Key Points

❖ Mental health professionals can play a key role in assisting transgender and gender nonconforming persons to explore and actualize their gender identity. Surgeons should discuss the various medical interventions available to affirm gender identity and support these patients in coping with the psychosocial challenges many continue to face.

❖ The social stigma attached to nonconformity in gender identity and expression negatively impacts mental health. Factors associated with resilience include family support, transgender community connectedness, and identity pride.

❖ Mental health professionals can help to facilitate identity development and improve quality of life. Medical providers and surgeons are encouraged to coordinate care with mental health professionals.

❖ Transgender and gender nonconforming children, adolescents, and adults can benefit from an interdisciplinary approach to the promotion of transgender health.
Role of the Mental Health Professional

According to the "Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People" (TGNC), set forth by the World Professional Association for Transgender Health (WPATH),1 mental health professionals may serve TGNC people and their families in a various ways, depending on individual needs. The roles include assessor or evaluator, counselor, psychotherapist, educator, and advocate. Psychological assessment or evaluation typically covers three domains: gender dysphoria, mental health, and psychosocial adjustment. Based on this assessment or evaluation, counseling and psychotherapy follow an individualized treatment plan. Counseling may include assisting TGNC individuals and their families in making an informed decision about interventions to affirm gender identity. These interventions may include changes in gender role and expression, voice therapy, hormone therapy, and/or surgery. Psychotherapy may include exploration of gender and sexual identity but also treatment of mental health concerns. TGNC people may be extra vulnerable to mental health concerns because of the stress associated with being differently gendered and the social stigma attached to gender nonconformity. Mental health concerns, whether or not related to gender nonconformity, may also exacerbate the psychosocial challenges TGNC people face as they explore and seek to affirm their gender identity. Education may include providing information and facilitating access to community resources so that TGNC people and their families can make informed choices and can benefit from peer support. It may also include educating the environment (for example, schools, workplaces, organizations, and institutions) and policy makers about gender diversity and the needs of TGNC people. Finally, mental health professionals can play a key role in advocating for transgender rights on an individual, interpersonal, and sociocultural level. Th s may include supporting changes in identity documents, advocating for sexual and reproductive rights, and supporting antidiscrimination legislation.

Competency in mental health care for TGNC people and their families varies based on the mental health professional's role. All mental health professionals should be culturally competent in transgender care. Cultural competence can be defined as the process in which the health professional continuously strives to achieve the ability to effectively work within the cultural context of the patient.1,2 Th s includes awareness of one's own biases and prejudices, knowledge about the patient's belief system and worldview, the skills to conduct a cultural assessment while avoiding stereotypical judgments and assumptions, cultural encounters with patients from diverse backgrounds, and the desire to engage in the ongoing process of building cultural competence. In transgender care this includes ensuring a clinic environment that reflects gender diversity in posters, brochures, registration and intake forms, the use of preferred names and pronouns, and access to all-gender bathrooms. It also includes open communication between provider and patient about gender identity and gender affirmation to the extent that it is relevant to the presenting concern. Clinical competence in the assessment and treatment of gender dysphoria goes a step further, because it requires specialty training and supervision.1 In addition, mental health professionals working with TGNC children and adolescents should have training in developmental psychology. Moreover, mental health care for TGNC people and their families is best provided in consultation with providers of other disciplines (for example, medicine, education, and social work) involved in the patient's care.
Assessment of Gender Dysphoria

Mental health professionals are often the first health care providers that TGNC patients will seek out. Although some patients will present with gender dysphoria as their chief complaint, others may desire treatment for other related or unrelated mental health concerns. Before addressing gender dysphoria, the mental health professional should first perform a complete psychosocial history. If patients wish to further explore their gender identity and any associated dysphoria, the clinician can move forward with the assessment and treatment of gender dysphoria.

