Graduate Student Journal of Psychology
2018, Vol. 17

Working with Transgender Clients: Considerations for Psychological Testing and Assessment

Kat Lewitzke, Psy.D.
Michigan School of Professional Psychology

Psychological assessment is an important component of clinical psychology. It allows for a greater understanding of an individual's in various ways including socio-emotional functioning, cognitive and neurological processes, and/or adaptive skill, among others. Psychologists incorporate and execute a combination of methods to reach a hypothesis about a person. Tests can be standardized and norm-referenced for particular age groups, grades, or gender. Yet, little has been spoken of regarding protocols to be taken when assessing clients who do not identify with their assigned sex. This article provides a theoretical overview regarding sex, gender, and transgender identity, and moves into applying professional considerations for utilizing gender-normed assessments. In particular, there is a focus on promoting clinical awareness and upholding ethical standards when working with transgender populations. As of present, guidelines and set protocols specifically for psychological testing with this population have not been established. This article attempts to outline procedures and applications which are exclusively intended for working with transgender populations in psychological testing. Included are the American Psychological Ethical Standards, the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, along with the *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender-Nonconforming People*. The importance of multiculturalism, as well as recognizing issues of diversity, is further discussed. This article also creates a paradigm for future studies to establish norm-referenced testing.

There have been continuous attempts to distinguish and understand sex from gender (e.g., Money, 1955; Prince, 2005). Traditionally, whereas sex refers to one's assigned gender (i.e., based on genitalia and biological characteristics), the perception of gender is a socially constructed concept (Money, 1955). However, gender has now been more modernly defined as the collection of mental and behavioral traits that differ in one's personal identity and expression of masculinity and femininity (Levay & Baldwin, 2009). This can range in everything from the clothes one wears, to the way a person talks and walks. There are even gender specific names, which can further reinforce the manifestation of one's identity to his or her sexual category. Yet, while gender has traditionally been delineated in binary terms, there has been an increase to conceptualize gender through a feminist, queer, and/or postmodern approach. These theories propose a more fluid approach to gender, and further indicate that gender concepts are influenced through power differentials, social interactions, and group norms (Bilodeau & Renn, 2005; Burdge, 2007; Butler, 1990; Halberstam, 1998).

Transgender describes an umbrella term for individuals who identify with and express a gender that is different from their sex assigned at birth (Bornstein, 1994; Levay & Baldwin, 2009; Prince, 2005). This may act as in inclusive category for a wide range of identities such as persons classify themselves as gender non-conforming, male-to-female persons (i.e., a person assigned as male at birth who transitions and identifies as female), female-to-male persons (i.e., a person assigned as female at birth who transitions and identifies as male), transsexual, bi-gender, or pangender, among others (Bornstein, 1994). Gender identity is not easy to define, and even Facebook recognizes the complexity of it. Since February of 2014, the social media site now offers about 50 custom gender options (Griggs, 2014). Despite the recognition for gender variably provided by social media, the transgender population has been frequently and habitually underrepresented in the field

Keywords: transgender, clinical, testing, assessment, ethics, multiculturalism

Please address correspondence regarding this article to: katlew.dr@gmail.com

of psychology. This is especially evident for clinical assessment in regards to the creation and interpretation of norms for various psychological instruments. The purpose of this article is to promote a working model for clinicians in the areas of psychological testing. Throughout this article, a brief outline of gender and transgender identity and gender non-conforming identity development will be provided, as well as a review of the literature concerning clinical assessment in an effort to promote ethical testing protocol and interpretation for psychologists working with transgender clients.

Gender and Identity

Children develop an awareness and understanding of gender and sex differences from an early age. Most infants at just 6 months old can already distinguish between male and female voices (Miller, 1983); and at 1-year of age can categorize faces by gender, along with sex-typical hair length and clothing styles (Leinbach & Fagot, 1993). Kohlberg (1966) proposed a cognitive developmental model of gender identity to describe how young children learn to understand their gender. His theory progresses in three stages: *basic gender identity, gender stability*, and *gender consistency*. It appears that gender identity in children is recognizable in as young as 2 to 3-years old (Fagot, 1985; Kohlberg, 1966). During this stage, children can identify, discriminate, and apply gender labels. Around age 3, children move into the gender stability stage. It is here that physical appearance or gender stereotyped activities become noticeably understood. For instance, if a man is wearing a dress he may be categorized by the child to be a woman; or, a girl may believe she will become a boy if she plays football. However, the perception of gender constancy, which is the realization that sex categories are permanent (i.e., the idea that a man dressing up as a woman is still a man), begins to occur around ages 3½ to 4-years old (Bem, 1989). This is referred to as gender consistency, and is the third stage of Kohlberg's (1966) theory. Therefore, children apparently go through a one- to two-year period of being able to recognize and categorize their own sex, prior to developing an awareness of its nature and consistency. When children reach the stage of gender consistency, the idea of gender permanency is developed. Kohlberg claimed that children fully understand that gender will remain the same, or constant, throughout the lifespan at around age 6 (Kohlberg, 1966). Although Kohlberg's model follows a traditional understanding of gender conformity, it may also be applicable to transgender persons as the realization of gender identity follows a similar path. Additionally, since gender differences have been noted on psychological assessments (i.e., De Goede & Postma, 2008; Lippa, 2010), some tests have been normed; with similarities and differences in strengths to be interpreted with fairness (Willingham & Cole, 2013). These concepts will be discussed in greater detail throughout the article.

