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**Guidelines for Psychosocial  
Assessments for  
Sexual Reassignment Surgery**

**or**

**Gender Affirmation Surgery**

**Comprehensive assessments and  
psychoeducation**

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**Executive Summary**

julie graham, MFT

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## How to Use This Document

Changing one's physical body is medically necessary for some transgender, transsexual or gender non-conforming patients to reduce gender dysphoria and improve their quality of life.<sup>1</sup> Genital surgical procedures may be referred to as Sex Reassignment Surgery (SRS) or Gender Confirmation Surgery (GCS) or Gender Affirmation Surgery (GAS).

International guidelines from the World Professional Association of Transgender Health (WPATH) Standards of Care 7<sup>2</sup> (SOC7) have established that assessments by qualified mental health professionals are a necessary component of the process.

This document was created to provide mental health practitioners information to realistically respond to the legitimate need for transition-related surgeries in a public health population. The lens that is required to view the strengths and weakness of this document or to properly care for the transgender, transsexual and gender-nonconforming is distinctive from the one used for enfranchised, well-resourced people with the means through private health insurance or the ability to pay out of pocket for services. This document is not intended to put additional barriers on individuals receiving care within public health systems, but aims instead to ensure that they also have opportunities to access high quality treatment and achieve good health outcomes.

The majority of people seen by the Transgender Health Program will move easily through these guidelines. Some people may feel a little hassled by the WPATH requirement for two mental health evaluations. We are focusing on relevant pre-operative preparation that should result in improved post-operative outcomes for a vulnerable and highly stigmatized population. If clinicians do a good job, clients will feel they learned something they did not know and have increased comfort disclosing mental health and substance use related information to their surgeon. Hopefully, they discover that they can trust MHPs to have their best interests at heart and they might return to see a MHP at some point in the future if the need arises or when information they learned during the assessment surfaces as a

question or problem for them.

Therapists need information and background to inform their clinical view of the person sitting in front of them desirous of a letter for transition related surgeries. It is not a replacement for good clinical judgment. It is not exhaustive. It is a beginning. What we don't know about the long-term implications of transitioning is much greater than what we do know.

What we do know, right at this minute, is that the majority of people who desire to transition, will improve after they transition.<sup>3</sup> There are issues related to timing of interventions and information that can improve an individual's experience in the hospital, in recovery and throughout their life. In public health, we want to improve the long-term quality of the lives of transgender, transsexual and gender non-conforming people. We are invested in a healthy community.

We also know that some people regret that they took hormones and/or had surgery. There is little research on transgender people and the research on people who regret transitioning is almost non-existent. Often regret is related to the continuing discrimination against transgender people in society. Surgery does not alleviate this. This means that the advocacy that many transgender medical and mental health care providers have always done is far from finished because surgical interventions are now available. We must continue to address making the world safer for gender non-conforming children and adults regardless of their body.

We also must address co-occurring mental health issue and the environmental context of our clients. The Vancouver Coastal Transgender Health Program discusses the importance of addressing co-occurring mental health: "Unless treatment of gender concerns and concurrent mental health concerns are embedded in safeguarding or improving the client's social adjustment, it is unlikely that the goal of achieving better mental health and well being will be achieved."<sup>4</sup>

What we are striving for is described by providers at an Italian Gender Clinic in reviewing their fourteen year history. "Our patients' high level of

satisfaction was due to a combination of a well-conducted preoperative preparation program, competent surgical skills, and consistent postoperative follow-up.”<sup>5</sup> Mental health providers and the psychosocial assessment are components of improving patient outcome in each of these steps.

This document can be read as a whole or viewed as individual sections. As a result, there may be some duplication of information when it is applicable to more than one topic. Readers can look at the in-depth section or references for more information. This document is the product of years of working with a very diverse group of clients, getting feedback from other clinicians with years of working with clients, and talking to people who had concerns about their community.

If you have questions or disagreements, email me.

Just as everything related to gender is always evolving. This too will evolve.

julie graham, MFT

Gender Services Coordinator

South Van Ness Behavioral Health

San Francisco Department of Public Health

For more information regarding these guidelines:

[julie.graham@sfdph.org](mailto:julie.graham@sfdph.org)

## Components of a Comprehensive Assessment

The assessment serves multiple purposes. It diagnoses gender dysphoria or rules out other conditions that may cause gender dysphoria. It ensures the ability to make an informed consent. It identifies co-occurring diagnoses, including conditions related to discrimination and minority stress. It identifies information necessary for the medical team to provide the best care and addresses unmet psychosocial needs that would interfere with aftercare. Readiness is still a critical component of the assessment when public health clinicians are looking at the long-term health of a client or patient. The assessment also serves to scaffold a person's decision-making and to affirm their identity.

There is no test that can determine who will benefit from surgery and who will not. No one has the ability to see into the future and quite often, clients are taking their best guess as well. Clinical judgment and knowledge is important in assisting clients to develop the most relevant treatment plans. Until the clinician begins the assessment, there is no way to know how many sessions an assessment will take or how long it will be.

A comprehensive assessment for gender dysphoria covers a lot of territory. It includes a gender assessment and a solid basic assessment as well as identifying strengths and resources. Most agencies and clinicians have their own clinical assessment tools. A current Mental Status Exam (MSE) is important for informed consent. A sexual history should be completed to understand how a client experiences their sexuality, their body and to explore how that might change post-surgery. This is an important area to explore for sex workers.

## Screening

Diagnosis is a very sensitive issue and should be carefully discussed. This is particularly true for a community who has been told their whole lives they are crazy. Gender Dysphoria is listed in the DSM and this can reinforce that gender alone is a mental health problem. More often than not, mental health issues result from stigma and discrimination. Psychoeducation regarding minority stress and its psychological and physical impact as well as the effects of abuse can reduce internalized stigma and create an environment of empowerment.

There is no standard gender screening tool.

