

USING THERAPEUTIC ASSESSMENT IN PSYCHOLOGICAL ASSESSMENTS REQUIRED FOR SEX REASSIGNMENT SURGERY

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Although the American Psychological Association has called upon all psychologists to educate themselves about the needs and concerns of transgender individuals (APA, 2008b), some psychologists will pursue advanced training and expertise in working with transgender clients. One area of specialized competence is the evaluation and referral of individuals seeking medical (i.e., hormonal or surgical) interventions for gender dysphoria. Most medical professionals rely on the *Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People* published by The World Professional Organization for Transgendered Health (WPATH, 2012). These *Standards* recommend independent evaluations of transgender individuals from qualified mental health professionals before medical interventions (i.e., hormones or surgery) are begun. I have conducted such assessments numerous times in my career and have developed a protocol based on the principles of Therapeutic Assessment that I believe adheres to the *Standards of Care* and is respectful of the rights and concerns of transgender clients. My goal in writing this chapter is to describe and illustrate my approach.

My Personal and Professional Context

I am a gay man who “came out” in the mid-1970s in the United States, and I was often targeted as a “sissy” in the small rural village in which I grew up.

I would like to thank Monrovia Van Hoose and Sarvenaz Sepehri for their helpful comments on an earlier draft.

As a result of these and other experiences, I am sensitized to the experience of gender-nonconforming individuals and to members of other “despised groups.” During my graduate training in clinical psychology at the University of Minnesota, I was a research assistant on a study of individuals who had undergone Sex Reassignment Surgery (SRS) at the University of Minnesota Hospitals. I was deeply touched by the lives of the transsexual men and women I interviewed for this project, and this experience broadened my perspective on gender and gender identity forever. Also, during this time, I assessed and treated a number of gender-nonconforming boys and their families—both during my psychology internship and fellowship and after I became a licensed psychologist and opened my private practice in Austin, Texas. In 1984 I accepted a faculty position in clinical psychology at the University of Texas, and my early research was focused on the assessment and measurement of gender identity. I am the co-author of a book that touches upon these topics (Martin & Finn, 2010).

In 1986 I also began consulting to other medical and mental health professionals by providing assessments of transgender adults and teens seeking hormonal and surgical interventions. At first, I leaned heavily on other experts who did this kind of work, but as I gained confidence and experience, I worked more independently. At the time I write this chapter, I have conducted between 20–25 independent evaluations of transgender adults, adolescents, and (recently) children seeking medical interventions for gender dysphoria. I have also worked in individual, couples, and family therapy with many transgender clients, including clients pursuing psychotherapy prior to scheduling SRS. (The current *Standards of Care* do not require psychotherapy prior to surgical interventions, but many physicians feel more comfortable if a client has had psychotherapy.)

Cultural and Political Context

Although there is increasing public awareness of transgender issues and increasing activism on the part of the transgender community, transgender and gender-variant people continue to face discrimination and stigmatization on a routine basis (APA, 2008a). Any psychologist serving transgender clients needs to be acutely aware of the cultural and political context in which these clients live and to think through a number of questions that arise in this line of work. One question is whether the psychologist is unwittingly buying into a limited, either-or view of gender and gender roles by participating in a process where people medically alter their bodies in order to fit into society and be happy. Some “radical feminists” (as they refer to themselves) have argued that medical interventions for gender dysphoria would not be necessary except for our sexist culture, and that such medical interventions demean “womyn-born-as womyn” (Jeffreys, 2014; Raymond, 1979). I agree that our society is still very limited in its view of what is appropriate gendered behavior, and I always explore a range of options with the transgender individuals who seek support and encouragement from me as a psychologist. Increasingly, many of my clients have opted not to

undergo what once would have been considered “complete” Sex Reassignment Surgery, and some do not have a goal of presenting themselves as gendered. For those who are seeking medical interventions, I am sympathetic to their desire to make their bodies congruent with their gender identities, and I am bolstered by the many research studies that show highly positive outcomes for such medical interventions with well-screened applicants. (See Lev, 2004, for a review of this research.) I consider myself a feminist and am extremely sympathetic to the disadvantages of being a woman in society, but I reject the claim that the choices my transgender clients make further injure women.