Transgender Identity

Gender identity describes an individual's internal working model and sense of self as male or female on a spectrum of characteristics (Wilchins, 2002). *Cisgender* is the word used to refer as any individuals who are not transgender, meaning that they identify with a complimenting balance between their assigned sex and gender expression. This includes the majority of the population, in which a person's assigned sex and identifying gender align (Schilt & Westbrook, 2009). A *transman* refers to a female to male transgender person; wherein a person was assigned as female at birth as male, but gender identifies as a male. A *transwoman* is a male to female transition, and describes a person who was born male, but identifies as female (Levay & Baldwin, 2009). In 2013, the *DSM-5* (American Psychiatric Association, 2013) replaced the diagnosis of gender identity disorder to gender dysphoria. This shift highlights that a transgender identity is not a disorder in itself. Furthermore, this decision was made as an attempt to ensure clinical care and reduce stigma for individuals who see, feel, and identify themselves as a different gender than their assigned sex (American Psychological Association, 2013b). Furthermore, Gender dysphoria is demonstrated in a variety of ways, such as an intense desire to be treated and live one's life as the opposite of their assigned sex. The incongruence may even create a strong desire to alter or get abate primary and/or secondary sex characteristics (American Psychiatric Association, 2013).

Transgender men and women have existed throughout human history, and across all cultures (Levay & Baldwin, 2009). While there is not precise number of persons identifying as transgender, Gates (2011) estimated that there are approximately 700,000 transgender

individuals living in the United States; which totals about 0.3% of the adult population. A true count remains a challenge for various reasons. Many individuals continue to struggle with finding self-acceptance, and fear the process of 'coming out' due to social acceptance (Grant et al., 2010). Additionally, while there are well-regarded surveys, such as the U.S. Census Bureau and Center for Disease Control, which collect data on one's biologically assigned sex, these fail to capture a person's identifying gender (Chalabi, 2014).

Feminist, postmodern, and queer theories discuss gender identity as a function of a fluid, rather than rigid or binary, existence (Bilodeau & Renn, 2005; Burdge, 2007; Butler, 1990; Halberstam, 1998). Gender schema theory, developed by Bem (1981), emphasizes the sociocultural experiences that influence masculine and feminine schemas in the development of gender roles. It has also become an increasingly more accepted hypothesis that gender identity is programmed at birth (Bao & Swaab, 2011), and is influenced by social interactions and power inequalities (Bem, 1981; Butler, 1990; Halberstam, 1998).

Feelings of a lack of alignment, or mind-body discord, between one's assigned sex and gender generally begin in early childhood; often as young as ages 2 or 3 (Kennedy & Hellen, 2010). This is also the time at which children begin to conceptualize gender (Fagot, 1985; Kohlberg, 1966; Pardo, 2008). While Kohlberg (1966) discussed the understanding of one's gender to begin at this young age, it appears that a realization of transgender identity develops for persons at this same time (Kennedy & Hellen, 2010). The majority of transgender individuals report becoming aware of their identity by age 8 (Kennedy, 2008; Kennedy & Hellen, 2010). Some may report this recognition as transpiring later, around ages 12 or 13 at the onset of puberty when there are changes in physical body appearance (Pardo, 2008). A heart-rending example is the story of David Reimer, otherwise known as the *John-Joan-John* case. David was born a boy but tragically lost his penis at 8 months during a botched circumcision. He was then surgically reassigned as female, forced to take estrogen medications, and socially raised as a girl. Despite these efforts, as well as not initially knowing his assigned sex at birth, David struggled to identify as female and eventually transitioned back to male at the age of 15 (Colapinto, 2000).