There are certain mental health conditions that must be ruled out. There are other conditions that are co-occurring with gender and should be routinely assessed for. These include: dissociative experiences, trauma related diagnoses (ie, Borderline Personality Disorder, PTSD, Dissociative Disorders), mood disorders, Body Dysmorphic Disorder, substance use, psychotic process and delusional disorders.

The clinician should evaluate the ways a person participates in the assessment and how they answer questions to identify if there are processing issues that should be addressed and accommodated. It is particularly important to be strengths-based and acknowledge resilience. Additionally, we want to ensure that the individual desiring this procedure is making a choice for themselves and not feeling coerced in any way.

In the course of the assessment, if we discover that the person processes information differently than most people, has a learning difference, or cannot read, adjustments must be made. Further, if the person would be better served in another language, we must provide that linguistic competence. This information should be included in the letter documenting the assessment so that the medical team can also accommodate the client.

## What is Gender Dysphoria?

Gender dysphoria is a psychological, and for some, a spiritual discomfort or distress that describes the experience of a mismatch between an individual's biological sex and their gender identity and/or between how a person knows themselves to be and how they are perceived and treated by others. When gender and sex or gender and perceived sex do not match, it can create emotional pain and confusion for a person. When this distress creates a functional impairment, it can be formally diagnosed as gender dysphoria.

Gender dysphoria may be treated by psychotherapy, social transition hormonal intervention and surgical intervention. Psychotherapy is often not enough to reduce the distress a person feels and they may require a physical change.

Because gender is complex as a social issue and because it is an intensely individual experience, it can feel very confusing to clients and clinicians.

For most people, their gender and biological sex match.

Gender is complex.

Gender exists along a continuum.

Gender dysphoria does as well.

People with gender dysphoria have a strong and persistent dis-identification with their natal sex. Most transgender people have the desire to live according to their gender identity, rather than their natal sex. People with gender dysphoria may also feel alienated from the social expectations of their natal sex and have the wish or the desire to live according to their gender.

Some transgender people are not dysphoric even though they are transgender. Being transgender does not necessarily mean a person is dysphoric. People who have transitioned medically or socially may identify as transgender, but their body now feels more in alignment and they are no longer dysphoric or the dysphoria they have doesn't cause functional impairments.

Gender identity is not always driven by an individual's physical body. A person may know they are a man or woman or both or neither and do not need to make surgical changes to their body. For instance, some transgender women

have no interest in genital surgery. They may see their penis as a large clitoris and feel fine about their anatomy. A number of transgender people do not want to pursue surgery for a variety of reasons that might be about surgical risks, religious or cultural reasons or simply personal preference. It does not change their core identity if they choose not to have surgery.

Many gender dysphoric people are extremely uncomfortable with and alienated from their anatomical bodies. This dissatisfaction may result in depression, anxiety, and isolation and it is psychologically painful. Dysphoria creates functional impairments in a person's life and for many people, surgery is the only means of reducing that dysphoria.

Gender dysphoria is not minority stress or internalized stigma. However, gender dysphoria is exacerbated by discrimination and the inability to express oneself safely. This can lead to isolation and problems with self-esteem.

Gender dysphoria is not about sexual orientation or sexual preference. Just like anyone else, a person with gender dysphoria may be heterosexual, homosexual, asexual or bisexual. SRS/GCS is not a cure for homosexuality. It is important to know that an individual's sexual orientation or preferences may change in the process of transition. It also may stay exactly the same. This is an important discussion.

Surgery is a procedure to reduce the long-standing gender dysphoria. While not everyone with gender dysphoria endorses the following symptoms, the following are possible examples of symptoms of gender dysphoria: The desire to be rid of one's genitals or secondary sex characteristics. Feeling disgusted or repulsed by one's own genitals. Not wanting to take a shower or look at one's genitals. Avoiding mirrors. Feeling as though one is truly the opposite sex despite the physical body. A transgender woman may shave the hair from her body, a transgender man may bind his breasts to have a male contoured chest. Depression related to the inability to live as one's authentic self. Wearing clothing or behaving in ways that would be considered typical or stereotypical of the opposite natal sex. Pre-occupation with how one looks and how to be perceived as the opposite of or differently from their natal sex. Problems related to body image, self-esteem and self concept. Gender identity issues can interfere with friendships and inmate relationships.

## How to Frame the Assessment

Assist the client to feel as comfortable as possible. Explain the framework for the assessment and be transparent. While we are evaluating issues related to gender and other diagnoses, mostly, we are preparing a patient or client to have a successful post-surgical outcome and hopefully a positive long-term outcome. We want to normalize and validate the client's experience of their gender identity and instill confidence that we want the best possible outcome for a patient across their entire lifetime. This is one procedure, a very important procedure with lifelong irreversible results, but only part of the responsible care and treatment for gender dysphoria.

The assessment should be sensitive to gender within the cultures that a person inhabits and the meanings and experiences within those cultures. A clinician must understand the context in which a person inhabits their gender identity and support a person in exploring both the consequences of physical transition and non-physical transition. One of those contexts is that many people have immigrated here from other places and some people plan to return to those places. In San Francisco, clinicians may have area-based beliefs and biases. An example could be that some clinicians do not believe in binary genders, but the client and the community they are returning to may be hostile to the spectrum of gender identities.

Providers should do informed consent about the assessment itself. This means informing clients about the intention of the assessment, possible outcomes, and kinds of questions that will be asked. Clients can refuse to answer questions. Ensure that clients understand at the outset that one possible outcome of an assessment is a diagnosis of Gender Dysphoria, and potentially, other mental health conditions as well. Give clients the choice to end the assessment if they do not want that diagnosis or others.

Surgery is a medical intervention to treat gender dysphoria which is why the diagnosis matters. Research has shown that in general, people who have mental health issues are likely to be less content with their surgical outcomes than people without mental health concerns. Research also shows that people who are isolated have worse outcomes and that poor people, in general, fair worse in the health care system. Relevant support and education may improve this experience for transgender people undergoing surgical procedures.