- A second question, which I take very seriously, is that raised by some transgender activists: Am I placing myself in a disrespectful, “one-up” power position by serving as a “gatekeeper” to those transgender individuals seeking medical interventions? I struggled with this question a great deal initially, for several reasons. First, in recommending clients for medical interventions, for years I was typically required to certify that they had an official Gender Identity Disorder according to the then-current *Diagnostic and Statistical Manual of Mental Disorders*. I worried that this label contributed to my clients’ sense of alienation and shame, and I always carefully discussed my use of this term with them. The current *DSM-5* (APA, 2013) has helped remove stigma from the official diagnostic system by utilizing the term Gender Dysphoria instead of Gender Identity Disorder. Second, I was acutely aware of my gatekeeper position with those individuals who wanted me to endorse medical interventions that I felt I could not recommend. Clearly, I was prioritizing my professional judgment over their wishes, and I never made such decisions lightly. But I was also aware that there are documented cases of individuals who have greatly regretted having undertaken medical interventions to change their primary and secondary sexual characteristics, and that most of these “errors” result from poor screening procedures (e.g., Olson & Möller, 2006). Also, several of the clients whom I declined to recommend for medical interventions told me later that I had made the right decision, and that they were grateful. So I have continued to feel good in the role of screening transgender individuals for medical intervention, but I have worked hard to develop a procedure that empowers such clients, helps them feel respected, and creates an environment in which they can explore what is best for them. In a subsequent section, I will describe this procedure, but first, since my approach is based on Therapeutic Assessment, let me give a brief summary of that paradigm.

A Brief Review of Therapeutic Assessment

Therapeutic Assessment (Finn, 2003, 2007; Finn & Martin, 2013; Finn & Ton-sager, 1997) is a semi-structured form of collaborative psychological assessment in which psychological testing is used at the core of a time-limited therapeutic intervention. Therapeutic Assessment builds upon the pioneering work of assessment psychologists like Constance Fischer (1970, 1978, 1985/1994) and

Leonard Handler (1999, 2006, 2012), who began—in the 1970s—transforming the traditional procedures of psychological assessment to make the experience of being tested less traumatizing, more respectful, and more helpful to clients. Fischer and Handler reduced the power imbalance that had historically existed between assessor and client as much as is feasible, and they included clients as active participants in setting assessment goals, interpreting tests, reviewing written reports, and formulating next steps after an assessment. Early in my career, I noticed that when collaborative assessment procedures were used, clients showed measurable benefits as a result of an assessment (Finn, 1996a; Finn & Tonsager, 1992). This eventually led to the development of Therapeutic Assessment (TA), a semi-structured form of Fischer's and Handler's models, which has been widely researched in a number of settings. As summarized by Finn & Martin (2013), TA has been shown to benefit clients in a number of ways, including (a) aiding in symptom reduction; (b) increasing self-esteem, hope, and treatment compliance; and (c) facilitating concurrent or subsequent psychotherapy.

Collaborative and Therapeutic Assessment (CTA) have largely been used in clinical settings with voluntarily referred clients, but Fischer has written extensively about using collaborative assessment in potentially adversarial assessment situations, such as the selection of nuclear plant operators (Fischer, 1985/1994) or child-custody situations (Fischer, 2004). Also, others have written about using CTA or TA with involuntarily referred foster parents and children (Purves, 2002), as part of an executive advancement evaluation (Fischer & Finn, 2014), and in parenting plan evaluations (Evans, 2012). The basic CTA approach to such assessments is to acknowledge the potential conflicts of interest inherent to such situations, make it clear what information will and will not be given to sources outside of the assessment (e.g., judges, bosses, social workers), and then see if the assessment can be useful to the client within this context. When clients demonstrate reservations about being fully disclosing, assessors acknowledge that the clients are showing good judgment, rather than accusing them of being “resistant” or “defensive.” Many of the published case examples show that CTA can be helpful to involuntarily assessed clients as well as to the professionals called to make decisions about their lives (judges, bosses, etc.). Hence, there is independent evidence to support the idea that TA is applicable to the assessment of transgender clients who are interested in receiving medical interventions.