Various models of transgender identity development often begin with an initial awareness, anxiety, and distress of feeling different from a person's assigned sex. This creates confusion, and there may be a period denial or attempt to repress the experienced internal tension. Yet, a process is followed by educating one's self and establishing support. When acceptance for the desired identity has been formulated, the individual can then begin to integrate one's self into society (e.g., Devor, 2004; Lev, 2004). It has been suggested that applying traditional human development models, such as Erikson (1968) and Marcia (1966), may be not be entirely appropriate for transgender populations because these constructs are based on traditional gender role constructs (Mallon, 1999). There are models that exist to specifically address developmental issues, yet these rather reflect a social process of personal experience in the understanding one's self (e.g., Devor, 2004; Lev, 2004; Mallon, 1999; Bilodeau & Renn, 2005). One example is Lev's (2004) *Transgender Emergence Model*; which includes six stages that examines how transgender individuals come to conceptualize and appreciate their identity. This model further integrates the responsibility of the counselor, such as normalizing and exploring the process with the individual. However, while research and awareness for transgender populations has increased (e.g., Denny, 1998; Devor, 1997; Glicksman, 2013; Lev, 2004), there is still a need to understand and establish non-stigmatizing practices of transgender identity development (American Psychological Association, 2015; Bockting, 2014; Mallon, 1999; Morgan & Stevens, 2008). Additionally, there is even a greater need to understand and established standard and ethical psychological testing protocols with transgender clients.

History of Transgender Testing and Assessment

For several decades, society, along with the psychological community, pathologized and stigmatized transgender clients (Glicksman, 2013). There has been a heavy emphasis on cisgender lifestyles, with a view of binary gender versus gender fluidity. Individuals have been expected to conform to an identity that aligned with their assigned sex (American Psychological Association, 2015). Until the 1970s, psychotherapy as a means to reestablish a gender that reflects a person's assigned sex was the primary treatment for gender

identity disorder. This treatment has shown to be ineffective; and instead, psychologists are now advised to maintain a supportive role, create a non-stigmatizing environment, and promote acceptance (Glicksman, 2013). However, despite these strides to establish awareness and understanding, it was reported in a study as recent as 2013 that transgender populations more often face rejection and negatively from society than lesbian, gay and bisexual individuals (Norton & Herek, 2013). Additionally, practitioners need to be educated on proper term usage, and be aware of the harsh social impacts which transgender individuals continuously face (American Psychological Association, 2015; Glicksman, 2013).

Lothstein (1984) completed an extensive review of 41 studies spanning over 30 years, from 1953 to 1983, regarding psychological testing with trans-persons. Findings suggested that lower stability and greater psychological disturbance appeared more often in male to female transgender than female-male transgender. There was also evidence which reported that pre-operative transgender individuals still living in the male gender role had higher psychological problems than persons living as female. This may be reflective of social stigma. Furthermore, there have been suggestions to propose an increase of psychological stability and adjustment in male to female transgender persons following the initiation of sex-reassignment surgery. While this study occurred over 30 years ago, the information is still critical for interpretation of testing results. Psychologists should be mindful of this when conducting assessments, and how existing discomfort may increase symptoms of anxiety and/or depression; which may then affect other scores, such as processing speed (Tsourtos &Thompson, 2002) or inattention (Darke, 1988).

It has been consistently emphasized in the research that psychopathology is not a requirement of transgender development. Specifically, maintaining a transgender is not rooted in psychopathology, but should be conceptualized as a manifestation of physical, social, and psychological conflict with which the client is enduring (Fleming & Feinbloom, 1984). Closer examination with an adolescent population reported that youth identifying as transgender did not significantly differ from cisgender individuals in regards to thinking disturbances and negative self-image. However, adolescents seeking psychiatric care conveyed higher levels of pathology symptoms than both transgender persons and non-transgender not in treatment (Cohen, Ruiter, Ringelberg, & Cohen-Kettenis, 1997). Furthermore, while an absence of pathology in transgender populations have been reported in studies utilizing various versions of the MMPI, elevations in scale 5 (masculinity-femininity) have been noted (Cole, O'Boyle, Emory, & Meyer, 1997; Miach, Berah, Butcher, & Rouse, 2000; Tsushima & Wedding, 1979). This elevation was reported to be most prevalent and significant in transwomen populations (Cole et al., 1997). Findings from this are suggestive that applying a person's identifying gender verses assigned sex will reduce the tendency to pathologize, and would act as a more congruent and clinically appropriate method.

Considerations for Carrying out Testing with Transgender Clients

Differences between genders have been noted, but research remains narrow in the area of transgender identity. This further leads professionals limited in their ability to treat and interpret clinical data from this particular population. There are currently no set protocols on how to ethical administer, score, and infer psychological assessment among transgender clients. The question remains: Are professionals to interpret data in accordance with one's assigned sex or identifying gender? In this section, concepts have been included from the American Psychological Ethics Code, along with the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, and attempted to assimilate components from *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender-Nonconforming People* to be used for psychological testing use with transgender clients.