Explain to the client or patient that the assessment is not an attempt to dissuade or disrupt an individual's transition plan, rather it is to support them to successfully decrease dysphoria and increase the likelihood of a positive outcome following surgery. Explain that we are generally following the WPATH SOC version 7<sup>1</sup> that replaced the previous ones from 2001. Many people do not understand the sweeping changes in the 2012 version of the SOC and do not know that there is no longer a requirement for therapy. However, the assessment could result in a recommendation for psychotherapy.

The assessor should inform the client that they will answer any questions that the client has about the process along the way. Assessors may need to explain the intentions behind the questions they ask. For instance, when asked about substance abuse, a patient may minimize a particular symptom if they believe the assessor may use that information to deny them access to surgery. A client may feel more comfortable disclosing their genuine experiences if the assessor has explained that the reason we want to know about substance use is because we want to help them prepare for successful results. Clinicians want to prevent people going through withdrawal when they are trying to recover from surgery, or prevent substance use from interfering with the effectiveness of anesthesia during surgery, or with post-operative medication and pain management.

Substance use will not prohibit someone from having surgery. Active addiction may stop them from having it right this minute. It is important to have the frame of "not yet," rather than "no," the attitude of "Let's get you stable and then get your surgery." Addressing substance abuse is a step towards surgery.

Another example is sexual assault related issues. Clients may fear they will have their real gender concerns dismissed as a manifestation of trauma. It may be important to explain about PTSD and the potentially triggering experience of having genital surgery when a person is a sexual trauma survivor.

If the client is dissociative or actively struggling with significant PTSD symptoms, an extended assessment may be necessary. If the person is not, providing the education that they may experience acute or post traumatic symptoms following surgery might help them in decreasing their distress and to understand what is happening for them should they have this experience. It is important to name and normalize these experiences.

Some people are worried that access to this important treatment will disappear. They may decide to have surgery now before they lose their chance, regardless

of whether they feel completely prepared. In the past, they may have had access to hormones cut off or lost other important services. People may feel hurried or desperate; that they must have surgery before the rules change or Medi-Cal changes its mind. Clients need to have accurate information and reassurance.

There may be a significant lag time between the initial assessment and the surgery. Clients need to have a plan in place to tolerate the waiting period or get support with waiting if the clinician anticipates this will be a challenge for a client. Often, gender is the only thing a person can focus on when they are experiencing acute distress. After surgery, this may lead to new problems if their whole life has been focused on this singular goal rather than building a robust life. Clients need to be prepared that even though they may get a surgery date, sometimes there are unforeseen occurrences that cause a surgery to be cancelled. People will be rescheduled if this unlikely scenario occurs. However, people need to be able to tolerate that sometimes things go wrong, whether it is the hospital going on strike or a negative outcome from surgery. Recently, there was a suicide in northern California that was ascribed to surgery being cancelled.

The assessments are a chance for people to fully explore anything they are concerned about related to surgery or their transition or their mental health in general. We will assist people to identify other needs, receive referrals for coping skills development, strengthen their existing internal and external resources and get assistance with other problems that may arise.

<sup>1</sup> Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W., Monstrey, S., Adler, R., Brown, G., Devor, A., Ehrbar, R., Ettner, R., Eyler, E., Garofalo, R., Karasic, D., Lev, A.I., Mayer, G., Meyer-Bahlburg, H., Hall, B. P., Pfaefflin, F., Rachlin, K., Robinson, B., Schechter, L., Tangpricha, V., van Trotsenburg, M., Vitale, A., Winter, S., Whittle, S., Wylie, K., & Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people, 7th version. *International Journal of Transgenderism*, 13(4)  
[http://www.wpath.org/site\\_page.cfm?pk\\_association\\_webpage\\_menu=1351&pk\\_association\\_webpage=3926](http://www.wpath.org/site_page.cfm?pk_association_webpage_menu=1351&pk_association_webpage=3926)

## First Assessment

If the client is in mental health treatment, and their gender experiences are well known to the assessor, the initial assessment could happen in a single session. If the client's gender issues are not well-known to the assessor, then the length of the assessment will be based on the information identified by the client and the assessor. The number of sessions will vary based on the assessor's knowledge of the client, whether a person is stable and ready or inadequately resourced or struggling with a mental health or substance use issues that confound the diagnosis or complicate consent, or aftercare planning.

## Second Assessment

The second assessment criteria are the same as the first assessment and completed by a different MHP. The second assessor is confirming the initial assessment. The second assessor must confer with initial assessor after reading the initial letter documenting the assessment and will explore progress on the treatment plan created with initial assessor. The assessor may request documents related to the assessment if needed.

Initial assessors are more likely to be therapists for the client. The second assessor may evaluate issues related to the possible countertransferences that may develop.

The second assessment would generally be briefer for the client but the assessor determines the length of time required. If the first assessment is solid and the patient was well known to the therapist and the primary care provider, and there are no complications or significant unaddressed co-occurring diagnoses, two sessions a month apart are adequate for the second assessor.

## History of Mental Health Care in the Transgender Community

Many transgender people have been harmed or poorly served by mental health professionals in the past. Assessments and therapy were something providers did TO people, and not FOR people. Assessments were used to delimit the boundaries between those who were and those who were not permitted access to medically necessary care. This resulted in mental health and medical professionals deciding what someone's true identity was and controlling the way a person was permitted to be in the world.

In response, transgender people had to look out for themselves and took their health into their own hands. They had to work around therapists and doctors, knowing that they needed to protect themselves from medical and mental health professionals who might not have their best interests at heart. The failures of the medical and mental health professions created a rift, a lack of trust and a need for vigilance and advocacy.

This is the environment which the San Francisco Department of Public Health is attempting to change through education and advocacy. True change develops slowly and sustainable change is a process. The Transgender Health Program is in the very early stages of its development. In 2013 the Health Commission agreed to pay for necessary surgery for the transgender community. In April of 2013 the Department of Managed Health Care revoked the right of insurance companies to restrict and exclude medically care from transgender people through the Insurance Gender Nondiscrimination Act (IGNA).

