sample sizes were too small to be useful.

c. The research had poor reliability.

5. (For \$500) Emerson and Rosenfeld (1996) argue that when transgendered individuals disclose their gender identity, their family members progress through several specific stages of adjustment. What occurs during stage four?

- a. Denial and shock.
- b. Depression and Grief.**
- c. Anger and frustration.

Treatment Options

1. (For \$100) Which of the following is **NOT** an effect of taking feminizing hormones?

- a. Decreased libido.
- b. Faster growing hair.**
- c. Skin becomes softer.

2. (For \$200) Which of the following is **NOT** an effect of taking masculinizing hormones?

- a. Cessation of menstruation.
- b. Male pattern baldness
- c. Rougher skin.**

3. (For \$300) A phalloplasty is a surgical procedure that creates a penis using a skin graft from the individual's arm. Which of the following is **NOT** a serious concern associated with this surgery?

- a. Infection.
- b. Losing sensation in the donor arm.
- c. Blood clots.**

4. (For \$400) When is regret following surgery most likely to occur?

- a. Immediately after the operation.**
- b. One year later.
- c. 10 years later.

5. (For \$500) Which percentage of individuals surveyed in the National Transgender Discrimination Survey reported currently receiving or hoping to receive hormonal therapy?

- a. 85%.**
- b. 70%.
- c. 44%.

Appendix V

Review Game Board Set-up

Category				
Background & History	Oppression & Co-occurring Mental Health Issues	Role of the Counsellor	Family & Loved Ones	Treatment Options
\$100	\$100	\$100	\$100	\$100
\$200	\$200	\$200	\$200	\$200
\$300	\$300	\$300	\$300	\$300
\$400	\$400	\$400	\$400	\$400
\$500	\$500	\$500	\$500	\$500

Appendix W

Workshop Evaluation Form

Please check the response that best fits your experience of the workshop.

	1 Strongly Disagree	2 Disagree	3 Neutral	4 Agree	5 Strongly Agree
The workshop content was presented in a clear manner.					
The workshop content was relevant.					
The workshop content was comprehensive.					
The workshop content will be useful for my current or future work with clients.					
The workshop was interesting.					
The goals of the workshop were met.					
The workshop was well-paced.					
The workshop was well-organized.					
The workshop included a good mix of different activities.					
The facilitator was knowledgeable.					
The facilitator was well-prepared.					
The facilitator was responsive to participants' questions.					
I would recommend this workshop to others.					

What did you like best about this workshop?

What did you like least about this workshop?

How could this workshop be improved?