As I have written about elsewhere (Finn, 2009), the core values of TA are collaboration, respect, humility, compassion, openness, and curiosity. As I will now explain, I try to integrate these values into my assessments of transgender clients seeking my assistance in obtaining medical interventions for gender dysphoria.

Therapeutic Assessment of Individuals for Sex Reassignment Surgery

So what is the role of a psychologist conducting psychological assessments of transgender individuals seeking medical interventions? The *WPATH Standards*

of Care (2012) spell out five tasks as follows: (1) “to assess clients’ gender dysphoria in the context of an evaluation of their psychosocial adjustment” (p. 23); (2) to provide information regarding options for gender identity and expression and possible medical interventions; (3) to assess, diagnose, and discuss treatment for coexisting mental health concerns should they be present; (4) if applicable, to assess eligibility, prepare, and refer for hormone therapy; and (5) if applicable, to assess eligibility, prepare, and refer for surgery. For these last two objectives, the *Standards* spell out a list of specific criteria to be used in determining eligibility. For example, for vaginoplasty in male-to-female transgender clients, one of the criteria is “12 months of continuous living in a gender role that is congruent with their gender identity” (p. 106).

The *Standards* explicitly state that these criteria are based on expert consensus opinion about what has been found to be most beneficial to clients. The *Standards* also emphasize that decisions about medical interventions are “first and foremost a client’s decisions” and that the responsibility of mental health professionals is “to encourage, guide, and assist clients with making fully informed decisions and becoming adequately prepared” (p. 25). I believe this stance is appropriate and well-balanced and congruent with the core values of TA. It also helps address a problem noted by Lev (2004) and others—that is, that the gatekeeper function of the assessor can make it difficult for clients to fully explore all sides of the decision to undertake medical interventions. I try to address this concern through frank discussion with my clients in the initial session of our work together, and I make it clear that I consider it normal and healthy for clients to have mixed feelings at various stages of their decision to undertake SRS. I will now turn to my case illustration.

Therapeutic Assessment of Lana

“Lana” was a 44-year-old transgender woman referred to me by Dr. K, a psychotherapist in Austin, Texas, who frequently works with transgender clients. Lana was applying for SRS with Dr. X and his team in Canada, and the program she had chosen required two letters of recommendation from “clinical behavioral specialists.” As was appropriate, Dr. K was writing the first letter, and she asked me to evaluate Lana to see if I felt comfortable writing the second recommendation. I agreed, and Lana called and scheduled an initial session.

Initial Session

When I met Lana in the waiting room, she was dressed in a light blue, long-sleeved, knee-length dress and high heels. She had long blonde hair, and I noticed her height (6’2”) and the scarf around her neck, both of which reminded me of other transgender women I know. Lana greeted me in a strong, slightly raspy, mid-range voice with a Texas accent, and she thanked me for agreeing to see her. In my office she complimented me on the homey feel of my waiting room,

made herself comfortable on the edge of a sofa, and looked at me directly and expectantly. I said that I understood from Dr. K that Lana was seeking a second letter recommending her for SRS, and she said that was true. I asked what she understood already about such letters and if she had any questions about my approach. Lana was clearly familiar with the WPATH *Standards of Care*, and she confidently recited the criteria she knew I would be considering. She then asked how many times we would need to meet in order for me to form my opinion. I said that was an excellent question and that it would depend on several things. I then took the opportunity to explain how I approach these types of assessments:

In the end, I strongly believe that whether you go ahead with this surgery is mainly your decision, although Dr. X's team requires you to have this second assessment. If you decide to work with me, I see my job as follows. First I want to give you any information you need and answer any questions I can about SRS so you can be sure this is a step you want to take. Second, there are a few conditions besides gender dysphoria that sometimes lead people to seek SRS. So, by talking and using psychological tests, I want to make sure that you don't have one of these conditions. Third, because the surgery is difficult and you'll need support, the Standards of Care ask me to evaluate whether you have the supports you need to recover well afterwards and live in your new life. Last, because this is such a big step, and there are rare instances in which people have regretted having SRS afterwards, I may raise certain issues for you to think about further and support you while you do that. If I don't find any mental health or practical blocks to your having the surgery and if at the end of our discussions you still want to go ahead, then I will happily write a letter of recommendation to Dr. X.