The American Psychological Association established the Ethics Code for working psychologists to use professional guidance when making decisions as part of their clinical, academic, or scientific roles. Instruments chosen for evaluations must have established validity and reliability. This entails that the psychometrics are sound for the instrument, as well as for the population of interest. Some tests, such as the CAARS (Conners, Erhardt, & Sparrow, 1999) and MMPI (Butcher, Graham, Williams, & Ben-Porath, 1990), are gender-normed,

meaning that there are different scores and interoperations for gender. However, as of present, there are no tests, protocols, or studies which specifically normed for transgender populations.

Differences in a variety of cognitive and personality traits have been found between men and women (Levay & Baldwin, 2009); including aspects of visual-spatial perception, reasoning, judgments, and memory tasks. Specifically, research has found that men generally display higher developed visuospatial skills than women, as well as greater skills in target accuracy and navigation (Goldstein, Haldane, & Mitchell, 1990; Levy & Baldwin 2009; Peters, Manning, & Reimers, 2007; Moffat, Hampson, & Hatzipantelis. 1998; Watson & Kimura, 1991). However, women reportedly outperform men in areas involving fine motor manipulation (Peters, Servos, & Day, 1990), recalling object location (De Goede & Postma, 2008), and verbal memory and fluency (Weiss et al., 2006). Variations in personality traits across genders, such as behaviors, feelings, attitudes, interests, and values, have also been examined. Men and women tend to display different interests; with women being more interested in people or socially related activities, while men prefer thing-oriented pursuits (Lippa, 2010). Gorski (1998) proposed that these differences in male-female performances on visual-spatial and verbal tasks are the result of early hormonal exposure on specific regions of the brain during neural development. While the understanding of binary cisgender regarding cognitive and personality traits has been established, we could further our clinical knowledge by researching transgender performance on such tasks. Studies on brain activity have also revealed that one's brain activity is more concurrent with his or her identifying gender (rather than assigned sex) (Rametti et al., 2011a; Rametti et al., 2011b). Therefore, it appears important to assess possible parallels between the performance of cisgender men with transmen, and cisgender women with transwomen.

Furthermore, differences in cognitive and personality traits across cisgender populations (Levay & Baldwin, 2009) need to be taken into consideration when assessing and interpreting data for transgender populations. According to results from a meta-analytic review by Archer (2004), men also score higher on written tests of aggressiveness. This was noted on both self and peer reporting. Additionally, across most cultures, men reportedly show more verbal and physical aggression, and have greater incidences of committing crimes (Archer, 2004); whereas women generally tend to express aggression through indirect or non-physical means, such as malicious gossip (Hess & Hagen, 2006). Current available research (although limited) appears to suggest the use of gender identity congruent norms use for interpretation (i.e., Lippa, 2010; Micah, 2000; Rametti et al., 2011a; Rametti et al., 2011b). There appears to be some evidence to support that applying gender identity congruent MMPI/-2 norms (in place of assigned sex norms) resulted in transgender profiles to be reported within normal limits on a majority, if not all, scales (Micah, 2000).

In 2015, the American Psychological Association established *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (TGNC; hereafter *Guidelines*) as in introductory resource to "assist psychologists in the provision of culturally competent, developmentally appropriate, and trans-affirmative psychological practice with TGNC people" (American Psychological Association, 2015, p. 2). Trans-affirmative practice entails the practice of marinating awareness, consideration, and supportive care for the identities and personal experiences of TGNC individuals (Korell & Lorah, 2007). The intent is to recognize the importance of clients of minority and culturally diverse backgrounds, and created guidelines "intended to enlighten all areas of service delivery, not simply clinical or counseling endeavors" (American Psychological Association, 2015). Guidelines are aspirational and aim to promote respect of the client's culture, as well as maintaining knowledge on current and relevant research. Psychologists should also be aware of how their own attitudes, ethnicity, and cultural background may influence interpretation of data surrounding the client's psychological processes (American Psychological Association, 2015). In following with these guidelines, psychologists should attempt to understand where clients are in their transition process. Yet, even with an aspirational outline, it would be more ethically sound to engage in research that addresses the interpretation and procedures of transgender identity in psychological assessment. I propose that it is important for psychologists to be fully competent in their education and training to deal with the various ethical concerns that deal with

transgender clients. Perhaps an awareness and understanding of qualitative analysis should be integrated into the interpretation, rather than solely basing practices on quantitative reports. Transgender clients experience an elevated risk of becoming victims of various violent and traumatic acts (Mizock & Lewis, 2008). Therefore, it is important for working professionals to maintain knowledge on feminist and multi-cultural theory and techniques to minimize distress of the client (Richmond, Burnes, & Carroll, 2012). Maintaining a fluid verses binary approach to gender identity will expand the clinician's own cultural awareness, and reduce pathology of the client (American Psychological Association, 2015). It is also advisable that psychologists take reasonable steps in explaining the assessment results. This could imply that during the feedback session, the examinee is aware of why certain scales were elevated over others; or how a particular gender norm was chosen for interpretation.