Transition related services would be made available for transgender, transsexual, and gender-nonconforming people through Medi-Cal and Health San Francisco on a case-by-case basis.[1] While critically needed, these changes did not address the underlying issue of provider capacity or the lack of an infrastructure. San Francisco had a mandate to provide desperately needed and necessary surgical interventions but had no infrastructure in place to provide those services. A small group of people set out to expand the limited services that existed and to create new services without an applicable model. San Francisco would be the first city in the United States to provide this care.

This is a complex city in which to start a public health revolution. Transgender, transsexual, and gender non-conforming people are not a homogeneous group. They represent the various cultures that are at home here

in the Bay Area. They are from all socioeconomic classes and ethnic backgrounds, they are neurotypical and neurodiverse, young and old, with varying health statuses and unique health care needs. Transgender people may be employed, educated and own their own home filled with friends and family and others may be refused employment, homeless, discarded by their families, and self- medicating with alcohol and other drugs.

Transgender people are also not a static or monolithic group and our understanding of gender identity and gender expression continues to evolve right along with the transgender community. People identify in a multitude of ways regarding their gender, sexual orientation or preference, gender expressions and as individuals. Many ethnic and cultural communities have identities and language that do not necessarily match up with the Western idea that identity creates behavior and that everything has words to describe it.

There is no one transgender community, instead there is a multiplicity of communities. Each person must be respected as the individual that they are and as the expert on their own life.

Something that we do know is that perceptibly transgender adults are the targets of discrimination and abuse, and this targeting is worse for transgender women of color and immigrants. Gender non-conforming children are bullied in school and abused and rejected by their families. Because of this, transgender people have increased risk of mental health and physical health problems. We know that transgender, transsexual and gender non-conforming people are disproportionately affected by employment discrimination, homelessness, smoking, and the illnesses connected to discrimination and stigma-depression, substance use, HIV and Hep C. The suicide rate for transgender people is appalling.

The people who utilize public health services generally have additional needs that people who have access to private health insurance, safe homes, quality food, breathable air, and sleep without gun shots outside, screaming neighbors, and vermin-infested rooms do not experience. Combining gender and enforced poverty means that a transgender resident of San Francisco will likely have poorer quality of life and a shorter life. In response to these truths, transgender activists, advocates and allies insisted that San Francisco could do better.

The San Francisco Department of Public Health has made a commitment to improving care and ensuring people receive relevant, informed and unbiased

care. Mental health providers do not do reparative therapy. Gender sensitive therapists are committed to fixing the decades of misdiagnosis and disregard for transgender people. Many people are now eligible for free or low-cost therapy through Health San Francisco and the ACA. Therapy is no longer only for people who have insurance and financial resources or for those people who are mandated or coerced. Therapy should provide transition-related support, assistance decreasing gender dysphoria and coping with minority stress, discrimination and stigma.

The goal of the psychosocial and mental health assessments is to ensure clients have the necessary information and the psychosocial support that they need to make the best decisions for themselves and have the best outcomes. Providing surgery without improving the dailyness of people's lives will help some people. Providing surgery as part of an integrated package of services that respects a person as a whole person improves their quality of life, and hopefully will the extend the lifespan of the transgender community. The goal of this document is to provide the basic information that therapists who are providing gender-related assessments can think holistically about the needs of transgender people in public health.

[1] Transgender Law Center Medi-Cal Fact Sheet. <http://transgenderlawcenter.org/issues/health/medical-fact-sheet>

## Philosophical and Clinical Underpinnings

Any requirement that a mental health provider puts in place may be seen as a barrier given the hostile and paternalistic gate-keeping history inflicted on the trans community by mental health providers. That response, although understandable, is not accurate regarding the education and preparation program within the Transgender Health Program, or mental health care from Community Behavioral Health Services or the Department of Public Health.

Transgender people in the public health setting are not simply their gender identity. Just as gender-related care was ignored or dismissed, the psychosocial aspects of an individual's life should not be minimized or ignored when preparing an individual for a stressful, irreversible, life changing surgery. Requirements regarding stability are not barriers to care; rather they are a recognition of the context of people in the public health setting. Identifying unaddressed needs is an attempt to provide better outcomes.

When the DMHC declared that insurance companies needed to provide access to medically necessary care on a case-by-case basis, it did not assure that this “equal” access would mean equal results. There will still be well-resourced people and under-resourced people. Under-resourced people generally have poorer outcomes in the health care system. People with mental health issues generally have poorer outcomes. While this is true, it does not mean that any given individual will have a bad outcome. It also does not mean that providers have to accept this as true instead of fighting to ensure that poor people, people with mental health issues, and isolated people have results that are acceptable to THEM.

This manual is an effort towards providing clinicians with the information they need to assist patients to make genuinely informed decisions and to plan for pre, peri, and post-operative care with a focus on keeping the person as stable as possible throughout their surgical experience. Well resourced or under-resourced, public health care clinicians want everyone to have the best possible result.

Equality is not only saying all people should have access. Genuine equality makes that access relevant and makes that access genuinely attainable. When people say that surgery or transitioning improves outcomes, those treatments occur within a sociopolitical context. The people who rely on the public health department in San Francisco are usually struggling. We serve people living on

SSI, people who are underemployed, undocumented, homeless or marginally housed in SRO's in high crime neighborhoods, trauma survivors, substance abusers, mentally ill people and people who are trying as hard as they can to contribute to society and build a life for themselves against steep odds.

The role of public health providers is to try to level the playing field long enough so that transgender, transsexual and gender-non-conforming patients will have a reasonable shot at a positive outcome from a surgical intervention. We do this through accurate diagnosis, education and psychosocial support. Just as a person needs to know that a medical problem like diabetes being poorly managed will affect their possible access and outcome from surgery and attempt to stabilize their blood sugar and diet, people need to know about the implications of poorly controlled mental illness or the impact of their homelessness on access and outcomes.