Lana appreciated that I saw the SRS as ultimately her decision and said that she was willing to talk about any aspect of her life and her reasons for wanting the surgery. We agreed on an estimated price for the assessment—which might change if we spent more time together than I anticipated—and Lana asked a few other appropriate questions, such as how many people I had previously evaluated for SRS. After this it was clear we had decided to work together, and I asked Lana to tell me about her process of deciding to live as a woman.

Lana's Story

Lana had approached Dr. K 20 months earlier after becoming clear that she “wanted to become a woman.” At that point in time, Lana was living as a man (named “George”), and she and Dr. K spent five to six months sorting through Lana’s feelings and background. Lana told me that she had felt confused about her sexuality and gender since she was a teenager. As a young man, George had hung around with gay men and had many same-gender sexual experiences. But

these were not very satisfying as he wasn't erotically attracted to men. At the age of 22, "George" had married a woman and had two children—a daughter who was now 17 and a son who was 15. In contrast to usual gender roles, George's wife had worked, while he took care of the house and the children. He greatly enjoyed this arrangement and kept thinking, "I should have been born a lesbian. I love women, but I also want to be a woman." Also, when other couples would visit, George would end up sitting with the women rather than the men. Around the age of 33, George began to cross-dress whenever his wife and children were out of town visiting her parents, and he began to feel, "I will die if I can't become a woman." During one of his weekends alone, a gay friend arranged a date for George with a man, and he discovered that he "loved being treated like a woman." He told his wife about his feelings, and they pursued couples therapy. The therapist told George he had to "embrace his masculinity" and, in the end, the marriage broke up and George moved to Austin, leaving his children with his wife.

In Austin, George went back to school and trained as a medical technician. He became romantically involved with and eventually moved in with a woman, Sara, and began cross-dressing when she was not at home. One day Sara came home early from work and found "Lana" dressed in women's clothes. Sara accepted this and bought dresses for Lana and accompanied her to bars. Eventually the relationship ended because Sara wanted to have children, and George stopped cross-dressing after a roommate told him, "George, you make an ugly woman." He married again, became a fundamentalist Christian, and "purged" his wardrobe. After three years of marriage, he became acutely suicidal and entered psychotherapy. The therapist helped him leave his marriage, and he had several "flings" with men that were unsatisfying. Finally, one day he saw the movie *My Life in Pink* (about a transgender boy who courageously holds onto his desire to be a girl in spite of family pressure and public discrimination). The next day George researched psychotherapists who worked with transgender clients and called Dr. K for an appointment.

Within the previous year, with Dr. K's help, Lana had begun living full time as a woman, had legally changed her name, and had successfully changed her gender on her driver's license from "M" to "F." She had begun hormone therapy under the supervision of an endocrinologist in Austin and was pleased with the ways her body had changed. She said she felt "calmer" and "happier" than ever before. She had begun attending a transgender support group at a local community counseling center, and she had worked with a speech pathologist on "feminizing" her voice. This was important to Lana because she was an amateur singer/songwriter who performed occasionally and sold her songs on the Internet. To help her appearance, Lana also had a number of electrolysis treatments and was saving money to do more. With Dr. K's help, she had written to and come out to her two children. They had been upset at first, but after several conversations and one visit, they were now supportive. During this whole period, Lana had continued to work at her job and had saved enough money for

a complete vaginoplasty. After research and consultation with peers, she chose Dr. X and his team in Canada to do her surgery, and Lana was ready to submit all of her paperwork if I agreed to write the second letter of recommendation.

I felt touched hearing Lana's story, and I told her I was impressed with the courage she had shown in facing her transgender feelings and deciding to act on them. She looked me in the eye and said that she would have had to kill herself if she had not. I replied, "That may be true, but it still takes a lot of guts to do what you're doing." Lana smiled and said, "I have always been stubborn!" I smiled back and I remember thinking, "I like her spunk."