Additionally, an understanding of the impact brought on by minority stress theory, which emphasizes the effects of how social situations cause stress and poor health for minority individuals (Meyer, Schwartz, and Frost, 2008), is important. This concept describes the health risks of sexual minorities, such as transgender individuals, which is increased and a result of conflict with the dominant social environment. The transgender population faces higher rates of psychopathology and discrimination compared to their cisgender peers. For instance, across the lifespan, it has been reported that they are at an increased risk of substance abuse, suicidal attempts, anxiety, and depression (Cochran, Keenan, Schober, & Mays, 2000). Despite these conflicts and the negative impacts, clinicians are faced with challenges due to the lack of appropriate interventions.

Any professional working with persons from transgender populations can follow the core principles outlined in the *Standards of Care (SOC) for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (Coleman et al., 2012). The *SOC* were developed by the World Professional Association for Transgender Health; an international advocacy association with multidisciplinary goals that aims to promote evidence-based treatments, policy, research, healthcare, and education for the transgender population. These standards were created to assist healthcare professionals when working with transgender individuals. Due to the prior establishment of these guidelines, core components of *SOC*, as outlined by Coleman (et al., 2012), will be integrated in attempted to be specifically applied for psychological testing and assessment with clients from transgender populations:

- *Exhibit respect for patients with nonconforming gender identities:* Psychologists should aim to exhibit humanistic principles of unconditional positive regard and empathy to build rapport (Cain, 2002). Psychologists need to consider differences in cognitive and personality traits between genders (Levay & Baldwin, 2009), and how these factors may be reflected in individuals' identifying with transgender populations. Psychologists must also be knowledgeable in current biological and social research regarding this specific population in the consideration of test report interpretation.
- *Provide care (or refer to knowledgeable colleagues) that affirms patients' gender identities and reduces the distress of gender dysphoria:* Client's should not be pathologized for their differences in gender identity or expression. Thus, using gender-based norms that converge with identifying gender may promote a more sound interpretation of results. Psychologists should also emphasize and interpret qualitative data (i.e., behavioral observations) just as importantly as quantitative results.
- *Become knowledgeable about the health care needs of transsexual, transgender, and gender nonconforming people, including the benefits and risks of treatment options for gender dysphoria:* Psychologists need to assess all clients in accordance to the referral question, and be cautious and sensitive when making interpretations, as well as recommendations; especially when working with clients from transgender populations. When appropriate, psychologists may recommend goals that allow for relief from negative self-concept and psychological distress.
- *Be prepared to support and advocate for clients within their families and communities (i.e., schools, workplaces, and other settings):* It is possible that a testing report be required and sent to such settings. Psychologists need to be prepared to explain testing results and interpretations to the involved parties, while supporting clients with best intentions.

Future Directions

There are numerous resources specifically targeted for transgender clients. Protocols have been created that outline procedures for conducting psychotherapy for both individual and group settings (Adler, Hirsch, & Mordaunt, 2012; Bockting, Knudson, & Goldberg, 2006; Mizock, & Lewis, 2008). Transgender clients may struggle to connect with professionals who lack competence and compassion for working with this population (Sanchez, Sanchez, & Danoff, 2009). To guarantee that a working alliance will be established and maintained, psychologists and persons from related professions need to become familiar with the gender identity research. Transgender terminology and language is continually changing. To facilitate better communication, working professionals should remain aware of and sensitive to the client's language (American Psychological Association, 2015; Bockting, Knudson, & Goldberg, 2006). Clinicians can turn to the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* for direction and inspiration. Additionally, this article provided an attempt to outline ethical practices when applying psychological assessments by integrating parts of the *SOC for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (Coleman et al., 2012). My efforts are mere recommendations and based on ethical principles. Yet, this outline barely constitutes a foundation to work from, and it is not nearly enough.

Our practice with this particular population greatly lacks empiricism in the area of psychological testing and assessment. Although the notion of *gender* has increasingly replaced *sex* in research settings (Haig, 2004), there is extensive investigation needed to further understand transgender populations. This is especially true due to the lack of professional guidelines for utilizing transgender norms for psychological assessment. We are missing an important piece to the puzzle, and these issues should no longer be neglected. If this problem persists, providing inadequate (and possibly unethical) care is at risk. It is imperative that psychologists address these concerns to move away from culturally encapsulated practices and improve awareness on the impact of culture in clinically work (Wrenn, 1962). In order to better address the clinical concerns of individuals identifying as transgender, valid measures need to be addressed. There has been an ongoing cisgender privilege in the area of psychological assessment; which has entailed failing to provide adequate standards to address the use of certain norms with transgender populations. If we are to uphold our ethical standards, there is a demand to push for testing instruments to provide interpretations and greater knowledge for transgender populations.