Gender dysphoria refers to discomfort with the sex and gender role assigned at birth. Gender dysphoria is also a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), where it is defined as a marked incongruence between a person's experienced/expressed gender and assigned gender of at least 6 months' duration and requires that the patient present with at least two of the following:

❖ A strong desire to be rid of his or her primary or secondary sex characteristics (or in young adolescents, to prevent the development of the anticipated secondary characteristics)
❖ A strong desire for the primary or secondary sex characteristics of the other gender
❖ A strong desire to be of the other (or some alternative) gender
❖ A strong desire to be treated as the other (or some alternative) gender
❖ A strong conviction of having the typical feelings and reactions of the other (or some alternative) gender

In children, the desire to be the other gender must be present and verbalized. For the diagnosis to be applicable, the incongruence must cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Mental health professionals must recognize that some patients and transgender community members may take umbrage to the idea that their gender identity issues deserve a DSM classification. This is a response that the clinician should be prepared for and able to deal with thoughtfully, professionally, and empathetically. Although some patients may enter the therapeutic relationship with a mature grasp on their gender identity, others may be less clear and have questions about their gender identity. Mental health professionals should explore with compassion and cultural competence the gender with which the patient identifies and avoid any assumptions before proceeding with a formal assessment and treatment of gender dysphoria.

The main approach to the assessment of gender dysphoria is the clinical interview. TGNC adolescents or adults are asked to describe their gender identity, how they feel about their current gender role and expression, how they feel about their body (particularly their primary and secondary sex characteristics), and what if any changes they have made or would like to make in gender identity, gender expression, and/or sex characteristics. Subsequently, a history of their experience with gender identity is obtained. TGNC children are asked whether they feel like a boy, girl, or other gender (for example, boygirl). Parents of TGNC children and adolescents are interviewed about their perceptions, observations, and the reports received about their child or adolescent regarding their gender identity, gender ex-
pression, and sexual development. For many of these domains, structured questionnaires have been developed that are either self-administered or interviewer-administered. These include the Gender Identity Interview for Children, the Gender Identity/Gender Dysphoria Questionnaire for Adolescents and Adults, and the Utrecht Gender Dysphoria Scale.

The assessment of gender dysphoria also includes other key components of sexual identity and sexual development. Most patients presenting with gender dysphoria report normative development of primary and secondary sex characteristics before gender-affirming medical interventions. However, some children born with ambiguous genitalia develop gender dysphoria. Many patients with gender dysphoria report a history of childhood gender role nonconformity (for example, feminine boys and masculine girls), and yet a substantial number of patients (particularly among those assigned male at birth) were not gender role nonconforming in childhood. Thus gender identity and gender expression are two distinct components of sexual identity that are not necessarily congruent. Sexual orientation, another key component of sexual identity, is also distinct from gender identity. TGNC adolescents and adults may be attracted to boys or men, girls or women, or both, as well as to other TGNC individuals. In assessing the patient’s sexual development, all these components should be considered, along with other aspects of sexuality, such as sexual fantasy, sexual expression, attachment, and love. The development of gender identity and gender dysphoria should be understood in the context of overall sexual and human development.

**Mental Health**

TGNC children, adolescents, and adults are at increased risk for mental health concerns, including anxiety, depression, nonsuicidal self-injury, suicidal ideation and attempts, symptoms of posttraumatic stress disorder, and substance abuse. When patients present to a mental health professional with questions about their gender identity or complaints of gender dysphoria, it is the responsibility of the clinician to also screen for and assess comorbid mental health conditions. Before finally deciding to see a mental health professional, patients with gender dysphoria have often dealt with years of social stigma, microaggressions, and social isolation resulting from their status as a gender and/or sexual minority. TGNC individuals may also experience physical violence.

In a U.S. national survey of transgender women and men, 44% reported depression and 33% reported anxiety. These high rates of psychological distress have been attributed to the social stigma attached to nonconformity in gender identity and expression. According to the minority stress model, TGNC people experience minority stress, which negatively impacts mental health. Minority stress processes include enacted stigma (actual experiences of rejection and discrimination), felt stigma (perceived rejection and expectations of being stereotyped or discriminated against), and internalized transphobia (discomfort with one’s own transgenderism as a result of internalizing society’s normative gender expectations). Indeed in the U.S. national survey previously cited, participants reported high rates of housing discrimination (12%), sexual abuse or assault (15%), physical abuse (24%), employment discrimination (38%), and verbal abuse or harassment (70%). Protective factors included family support and identity pride, and peer support and community connectedness buffered the negative impact of enacted stigma on mental health. Research is needed to better understand the mechanism of how stigma affects mental health and to develop tailored interventions. While exploring the history of the patient’s gender dysphoria, clinicians should be cognizant of the often hostile cultural environment in which
their TGNC patients came of age. The cumulative impact of this negative culture and its rejecting and sometimes violent attitude toward gender nonconformity and the subsequent trauma can have a serious impact on mental health. When caring for patients with gender dysphoria, the clinician should be vigilant for psychiatric comorbidities and prepared to apply the appropriate assessment tools to diagnose them.