Public health workers want to extend life, improve the quality of life and prevent bad outcomes, reduce the likelihood that an individual will experience overwhelming regret, and ensure that clients are genuinely informed with research that we have and understand the limitations of that research. If people experience regret, we want them to stay in care and be supported.

The first question that therapists must ask is:

Is the client in front of me likely to have a good outcome from surgery at this moment in time? If the answer is no, what is needed to assist the person to have the best result?

An accurate diagnosis is important to rule out other explanations that better explain the gender dysphoria. When the issue genuinely is gender dysphoria, clinicians must look at what interventions could improve the person's experience of dysphoria and their quality of life.

If a person needs to plan for adequate aftercare, to develop trauma-related coping skills, to explore realistic expectations, to find reliable and safe housing or apply for entitlements and benefits, so they do not have to try to return to work before their body is ready, those are components of a good outcome. If clients need to plan for possible complications, or to stabilize their anxiety to lessen potential post-operative distress, or quit smoking, reduce their alcohol intake or to find job-training while they wait for surgery so that they can

support themselves afterwards, these are all areas that mental health providers in the SFDPH can help with in an attempt to level the playing field.

Another question is what is the safest, least intrusive, and most reversible intervention to alleviate the client's gender dysphoria? Surgery is not always the answer. That question is not meant to construct a barrier to surgery, nor does it mean an individual must prove to the therapist that he/she/ze is transgender. Surgery does not equal identity. There are multiple configurations of psychological, social, hormonal, and surgical interventions that can create a viable transition. For some people, it might be therapy, for other people it might be therapy and hormones, therapy and surgery, surgery and hormones, for other people it is chest surgery alone and not hormones. For still others, only genital surgery can restore the feeling of an intact body that matches their internal identity

Only the patient knows what he/she/ze needs regarding their gender at any particular moment. The therapist's job is to ensure that clients know their choices and have realistically explored possible outcomes.

If surgery is the solution, components of planning for a good outcome include supporting people to develop a plan for adequate aftercare, planning for potential complications, and developing realistic expectations for surgical outcomes. Good outcomes are also individual-specific. When needed, a clinician will also help with trauma-related coping skills, reliable and safe housing, and applications for entitlements and benefits so they do not have to try to return to work before their body is ready. Clients may need to stabilize their anxiety to reduce potential post-operative distress, or quit smoking, reduce their alcohol intake or to find job-training while they wait for their surgery date so that they can support themselves afterwards. These are all the sorts of things that mental health providers in the SFDPH can assist with in an effort to ensure health equity/parity.

A component of providing responsive care is ensuring that clients feel empowered to ask questions of their medical providers and are able to identify and get their needs met. Therapy can help with this and with psychosocial adjustment and keeping one's self esteem intact while coping with discrimination. Therapy is not a requirement for everyone as it was in the past. However, many people will need clinical case management focused on improving the quality of an individual's life.

Gender is critically important and only part of an individual's life. After transition, a person must have the chance at longevity and an authentic and happy life. Identifying and decreasing potential peri- and post-operative complications related to mental health or psychosocial needs should be identified, assessed and addressed prior to surgery.

## What are Possible Outcomes from an Assessment?

- 1) A letter that states the person is an appropriate candidate to be evaluated for surgery and that there are no co-occurring concerns that must be addressed prior to surgery.
- 2) A letter that states that the person is an appropriate candidate and there are some things the surgeon and possibly the recovery room nursing staff need to know in order for the person to have the best possible outcome. (For instance, if the client has PTSD, an anxiety disorder, or a processing difference like autism spectrum disorders, or that the person best understands in a language other than English, and needs translators, etc.)
- 3) An agreement that the person is an appropriate candidate but that there are issues that must be addressed concurrently with planning for the surgical intervention. (For instance, the person has no social support and lacks an aftercare plan.) A treatment plan would be created to address these issues. This could also include referring a person back to their medical providers for more in depth answers to medical questions. A letter would be provided explicitly documenting these concerns and the plan to remediate them.
- 4) A treatment plan to address more significant problems that are barriers to informed consent or barriers to positive post-surgical outcomes. A letter would be provided when the person has stabilized in the identified areas, if it is still desired and appropriate. A time frame should be established. The person might be required to check-in every six weeks with the clinician who completed the assessment or the Coordinator of the Transgender Health Program.
- 5) A letter to the Primary Care Provider that says the person is not an appropriate candidate at this time and describes the basic barriers and explanations. This should be processed with the client and hopefully the client agrees and understands.

## What Does Stability Mean?

Change and stress can exacerbate mental health symptoms, and cause an individual to de-compensate, or their situation to worsen. Stress also interferes with the body's ability to heal. Genital surgery is a significant stressor. Recovery from genital surgery is also a significant stressor.

Clinician and client must have adequate understanding of the mental health history, needs, and the plan for addressing and supporting the client through a physically, emotionally and financially stressful experience. When these things are not in place, the clinician should assist the person to develop these supports or capacities in order to have positive outcomes. People must have the practical supports in place necessary to recover. The exact needs will vary by surgery and by the individual. For instance, an uncomplicated orchiectomy needs several days on a sofa and genital surgeries require weeks of healing and sometimes up to a year to fully recover. While someone doesn't have to commit to an entire year of healthy living, if we can assist the person to improve the quality of their life as they wait for surgery it's a step towards assisting the person to have a longer life with better quality.

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### Housing

Stable housing at a minimum for the duration of the recovery period.

Clients must have a place to go following surgery. It is better if a person has an ongoing safe place to live. (See *homelessness*)

Couch surfing is fine for uncomplicated orchiectomies. Extensive genital or chest surgery requires more stability. People may be sent home with drains or tubes. Genital surgery requires ongoing self-care that is not possible when a person is homeless. Patients must have enough space for privacy to be able to take care of medical needs, have access to clean water, be indoors, and safe for the period of time necessary to recover.

This housing should not be at risk. A person should not be worrying about their housing as they recuperate. Minimizing stress is important. Housing concerns should be assessed, for instance, transitional housing may be entirely appropriate, although it is technically considered homeless by some

definitions. Couch surfing may be fine following an orchiectomy, but inadequate following a chest reconstruction.