References

Adler, R. K., Hirsch, S., & Mordaunt, M. (2012). *Voice and communication therapy for the transgender/transsexual client: A comprehensive clinical guide*. San Diego, CA: Plural Publishing.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). Washington, DC: Author.

American Psychiatric Association. (2013a). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.

American Psychiatric Association. (2013b). Gender Dysphoria. *APA DSM-5*, Retrieved on May 18, 2015 from http://www.dsm5.org/documents/gender dysphoria fact sheet.pdf

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychological Association*, Retrieved on May 21, 2015 from http://www.apa.org/practice/guidelines/transgender.pdf

Archer, J. (2004). Sex differences in aggression in real-world settings: A meta-analytic review. *Review of General Psychology*, *8*(4), 291. Retrieved from http://domestic-violence.martinsewell.com/Archer2004.pdf

Bao, A. M., & Swaab, D. F. (2011). Sexual differentiation of the human brain: relation to gender identity, sexual orientation and neuropsychiatric disorders. *Frontiers in Neuroendocrinology*, *32*, 214–226. doi:10.1016/j.yfrne.2011.02.007

Bem, S. L. (1981). Gender schema theory: A cognitive account of sex typing. *Psychological Review*, *88*, 354–364.

Bem, S. L. (1989). Genital knowledge and gender constancy in preschool children. *Child Development*, *60*, 649–662. doi:10.2307/1130730

Bilodeau, B. L., & Renn, K. A. (2005). Analysis of LGBT identity development models and implications for practice. *New Directions for Student Services*, 2005, 25–39.

Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism*, *9*, 35–82. doi:10.1300/J485v09n03_03

Bornstein, K. (1994). *Gender outlaw: On men, women, and the rest of us*. New York: Vintage Books.

Burdge, B. J. (2007). Bending gender, ending gender: Theoretical foundations for social work practice with the transgender community. *Social Work*, *52*, 243–250.

Butcher, J. N., Graham, J. R., Williams, C. L., & Ben-Porath, Y. S. (1990). *Development and use of the MMPI-2 Content Scales*. Minneapolis, MN: University of Minnesota Press.

Butler, J. (1990). *Feminism and the subversion of identity*. New York: Routledge.

Cain, D. J. (2002). *Humanistic psychotherapies: Handbook of research and practice*. Washington, DC: American Psychological Association.

Chalabi, M. (2014, July 29). Why we don't Know the Size of the Transgender Population. Retrieved May 2, 2015. http://fivethirtyeight.com/features/why-we-dont-know-the-size-of-the-transgender-population/

Cochran, S. D., Keenan, C., Schober, C., & Mays, V. M. (2000). Estimates of alcohol use and clinical treatment needs among homosexually active men and women in the US population. *Journal of Consulting and Clinical Psychology*, *68*, 1062–1071.

Cohen, L., de Ruiter, C., Ringelberg, H., & Cohen-Kettenis, P. T. (1997). Psychological functioning of adolescent transsexuals: Personality and psychopathology. *Journal of Clinical Psychology*, *53*, 187–196. doi:10.1002/(SICI)1097-4679(199702)53:2<187::AID-JCLP12>3.0.CO;2-G

Colapinto, J. (2000). *As nature made him: The boy who was raised as a girl*. New York, NY: Harper Collins Publishers.

Cole, C. M., O'Boyle, M., Emory, L. E., & Meyer III, W. J. (1997). Comorbidity of gender dysphoria and other major psychiatric diagnoses. *Archives of Sexual Behavior*, *26*(1), 13–26. doi:10.1023/A:1024517302481

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., & Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*, *13*, 165–232. doi:10.1080/15532739.2011.700873

Conners, C. K., Erhardt, D., & Sparrow, E. (1999). *Conner's Adult ADHD Rating Scales: CAARS*. Toronto: MHS.

Darke, S. (1988). Anxiety and working memory capacity. *Cognition and emotion*, *2*, 145–154.

De Goede, M., & Postma, A. (2008). Gender differences in memory for objects and their locations: A study on automatic versus controlled encoding and retrieval contexts. *Brain and Cognition*, *66*, 232–242. doi:10.1016/j.bandc.2007.08.004

DeLacoste-Utamsing, C., & Holloway, R. L. (1982). Sexual dimorphism in the human corpus callosum. *Science*, *216*, 1431–1432.

Devor, A. H. (2004). Witnessing and mirroring: A fourteen stage model of transsexual identity formation. *Journal of Gay & Lesbian Psychotherapy*, *8*(1–2), 41–67.

Dubb, A., Gur, R., Avants, B., & Gee, J. (2003). Characterization of sexual dimorphism in the human corpus callosum. *Neuroimage*, *20*, 512–519.

Erikson, E. H. (1968). *Identity: Youth and crisis*. New York, NY: Norton.