TGNC adolescents are also more likely to have autism spectrum disorder compared with the general population. In a clinical sample of 204 children presenting with gender dysphoria, 16 (7.8%) had autism spectrum disorder compared with 0.6% to 1% of the general population. Similar higher rates of autism spectrum disorder traits have been found in an adult clinical sample, and in clinical samples of children and adolescents with autism spectrum disorder, a higher prevalence of gender dysphoria was found compared with the general population. The explanation for these findings remains unclear. However, mental health professionals working with TGNC patients should screen for autism spectrum disorder and incorporate the results in the care they provide.

A standard psychological evaluation can assess mental health and psychosocial adjustment. For TGNC children, adolescents, and adults, this evaluation should include an assessment of the impact of enacted stigma, felt stigma, and internalized transphobia on mental health and the resilience that they developed over time. Existing strengths and potential assets should be identified, which may include support from friends, family, and community. The evaluation should also include screening for suicidal ideation, substance abuse, and sexual risk behavior (for example, HIV risk behavior, hazards associated with sex work, and sexual violence), for which TGNC people have a heightened vulnerability. When indicated, a psychiatric consultation may be obtained (for example, in patients with symptoms of severe mental illness or when pharmacotherapy may be helpful to alleviate symptoms of depression or anxiety).

Given the disparities in mental health documented thus far, a comprehensive screen and assessment of identified mental health concerns resulting in a differential diagnosis is warranted for most individuals presenting with gender dysphoria. This will allow incorporating treatment of mental health comorbidities in an individualized treatment plan. Generally speaking, treatment is best provided in parallel, that is, mental health issues are addressed during the course of treatment of gender dysphoria. Effective management of mental health comorbidities will facilitate social changes to alleviate gender dysphoria, and progress with gender affirmation will improve self-esteem and self-care, foster a positive future outlook, and motivate the patient to sustain optimal adaptation.

**Transgender Identity Development**

Transgender identity development is a lifelong process. In the context of social stigma attached to gender nonconformity, transgender identity development has been described as a coming out process. Bockting and Coleman describe five developmental stages:

1. Pre-coming out
2. Coming out
3. Exploration
4. Intimacy
5. Integration
Individuals do not necessarily go through these stages in this particular order. Rather, these stages reflect developmental tasks commonly observed in clinical practice. The pre-coming out stage is characterized by feeling different. TGNC children and adolescents who are outwardly gender role nonconforming (for example, a feminine boy or masculine girl) are recognized as such by the people in their environment and are vulnerable to enacted stigma, which may take the form of rejection, harassment, and abuse. In the face of this adversity, they develop early resilience with the help of supportive others (for example, family members, friends, school, and mental health professionals). TGNC children and adolescents who are outwardly gender role conforming often conceal their gender identity in an effort to avoid enacted stigma. However, concealment is often accompanied by felt stigma (anticipated rejection and fear of discrimination), which may take a different emotional toll and contribute to anxiety, depression, and substance use.

The developmental task of the coming out stage is to acknowledge one’s transgender feelings to self and others. The mental health professional may be the first person the individual comes out to. Needless to say, a nonjudgmental, accepting attitude is critical without foreclosing what may be a process of exploring (avoid premature labeling), giving the individual permission to have an ongoing conversation about their gender identity and related concerns. Telling others involves taking calculated risks, starting with those who are close and most likely to accept. The mental health professional can coach and support the individual during this process. Family and friends often need time to understand and come to terms with the news that their loved one is transgender. The mental health professional can assist by putting reactions into perspective and referring both the patient and family to information and support resources. The exploration stage is a time of learning as much as possible about gender diversity, connecting with the transgender community, and experimenting with gender expression. In this stage individuals often make decisions about changes in gender role and gender-affirming medical procedures (hormones and surgery). Also, in this stage, individuals explore their sexuality and begin to define or redefine their sexual orientation. The mental health professional plays an important role in normalizing this process of exploration at any chronologic age, facilitating access to peer support, and assisting the individual in making fully informed decisions about changes in gender role, hormone therapy, changes in identity documents, and surgery.