Positive outcomes are unlikely when a person is recovering from chest surgery or genital surgery and must navigate homelessness. Patients should be set up to succeed and leave with improved health, rather than at higher risk for victimization, infection and readmission. Clinicians can assist clients to apply for housing, if needed, and create a plan for post-surgical recovery needs with the client.

### **What else?**

Homeless clients need extra care. 80 to 90% of homeless people are estimated to have a mental health diagnosis.<sup>1</sup> A 2009 review article on homelessness indicated that 4-7% of homeless people have cognitive deficits.<sup>2</sup> Cognitive deficits potentially have a negative impact on following healthcare directives and could interfere with informed consent. Traumatic Brain Injuries are a significant issue in the homeless population and should be assessed for and addressed.<sup>3</sup>

<sup>1</sup>Martens WH. A review of physical and mental health in homeless persons. *Public Health Rev.* 2001;29:13-33.

<sup>2</sup>Can J Psychiatry. 2009 Feb;54(2):123-33.

A systematic review of cognitive deficits in homeless adults: implications for service delivery.

Burra TA, Stergiopoulos V, Rourke SB.

<sup>3</sup>Traumatic brain injury among people who are homeless: a systematic review. *BMC Public Health.* 2012; 12: 1059.

Published online 2012 December 8. doi: 10.1186/1471-2458-12-1059

### ***Homelessness***

For a homeless individual to have a positive outcome requires that a patient's care team develop a plan to help support the client in achieving their desired outcome. Homelessness does not necessarily preclude an individual from having surgery. However, there are limits to what the Transgender Health Project can do and clients and their care teams may need to begin addressing

Poor health and homelessness go hand in hand. Homeless people are three times more likely to die than the population at large. Over half of all homeless people have chronic illnesses that will complicate their recovery from surgery. Homeless people are exposed to communicable diseases such as TB and pneumonia, problems related to exposure to the elements, poor sleep, and inadequate food. Homeless people often face potential violence on the street, and transgender people are targeted and experience extreme daily stress from discrimination and stigma. Homelessness is excessively stressful and being transgender increases that stress.

Recovery from surgery requires enhanced nutrition and sleep so the body can heal. Poor sleep puts people at risk for viral infections as well. Patients who are homeless and recovering are vulnerable to infection and illness as well as victimization. The reality is that a client likely would have to worry about protecting their medication or pain killers from being stolen or actually have them stolen. They may be less able to protect themselves and even the act of suddenly attempting to protect oneself can cause harm to stitches. Follow-up care can be especially difficult for homeless people. They have to focus on securing where they are sleeping each night.

Mental health issues, in particular trauma, and substance use including cigarettes may exacerbate healing. Clients can be rousted or arrested, and victimized. Complying with medical directives may be a lower necessity than finding a new place to sleep each day. Even in shelters, people may have to reapply every day. They may need to leave during the day and return only at night.

Already, people who are poor are at higher risk for a readmission. In hysterectomies alone, the percentage difference in readmissions from low-income to high income communities is extremely high.<sup>1</sup> Mortality is higher for people with Medicaid than private paying patients as are in-hospital complications including a 57% higher death rate than private pay patients.<sup>2</sup>

Homelessness is generally a source of distress for people. For people who live outside, being inside in a hospital and then in a place to recover can create its own special stress, including the possibility of acute trauma which the recovery staff would need to manage.

The clinician must think about housing in terms of the possibility that the client would have complications and that they would need more rather than

less care. Prepare clients to understand that being inside after being outside for many years will likely be a significant stressor. Utilizing motivational interviewing techniques may be helpful working with chronically homeless transgender people who would benefit from surgery but are unable to live indoors.

<sup>1</sup>Mehwish Qasim, M.P.H. and Roxanne M. Andrews, Ph.D. Post-Surgical Readmissions among Patients Living in the Poorest Communities, 2009 Statistical Brief #142

<sup>2</sup>LaPar, D, Bhamidipati, CM Primary Payer Status Affects Mortality for Major Surgical Operations

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## Financial Stability

Clients must have some means of supporting themselves during recovery. People deserve to have the time they need to recover and returning early to work can jeopardize their healing.

There are financial costs associated with surgery that are not covered by insurances and these include necessary medical supplies. Clients must have adequate food and have their housing/shelter covered. If these resources are not yet secure, clinicians must assist clients in developing and following through on plans to address and secure these resources before surgery.

Some people will be employed, others on SSI, or GA, or being supported by other people. Their financial situation should be secure for the duration of their recovery and hopefully longer. If a client is employed, they will be off work for a period of time as they recover and will lose wages as a result, meaning less money for the following month.

Clinicians can assist clients with applying for entitlements if needed or refer them for vocational training or to SSI or GA.

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## Post-Surgical Support and Caregivers

People need to have a realistic aftercare plan in place. The degree to which an individual has considered their aftercare is an indicator about a client's lack of information or lack of understanding about the extent of their surgical procedure.

Following release from the hospital, people need continued care. It starts with who will drive them home from the hospital. Patients will need a safe, private and healthy place to recover. They will also need to have people who can check their bandages, make sure they have not developed a fever, and provide basic caregiving.

Post-surgical support can be friends, family, IHSS or the medical respite care program. If at all possible, caregivers should speak the same language as the patients. This degree of support will vary by the type of surgery. Clinicians can assist people to identify who can fill these roles and make appropriate referrals for people who need to have additional support. Clinicians need to look at creating support with an eye towards the specific individual and their mental health needs. Respite care may be triggering for people with anxiety, PTSD or phobias.

People need to be able to attend follow-up appointments. They may need assistance or to be driven there.

There are practical things that people can do. If they have access to a freezer and a way to reheat food, they can make meals ahead of time and freeze them. If they are having chest surgery, they can move anything they will need to use so they do not have to reach over their head and set up their rooms so they do not have to carry anything. If they have children, ensuring someone else can provide childcare until they are capable of lifting a child, etc.