Fagot, B. I. (1985). Changes in thinking about early sex role development. *Developmental Review*, *5*, 83–98. doi:10.1016/0273-2297(85)90031-0

Fernández-Guasti, A., Kruijver, F. P., Fodor, M., & Swaab, D. F. (2000). Sex differences in the distribution of androgen receptors in the human hypothalamus. *Journal of comparative neurology*, *425*, 422–435.

Fleming, M., & Feinbloom, D. (1983). Similarities in becoming: transsexuals and adolescents. *Adolescence*, *19*, 729–748.

Gates, G. (2011). How many people are lesbian, gay, bisexual, and transgender? Williams Institute, UCLA School of Law. Retrieved May 21, 2015 from http://williamsinstitute.law.ucla.edu/wp-content/uploads/Gates-How-Many-People-LGBT-Apr-2011.pdf

Glicksman, E. (2013). Transgender today. *Monitor on Psychology*, *44*. Retrieved on October 21, 2015 from http://static1.1.sqspcdn.com/static/f/1468080/25884892/1421967436930/

Glicksman-transgender.pdf?token=m1nfd4Tu%2FMTISLUmJUBOlKcmBtM%3D

Goldstein, D., Haldane, D., & Mitchell, C. (1990). Sex differences in visual-spatial ability: The role of performance factors. *Memory & Cognition*, *18*, 546–550. doi:10.3758/BF03198487

Gorski, R.A. (1998). Development of the cerebral cortex: XV. Sexual differentiation of the central nervous system. *Journal of American Academy of Child and Adolescent Psychiatry*, *37*, 1337–1339.

Grant, J. M., Mottet, L. A., Tanis, J., Herman, J. L., Harrison, J., & Keisling, M. (2010). National transgender discrimination survey report on health and health care. *National Center for Transgender Equality and National Gay and Lesbian Task Force*. Retrieved on May 23, 2015 from http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf

Griggs, B. (2014, February 13). Facebook goes beyond 'male' and 'female' with new gender options—CNN.com. Retrieved on May 17, 2015 from http://www.cnn.com/2014/02/13/tech/social-media/facebook-gender-custom/

Haig, D. (2004). The inexorable rise of gender and the decline of sex: Social change in academic titles, 1945–2001. *Archives of Sexual Behavior*, *33*(2), 87–96. doi:10.1023/B:ASEB.0000014323.56281.0d

Halberstam, J. (1998). *Female masculinity*. Durham, NC: Duke University Press.

Hess, N. H., & Hagen, E. H. (2006). Sex differences in indirect aggression: Psychological evidence from young adults. *Evolution and Human Behavior*, *27*, 231–245. http://dx.doi.org/10.1016/j.evolhumbehav.2005.11.001

Kennedy, N. (2008). Transgendered Children in Schools: a critical review of homophobic bullying: Safe to learn—embedding anti-bullying work in schools, *FORUM*, *50*, 383–396. http://dx.doi.org/10.2304/forum.2008.50.3.383

Kennedy, N., & Hellen, M. (2010). Transgender children: more than a theoretical challenge. *Graduate Journal of Social Science*, *7*(2), 25–43. Retrieved from http://www.iiav.nl/ezines/IAV_607530/IAV_607530_2010_2.pdf#page=26

Kohlberg, L. A. (1966). A cognitive-developmental analysis of children's sex role concepts and attitudes. In E. E. Maccoby (Ed.), The development of sex differences (pp. 82–173). Stanford, CA: Stanford University Press.

Korell, S. C., & Lorah, P. (2007). An overview of affirmative psychotherapy and counseling with transgender clients. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed.) (pp. 271–288). Washington, DC: American Psychological Association.

Leinbach, M. D., & Fagot, B. I. (1993). Categorical habituation to male and female faces: Gender schematic processing in infancy. *Infant Behavior and Development*, *16*, 317–332. doi:10.1016/0163-6383(93)80038-A

Levay, S. & Baldwin, J. (2009). *Human Sexuality*. Sunderland, MA: Sinauer Associates.

Lippa, R. A. (2010). Gender differences in personality and interests: when, where, and why?. *Social and Personality Psychology Compass*, *4*, 1098–1110. doi:10.1111/j.1751-9004.2010.00320.x

Lothstein, L. M. (1984). Psychological testing with transsexuals: A 30-year study. *Journal of Personality Assessment*, *48*, 500–507. doi:10.1207/s15327752jpa4805_9

Mallon, G. P. (1999). *Social work practice with gay, lesbian, and transgender people*. New York: NY: Harworth Press.

Marcia, J. E. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology*, *3*, 551–558. doi:10.1037/h0023281

Meyer, I.H., Schwartz, S., & Frost, D.M. (2008). Social patterning of stress and coping: Does disadvantaged social statuses confer more stress and fewer coping resources? *Social Science & Medicine*, *67*, 368–379.