In the intimacy stage, the emphasis on identity development shifts from a focus on self to a focus on establishing and maintaining intimate relationships. This often involves facing fears of abandonment and learning when and how to communicate about one’s gender identity and sexuality in the context of dating relationships. It also involves developing an identity as a couple and how to deal with society’s heteronormative and homonormative expectations. Mental health professionals can assist by helping patients clarify and communicate their needs for intimacy and sexuality to their (potential) partners and by helping partners cope with felt and enacted stigma and the questions partners may have about their own identity. Finally, integration involves grief over lost time and missed opportunities and an appreciation of the added value of living life as a transgender person. In this stage individuals are often able to tolerate greater ambiguity in gender identity and expression, and being transgender is no longer necessarily the most defining aspect of their overall identity. During this time, many TGNC people give back to their community and contribute to making the world a better place for the next generation. During this stage mental
health professionals can facilitate grief, address internalized transphobia, witness personal growth, and learn a great deal from the patient's deeper insights into what it means to be a person of transgender experience.

**Working With Children and Adolescents**

TGNC children and adolescents present at younger and younger ages with gender dysphoria and for assistance in making informed decisions about changes in gender role and the available options for early, gender-affirming medical interventions. In childhood, nonconformity in gender identity can be hard to distinguish from nonconformity in gender role; the former is an indication of gender dysphoria. Moreover, the majority of gender role nonconforming children do not grow up to be transgender, and any gender dysphoria they may experience does not necessarily persist into adolescence. During puberty (ages 10 to 13 years), changes in social environment (with respect to gender roles among peers), anticipated and actual physical changes, and first experiences of sexual attractions and falling in love appear to contribute to critical changes in the intensity and persistence of gender dysphoria. Because the outcome is hard to predict, the approach to treatment is to provide a supportive environment in which the child's gender identity development can unfold without trying to bring about any particular outcome. This requires tolerating ambiguity and uncertainty, and care must be taken not to foreclose identity development.

For children with a history of intense gender dysphoria who have a strong adverse reaction to the onset of puberty, puberty suppression with gonadotropin-releasing hormone analogs is available. This allows monitoring of gender identity development and gender dysphoria for a period of time beyond 12 years of age before initiation of cross-sex hormone therapy (in case dysphoria persists) or discontinuation of suppression (in case dysphoria desists), so that puberty can continue congruent with gender identity. The role of the mental health professional is to counsel patients and families with information on what is known and not known about the benefits and risks of the various treatment options (including the potential harm of doing nothing); it is also to support them during this period of uncertainty and address any adjustment issues the child may face, regardless of whether these issues are related, or not to the presenting complaint of gender dysphoria. Thus far, follow-up research has shown favorable outcomes for youth treated with this approach.

Even before the age of puberty, gender nonconforming children may consider making a social transition in gender role (from female to male or male to female), including at school. Although such a social transition may alleviate gender dysphoria, caution is warranted, because qualitative research has shown that children for whom gender dysphoria does not persist may struggle significantly with the stress of reverting back to the original gender role. Moreover, some TGNC youth develop a gender identity outside of the gender binary (not male, not female, but an alternative gender such as genderqueer), revealing the limits of the concept of “transition,” whether social, medical, or both. What is known is that children with gender dysphoria are more vulnerable to poor peer relations and general behavioral problems and that these adjustment challenges, in addition to the gender dysphoria, could benefit from social and behavioral interventions. Mental health professionals can work with the child, family, school, and other health and social service providers to develop and implement an individualized, coordinated care plan.
The WPATH “Standards of Care” provide the following minimum criteria for puberty-suppressing hormones:

1. There is a long-lasting and intense pattern of gender nonconformity or gender dysphoria.
2. Gender dysphoria emerged or worsened with the onset of puberty.
3. Any coexisting psychological, medical, or social problems that could interfere with treatment have been addressed.
4. The adolescent has given informed consent, and particularly when the adolescent has not reached the age of medical consent, the parents or other caretakers or guardians have consented to the treatment and support the adolescent throughout the treatment process.