Clients who are concrete or struggle with executive function issues may need significant assistance in planning and executing aftercare.

## Documenting the Assessment

The letter documents the assessment and your clinical notes must document the assessment as well, including any particular tools or scales you may have used, and relevant information that supports your assessment. It should also demonstrate that informed consent occurred for the evaluation and that the patient is capable of informed consent. The Vancouver Coastal Health Transgender Health Information Program has excellent comprehensive resources. “Documenting history and current concerns” on page 5.

### Who is Qualified to Write a Letter?

A licensed mental health provider with gender sensitivity and knowledge of transgender people in public health settings. There is no certification that makes someone qualified; clinicians should get training, support and consultation. The Transgender Health Project can assist with consultation and skill development in gender related care. Supervision and continuing education related to gender is important. Therapists should be knowledgeable about gender-nonconforming identities and expression, the assessment and treatment of gender dysphoria,<sup>1</sup> and cultural differences regarding gender identity and expression.

Clinicians should be objective and not attempt to influence the client to match the clinicians own beliefs regarding gender transition. Clinicians should not attempt to change a person’s gender identity nor should they be suggest or advocate that a person should transition. Clinicians should be comfortable providing accurate and honest feedback based on the assessment and should affirm the person’s identity.

For the initial assessment, a therapist working with the client knows that client the best and that is very important. However, if clinicians provided services unrelated to a client’s gender identity they may not have explored this territory even if the client has been in therapy with them for a long time.

The clinician should know basic information about the procedures, the positive and negative outcomes of surgical interventions, aftercare needs and appropriate referrals for those needs. It is important to assess for the capacity to provide informed consent. The clinician should be comfortable assessing and diagnosing co-occurring disorders, and issues that interfere with good surgical outcomes.

***Why not a doctor? Why not a peer counselor?***

Mental health affects physical health and physical health affects mental health. This model is for collaborative treatment teams who respect each other's expertise working together with the whole person of the patient rather than only a part of the individual. Doctors, peer counselors and therapists all do important work but they do not have the same skills, training or experience.

Diminishing the importance of mental health providers is diminishing the importance of mental health. This is a reflection of the larger social problem of stigmatizing mental health and the reluctance of society to admit that mental health is important.

Practically, there are decreasing numbers of primary care providers in health care. Therapists are trained to do mental health assessments and it does not make fiscal sense to have a doctor either spend too little time trying to do the work of a therapist or take away time from other patients to do what therapists are trained to do. Peer counselors are not trained in the identification and assessment of mental health disorders.

When there is not a therapist at a particular site, the system of care must work with the site to bring mental health care to the patients at that site. As part of the new program, relevant models must be designed to that provide adequate care. For instance, patients who are reluctant to see a mental health provider can have peer counselors or peer navigators, with whom they are comfortable, attend sessions with them to advocate ensure that nothing inappropriate happens in the session. Doctors can assure patients that this is a necessary experience much like getting blood work or a clearance from a cardiologist or pulmonologist. Mental health is a specialty area that has bearing on the outcomes of and the indications for surgery.

## What Must Be in the Letter Documenting the Assessment?

1) It must be addressed to the surgeon or to the surgical team if the actual surgeon is not known, for instance Department of Urology.

2) Describe who you are, your experience with transgender clients and explain your relationship to the client and how long and in what capacity you know the person.

examples:

*I am a psychotherapist in private practice working with the Private Provider Network. I have provided psychotherapy for several transgender people in the past year. I met with John Doe once in July to assess for the appropriateness of a referral for hormones.*

**or**

*I am a gender specialist with South Van Ness Behavioral Health and work with a multi disciplinary team and am a member of WPATH. I am also a member of Bay Area Gender Associates. I met with the client and his partner for 6 months to address relationship communication problems.*

3) The description of the patient and their current gender identity and a brief history of their gender evolution.

*22-year-old Caucasian masculine appearing natal female who identifies as male and is seeking a hysterectomy to decrease his gender dysphoria. He began social transition at age 18 and began hormones in May of 2012 through Tom Waddell Health Center. He has responded well to hormones. He initially recognized his own gender when he went through puberty and had increasing body dysmorphia related to his developing breasts...*

4) Any Axis I and Axis II psychiatric diagnosis and medications that client is prescribed.

*The client has Gender Dysphoria and Attention Deficit Disorder with hyperactivity. Dr. Patel has prescribed 50 mg of Vyvanse daily for ADHD and Ambien which the client takes several times a week for sleep problems. The client has responded well to medication.*

5) That the patient meets the WPATH SOC. Write them out.

6) Any concerns about patient compliance.

*Client keeps appointments and has complied with treatment and the Standards of Care.*

7) Why the client wants this particular surgery; any research they did and what they understand, etc.

*Client wishes to have an orchiectomy in order to reduce her reliance on anti-androgens and hormones. She is concerned about her long term health and wants to be certain that her secondary sex characteristics never return. She does not want full SRS, preferring to have minimally invasive procedures. She does not want children and understand that she will not be able to have children of her own without banking sperm and she does not want to do that at this time. She understands that her sexual drive and sexual function may change as a result of surgery.*

Add to this your reasoning and assessment:

*The client currently presents with a mixed gender presentation which puts him at risk for harassment and violence. He is very dysphoric about his breasts. He reports that he despises his breasts and that they feel like growths or tumors and he wishes them gone. He would prefer scarring and a poor outcome to continuing to exist with breasts. He very likely will have decreased dysphoria following surgery.*

8) Current and past substance abuse.

*The client is in recovery from opiate addiction.*

*The patient uses medical marijuana daily to manage her anxiety.*

9) Aftercare plans and any unaddressed needs.

*The client has a supportive relationship with her sister who will be with the client throughout surgery and for the following two weeks. The client has arranged to be off of work for four weeks and has saved money to pay for post-operative necessities.*

*She has arranged her apartment to easily get around and plans to freeze meals ahead of time. Her case manager will call her daily once she is ambulatory.*

10) You welcome a call for further information.