Miach, P. P., Berah, E. F., Butcher, J. N., & Rouse, S. (2000). Utility of the MMPI-2 in assessing gender dysphoric patients. *Journal of Personality Assessment*, *75*, 268–279. doi:10.1207/S15327752JPA7502_7

Miller, C. L. (1983). Developmental changes in male/female voice classification by infants. *Infant Behavior and Development*, *6*, 313–330. doi:10.1016/S0163-6383(83)80040-X

Mizock, L., & Lewis, T. K. (2008). Trauma in transgender populations: Risk, resilience, and clinical care. *Journal of Emotional Abuse*, *8*, 335–354. doi:10.1080/10926790802262523

Moffat, S. D., Hampson, E., & Hatzipantelis, M. (1998). Navigation in a virtual maze: Sex differences

and correlation with psychometric measures of spatial ability in humans. *Evolution and Human Behavior*, *19*(2), 73–87. http://dx.doi.org/10.1016/S1090-5138(97)00104-9

Money, J. (1955). Hermaphroditism, gender and precocity in hyperadrenocorticism: Psychologic findings. *Bulletin of the Johns Hopkins Hospital*, *96*, 253–264.

Peters, M., Manning, J. T., & Reimers, S. (2007). The effects of sex, sexual orientation, and digit ratio (2D: 4D) on mental rotation performance. *Archives of Sexual Behavior*, *36*, 251–260. doi:10.1007/s10508-006-9166-8

Peters, M., Servos, P., & Day, R. (1990). Marked sex differences on a fine motor skill task disappear when finger size is used as covariate. *Journal of Applied Psychology*, *75*(1), 87–90. http://dx.doi.org/10.1037/0021-9010.75.1.87

Prince, V. (2005). Sex vs. gender. *International Journal of Transgenderism*, *8*(4), 29–32. doi:10.1300/J485v08n04_05

Rametti, G., Carrillo, B., Gómez-Gil, E., Junque, C., Segovia, S., Gomez, Á., & Guillamon, A. (2011a). White matter microstructure in female to male transsexuals before cross-sex hormonal treatment. A diffusion tensor imaging study. *Journal of Psychiatric Research*, *45*, 199–204. http://dx.doi.org/10.1016/j.jpsychires.2010.05.006

Rametti, G., Carrillo, B., Gómez-Gil, E., Junque, C., Zubiarre-Elorza, L., Segovia, S., & Guillamon, A. (2011b). The microstructure of white matter in male to female transsexuals before cross-sex hormonal treatment. A DTI study. *Journal of Psychiatric Research*, *45*, 949–954. http://dx.doi.org/10.1016/j.jpsychires.2010.11.007

Richmond, K. A., Burnes, T., & Carroll, K. (2012). Lost in trans-lation: Interpreting systems of trauma for transgendered clients. *Traumatology*, *18*(1), 45–57. doi:10.1177/1534765610396726

Sanchez, N. F., Sanchez, J. P., & Danoff, A. (2009). Health care utilization, barriers to care, and hormone usage among male-to-female transgender persons in New York City. *American Journal of Public Health*, *99*, 713–719. doi:10.2105/AJPH.2007.132035

Schilt, K., & Westbrook, L. (2009). Doing gender, doing heteronormativity: "Gender normals," transgender people, and the social maintenance of heterosexuality. *Gender and Society*, *23*, 440–464. doi:10.1177/0891243209340034

Tsourtos, G., Thompson, J. C., & Stough, C. (2002). Evidence of an early information processing speed deficit in unipolar major depression. *Psychological Medicine*, *32*, 259–265.

Tsushima, W. T., & Wedding, D. (1979). MMPI results of male candidates for transsexual surgery. *Journal of Personality Assessment*, *43*, 385–387. doi:10.1207/s15327752jpa4304_8

Watson, N. V., & Kimura, D. (1991). Nontrivial sex differences in throwing and intercepting: relation to psychometrically-defined spatial functions. *Personality and Individual Differences*, *12*, 375–385. doi:10.1016/0191-8869(91)90053-E

Weiss, E. M., Ragland, J. D., Brensinger, C. M., Bilker, W. B., Deisenhammer, E. A., & Delazer, M. (2006). Sex differences in clustering and switching in verbal fluency tasks. *Journal of the International Neuropsychological Society*, *12*, 502–509. doi:10.1017/S1355617706060656

Wilchins, R. A. (2002). Queerer Bodies. In J. Nestle, C. Howell, & R. A. Wilchins (Eds.), *Genderqueer: Voices from Beyond the Sexual Binary*. Los Angeles: Alyson.

Willingham, W. W., & Cole, N. S. (2013). *Gender and fair assessment*. New York, NY: Routledge.

Wrenn, C. G. (1962). The culturally encapsulated counselor. *Harvard Educational Review*, *32*, 444–449.