Facilitating Changes in Gender Role and Expression

Transgender coming out is first and foremost a psychosocial process. Just because a patient presents with gender dysphoria and may meet the criteria for a formal DSM-5 diagnosis of gender dysphoria does not mean that social and medical “transition” is indicated. Rather, today’s approach to care develops and implements an individualized treatment plan requiring coordination of care across providers of various disciplines (psychology, psychiatry, social work, endocrinology, surgery, and voice therapy) and various support resources (online and offline transgender community resources, legal assistance) tailored to the needs of patients and their family. In consultation with their health providers, patients make decisions among the various available options for intervention. Thus a patient assigned male at birth may decide to change gender role and expression and take feminizing hormones but not opt for surgery, or a patient assigned female at birth may opt for chest surgery without taking masculinizing hormones. These patients may identify as female or male, a transgender woman or man, or as genderqueer. Others, however, will pursue a more traditional path and take hormones, change gender roles (including a change in identity documents), and have gender-affirming surgery (breast/chest, genital, and/or facial surgery). In addition, the treatment plan may include treatment of other identified mental or physical health issues. Patients go about this process at their own pace, and the plan is often adjusted along the way. Mental health professionals can assist in the development and implementation of this individualized treatment plan, consult with the other providers and stakeholders involved in the patient’s care, and provide support along the way.

For many patients, changes in gender role and expression are the most frightening part of the process. It involves informing others who need to know, including family, friends, and typically after that employers and coworkers, teachers, and schoolmates. This involves taking calculated risks, putting the reactions of others into perspective, and recognizing that others need time to adjust. Particularly when family and friends are adjusting, a process that has been described as their own coming out or transition process, support from other transgender individuals who have gone through a similar process can be extremely helpful. Patients may include their families and friends in psychotherapy. Family therapy is useful, especially when the patient is a child or adolescent. Many support groups are available to TGNC individuals at all stages of coming out and to family members. Mental health professionals should be familiar with and can refer families and friends to available local and national support networks and services.
In addition to fears of rejection and abandonment by families and friends, changes in gender role and expression involve facing stigma and discrimination by society at large. Indeed, experiences of actual discrimination are more common among those who openly express their transgender identity, and yet peer support and transgender community connectedness can buffer the negative impact of these experiences on the patient’s mental health.\textsuperscript{7,24} TGNC individuals who identify as genderqueer or nonbinary and who may have a more ambiguous gender expression are extra vulnerable to social stigma and struggle with the fact that society is not yet very adept at accommodating their gender identity and expression. Mental health professionals can assist patients to navigate these challenges, access peer support, consult on gender role changes in the workplace, support changes in identity documents, and advocate on behalf of their patients or more generally for antidiscrimination and transgender rights, policies, and legislation.

**Preparation and Referral for Hormone Therapy**

According to version 7 of the “Standards of Care,”\textsuperscript{1} TGNC people can access hormone therapy without a referral by a mental health professional, particularly when the physician prescribing the hormones is appropriately trained in behavioral health and competent in the assessment of gender dysphoria. However, patients may want to obtain a consultation and work with a mental health professional to make a fully informed decision about hormone therapy and its psychosocial implications. Moreover, mental health professionals can play a key role in preparing the patient for hormone therapy.

The decision to feminize or masculinize the body through hormone therapy is first and foremost a very personal decision for the patient. However, mental health professionals working with TGNC individuals and their families are often called on to support this decision. Coordination of care with the other providers involved in the patient’s care is critical, whether or not the mental health professional is an integral member of a multidisciplinary specialty team. Progress in meeting the goals of the patient’s individualized treatment plan to alleviate gender dysphoria and address any other identified mental health issues is what should guide the timing of the onset of hormone therapy.