They do call. Some surgeons want to ensure that the letter was written by the person who signed the letter.

Chart the details of the assessment and the components of informed consent and put a copy of the letter in the chart.

## Examples of Acceptable Letters

### Sample Letter One:

Dear Dr. Doctor,

Re: John Doe DOB – August 14, 1987

Reason for Referral: Mr. Doe has requested that I write a referral letter to you for the following lower surgery procedures (metoidioplasty, vaginectomy and urethral lengthening). He meets the WPATH requirements for this referral. He is capable of informed consent and has carefully researched the procedures he is seeking.

Presenting Concern: Mr. Doe is a 32 year old Caucasian man with a full beard who reports being born female and having masculinized through prescribed hormones over the past seven years. He first consulted me in July of 2011 for a lower surgery assessment. I saw him twice at that time. Since it was apparent that he met the WPATH criteria, I suggested that he come back closer to his surgery date for a final assessment.

He returned in July of 2013 and reported that he has a consultation scheduled with you in September. His presentation two years later was similar to his initial presentation. He has a consolidated male gender identity and has dysphoria around his genitals. He has good insurance coverage for these medically necessary procedures and a well thought out aftercare plan. Hence, I am comfortable writing the primary referral letter.

Background/History: Joe reports that from his earliest memory, he never felt like a girl and knew he was not like other girls. During play, he was always the groom or the Dad and wanted to wear boy's clothes. During adolescence, realizing his attraction to girls, he thought he might be a lesbian.

Although he knew he wanted to marry a girl, he didn't feel like a lesbian and did not fit in with the lesbian community. He comes from a supportive family who have tried to help him. He moved to the Bay Area in 2003 because he believed he would find the support he needed and find himself here. He attended a trans support group and felt the other men there were "telling my story."

Joe began his physical and social transition at that time. He started living full time as male and began hormones in 2003 through Lyon-Martin Health Services. He saved for two years in order to have top surgery in 2008 with Dr. Michael Brownstein and had a hysterectomy through SFGH.

He has responded well to all of the medical masculinization procedures and has built a good life for himself as a man. He is a gardener and loves his work. He is not “out” at work and chooses to live stealth. He currently is not dating and feels that his body interferes with his openness to pursue a romantic or sexual relationship.

He has a productive and meaningful life. He enjoys his family, friends and colleagues. However, he feels limited in his physical activity because he is uncomfortable in locker rooms. He wants to “not have a vagina and to be able to stand and pee”. He wants “to be comfortable in my body” and having a vagina makes him feel “vulnerable and exposed.”

Current Assessment: DSMIV-302.85. He has no diagnosis on Axis II. He meets the DSM criteria and the old WPATH eligibility and readiness criteria as well as the new SOC 7 criteria. He has lived as male for several years, has taken hormones as prescribed, is capable of informed consent He reports no health problems and no substance use that would interfere with surgery.

Comments: From my perspective, Joe is an excellent candidate for the requested medical procedures so he can be more comfortable in his gendered self. He is aware of the possible complications and feels that the possible benefits far outweigh the risks.

If you have any questions or desire additional information please contact me. Thank you for working with me in the care of this individual.

Sincerely,

Pablo Psychologist, PHD

415-555-1212

## Sample Letter Two:

Marci Bowers, MD  
PO Box 1044  
Trinidad, CO 81082

Fax: 719-846-9500

June 12, 2011

Dear Dr. Bowers,

Ms. Pina Chacon has been under my care through the San Francisco Department of Public Health since January of 2005. I am a gender specialist and the coordinator of the Gender Services Program of South Van Ness Adult Behavioral Health Services and we have a multi-disciplinary Gender Team. SVNABHS was formerly the Center for Special Problems. I am also a member of Bay Area Gender Associates.

Ms. Chacon is a 54 year old biracial Latina and African-American transsexual woman who is a genetic male with a consolidated female gender identity. She is seeking an orchiectomy. She has Hepatitis C and her liver functioning has been in decline. She is deeply concerned that the hormones she takes are damaging her liver and she would like to take smaller quantities to protect her liver.

Once Ms. Chacon began hormones, she reported an increased sense of well-being. She has been living as a woman, dressing and behaving as a woman since 2006 and has legally changed her name. She has adjusted well to her transition. She has kept her medical appointments and as her hormone treatment progressed, she has continued her transition, undergoing facial feminization, a breast augmentation and ongoing facial electrolysis. Initially, the only barrier she faced to fully transforming her body was financial. Subsequently, she developed Hepatitis and her liver began to fail.

Ms. Chacon's identity is stable as is her psychological health and she is capable of making informed decisions. Ms. Chacon has explored choices regarding orchiectomy. She has extensively researched this procedure and understands the physical and reproductive implications. She has an adult daughter and has no desire to have more children. She is well informed about the procedure and the risks. She understands that future GCS/SRS options may change as the

result of the orchiectomy at this time. She realizes it may have an impact on her sexuality as well as change her sex drive which she reports is unimportant to her. She states that she will feel better about her body without testicles.

Ms. Chacon is diagnosed with Gender Identity Disorder and Bipolar Disorder II. She has been compliant and stable on medication. Her Bipolar Disorder has been well controlled, and once her financial situation became stable, her mental health improved. She has a history of Post-Traumatic Stress Disorder but her symptoms are well managed. She is sober, and is in long term recovery from alcoholism.

Ms. Chacon feels this is a necessary step for her health and survival as well as a positive step in her transition. Ms. Chacon is very careful and conscientious of her health and avoids behaviors that could damage her liver further. She is entirely sober, pays close attention to what she eats and works hard to improve her health. Anything that Ms. Chacon can do to protect her liver gives her hope for survival. She feels that having an orchiectomy will do that and lessen the burden of secondary sex characteristics.

Feel free to call me for further information.

Very truly yours,

Julie Graham, LMFT

Gender Services Coordinator

South Van Ness Adult Behavioral Health Services

415-642-4519