Preparation should include having realistic expectations and understanding the implications of hormone therapy for psychosocial adjustment and mental health. Discussing these expectations and implications with other TGNC persons who have the relevant experience can be extremely helpful in this regard. Preparation also includes establishing and maintaining social support from family and/or friends. With the help of readings and consultation with a physician (preferably one with experience in providing gender-affirming hormone therapy), the patient should be made aware of the risks and benefits of hormone therapy for physical health, taking into account overall health and chronic disease. Finally, preparation includes discussion of the implications of hormone therapy for sexual and reproductive health, with an explicit discussion of the available options for preservation of fertility.

The WPATH “Standards of Care”\textsuperscript{1} recommends that the mental health professional’s referral for feminizing or masculinizing hormone therapy includes a summary of the psychosocial assessment and diagnoses, duration and progress made in counseling or psychotherapy, a clinical rationale for hormone therapy and the patient’s standing in meeting the criteria,
documentation of informed consent, and a statement about the availability of coordination of care. The WPATH “Standards of Care” criteria for hormone therapy are:

1. There is persistent, well-documented gender dysphoria.
2. The patient has the capacity to make a fully informed decision and to consent for treatment.
3. The patient has reached the age of majority in a given country (if younger, see “Working With Children and Adolescents”).
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.

Preparation and Referral for Surgery

According to the WPATH “Standards of Care,” for gender-affirming breast/chest and genital surgery, referrals from one or two mental health professionals are needed to initiate surgical treatment. The mental health professional can assist the patient to make a fully informed decision about the various options for surgery and their timing, to have realistic expectations, and to understand the implications of surgery for psychosocial adjustment. Discussing these expectations and implications with other TGNC individuals who have experience in this regard is extremely helpful. The mental health professional should encourage the patient to obtain accurate information about surgical procedures, including their risks and benefits, through readings and consultation with qualified surgeons. Social support and the development of an aftercare plan are critical.

One referral from a qualified mental health professional is needed for breast/chest surgery (mastectomy, chest reconstruction, or breast augmentation); two referrals are needed for genital surgery (hysterectomy, salpingo-oophorectomy, orchietomy, or genital reconstructive surgery). The referral letter (or letters) should include a summary of the patient’s psychosocial assessment and diagnoses, duration, and progress made in counseling or psychotherapy; a clinical rationale for surgery and the patient’s standing in meeting the criteria; documentation of informed consent; and a statement regarding the availability for coordination of care. Others have recommended that the letter include information about how well the patient has adhered to the WPATH’s “Standards of Care” and the likelihood of future compliance and that the letter (or letters) provide a holistic picture of the patient, including a description of the patient’s socioeconomic status, functional status, and social history. Although this model of referral by mental health professionals is currently the accepted standard of practice, some members of the transgender community think that this creates an adversarial relationship in which the mental health professional serves as a “gatekeeper,” perceived as standing in the way of the transgender patient’s goals for transition. Rather, clinicians should do their best to act as a facilitator, working with the patient to achieve the highest quality of life possible.

The WPATH “Standards of Care” criteria for breast/chest surgery are:

1. There is persistent, well-documented gender dysphoria.
2. The patient has the capacity to make a fully informed decision and to consent for treatment.
3. The patient has reached the age of majority in a given country.
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.
For breast augmentation, patients who are taking feminizing hormones are encouraged to give hormone therapy sufficient time before breast augmentation surgery.

The criteria for genital surgery are:
1. There is persistent, well-documented gender dysphoria.
2. The patient has the capacity to make a fully informed decision and to consent for treatment.
3. The patient has reached the age of majority in a given country.
4. If significant medical or mental health concerns are present, they must be reasonably well controlled.
5. The patient has received 12 continuous months of hormone therapy unless hormones are not clinically indicated.
6. For genital reconstructive surgery (vaginoplasty, metoidioplasty, or phalloplasty), the patient must live for 12 continuous months in a gender role that is congruent with the patient's gender identity.

The rationale for this last criterion (criterion 6) is to provide ample opportunity for patients to experience and socially adjust to the gender role congruent with their identity before they undergo irreversible surgery.

After the patient has been referred for surgery, psychiatrists should collaborate with the surgeon and anesthesiologists to clarify the risks of the various psychotropic medications their patients may take. The psychiatrist may opt to adjust various medications before surgery. Although some psychotropic drugs may be safe during surgery, others may interact dangerously. Before surgery, psychiatrists should be aware of a number of other drug-drug interactions, especially if their patients are taking multiple psychotropic medications for comorbidities.

**Postoperative Tasks of Mental Health Professionals**

After the surgery has been completed, patients must check in regularly with their mental health providers. Postoperative care is fundamental for patients' psychological well-being. During the postoperative stages of care, the three broad categories of tasks for the mental health professional are:
1. Immediate postoperative mental health and behavioral health care
2. Facilitating postoperative adjustment
3. Continuation of long-term mental health care

In the immediate postoperative period, TGNC patients, like all surgical patients, may present with uncontrollable pain, confusion, agitation, and delirium. The mental health professional can aid the patient by ensuring that an appropriate support network will be at the bedside during the initial recovery period. This may be a challenge. Although patients may be pleased with the completion of much sought-after surgery and have improved body image, and decreased gender dysphoria, these feelings are not always shared by their families and loved ones. Patients may be faced with shock or confusion rather than support and may experience a wide range of reactions from acceptance and celebration to rejection and violence. Thus, adjustment during the first postoperative year may be far from what one may consider a honeymoon, and mental health professionals must provide the appropriate support and therapy. It also underscores the potential benefit from including family members and loved ones early on in treatment.
In the months after surgery, patients may face adjustment challenges. As patients recover and become more comfortable with their body, many wish to resume sexual function. Most function well from a social and sexual standpoint and are able to achieve orgasm. Others, however, may have difficulty finding sexual partners or may have lost interest in sex altogether. These issues can be addressed through sex therapy.

Regarding overall quality of life, multiple studies have demonstrated that treatment of gender dysphoria is beneficial for both transgender women and men. Among adolescents, more stable psychological function was found after surgery. Smith et al confirmed that treatment is effective, with regrets of transition being extremely rare. One transgender woman conveyed regrets and stated that her transition would have been more bearable had she had professional guidance through the adverse consequences she experienced, including intolerance of society, family, and her own children. As such, good aftercare and postoperative follow-up cannot be overstressed.

Research is limited, however, to cohorts of patients who have followed a traditional path of psychological evaluation, hormone therapy, a change in gender role from male-to-female or female-to-male, and surgery, and typically in that order. Studies have not reflected the diversity in gender identity, gender expression, and treatment options that TGNC individuals exercise today. Future research is needed to evaluate the outcomes of today's heterogeneous approaches to care, including the specific interventions delivered by mental health professionals, and on comfort with gender identity and role, mental and physical health, and quality of life.

Although quality of life tends to improve after surgery, patients must regularly see their primary care physician and mental health provider. Surgery, although a crucial component of gender affirmation for some, cannot teach patients how to live life as a transgender woman or man. Mental health professionals are responsible for providing their patients with adequate preparation for the challenges they can expect with transition, in addition to the rewards and satisfaction they may experience.

Postoperative psychotherapy in groups or individually should be part of the available care to support patients in their adjustment and life goals. Questions about gender identity may remain or resurface, providing the opportunity to accept one's identity as a person of TGNC experience on a deeper level. Some issues may not arise until some time after a gender role transition or surgery, such as worries and apprehensions about daily life related to gender (for example, facing questions about past gender markers on identity documents or disclosure of identity and background to a new health care provider) and issues regarding dating, relationships, and sexuality.

**Conclusion**

Mental health professionals play an important role in the care of TGNC people and in the interdisciplinary assessment and treatment of gender dysphoria. Transgender coming out is first and foremost a psychosocial process in which coping with social stigma attached to gender nonconformity is a recurring theme. Mental health professionals can facilitate identity development and resilience. Mental health professionals can also assist TGNC people in making a fully informed decision about the various treatment options available, in preparing patients for changes in gender role and/or medical interventions, and in providing support to TGNC persons, their families, and communities along the way. Finally, mental health professionals can advocate for better accommodation and acceptance in society and its institutions of the full spectrum of gender diversity found among this special population.
References