Lana's Assessment Question

As is typical in TA, I then asked Lana if she had any particular questions, doubts, worries, or concerns that she wanted to explore in our work together—besides whether she wanted to go ahead with the SRS. She paused and said she had been thinking about this ever since she had read about TA. She said the only question she had come up with was, "Is there anything else I need to do to be happy as a complete woman? I tend to think the vaginoplasty is the final piece, but I'd like to know if there is something else." I said this was an excellent question and that I would be happy to help her think it through, and I was sure Dr. K would help also. Lana and I agreed that we would try to address this question in our work together in addition to my evaluating her on the usual criteria for SRS.

Early Assessment Sessions

Although psychological testing is not required by the *Standards of Care* in evaluations for SRS, I typically do at least two tests in my assessments of this type: the MMPI-2 (Butcher et al., 2001) or MMPI-2-RF (Ben-Porath & Tellegen, 2008) and the Rorschach (1921). As I have written about previously (Finn, 1996b, 2007), I find that the MMPI and Rorschach are extremely useful to me and my clients in understanding a variety of issues. Early in our work together, Lana completed the MMPI-2, and since she was living as a woman, I scored it using female norms. Lana's MMPI-2 profile was unguarded—but not overly so—and this finding is relatively common when I assess transgender clients for medical interventions. I believe this result shows the trust clients have once I make it clear that they are free to talk about any emotion or thought without having to worry about my judging them unfit for SRS. Of note, there were no significant elevations on any of the Clinical or Content Scales of Lana's MMPI-2 profile. In brief, the MMPI-2 suggested that Lana was a sturdy survivor who functioned well in structured, nonemotional situations, and that she was free of any serious mental or personality disorder. The test also suggested that she was a somewhat extroverted person (Scale 0 = 42T) and that her gender identity resembled that of most biological women (Mf6 = 57T; Martin & Finn, 2010). I discussed these

results with Lana and she confirmed them and said she was relieved that the MMPI-2 reflected how she saw herself.

Rorschach

I scored Lana's Rorschach protocol with the Exner Comprehensive System (Exner, 2003)—the predominant system at the time I did her assessment. As with the MMPI-2, there were no signs of guardedness or any hesitations on Lana's part about doing the Rorschach ($R = 28$, $\Lambda = .52$). There also were no signs of serious psychopathology, just as with the MMPI-2. In fact, Lana appeared to be a woman with excellent psychological resources ($EA = 13.0$, $M = 9$, $D = +2$, $DQ+ = 12$) who had the capacity to work well with others ($H = 6$, $COP = 3$, $GHR/PHR = 5/3$) and excellent reality testing ($XA\% = .86$). There were a few indications of underlying shame ($FD = 3$, $V = 1$, Color-shading $Bl = 3$)—not surprising given the prejudice experienced by transgender individuals in our society—and suggestions that this underlying self-doubt might be covered by a confident presentation ($Fr + rF = 2$). There were also signs that Lana was "stubborn," as she had described to me earlier ($a/p = 13/1$).

The most significant event concerning the Rorschach came when Lana and I were discussing her actual responses immediately after the standardized administration of the test; this is a procedure from TA called the "extended inquiry" (Finn, 2007). On Card X of the Rorschach, Lana's first response had been,

A beautiful woman performer, singing in a nightclub in Paris. She is wearing a grey headdress, a pink feather boa, and a blue bustier. These are her green stockings and her pointed shoes. These other things on the sides are the colorful clothes of the audience. Everyone in the club is entranced with her and is secretly fantasizing about having a love affair with her—both the men and the women.

In the extended inquiry I asked Lana for any associations to this response, and she immediately said, "Oh, that is me, how I plan to be after my surgery. I also sing and I want to get back to performing. I guess this picture is my hope of how I will be. I think I've held myself back when I've performed before and that after my surgery I'll be freer and more confident." I then asked Lana to say more about everyone wanting to have a love affair with the singer. Lana said, "That is how I'd like to be too, so beautiful that everyone desires me. Just like with the performing, I think I don't feel attractive right now because I don't like my lower body. After I have my surgery, I'm sure I will feel more beautiful because I will be a complete woman."

I found myself reacting in two ways to Lana's disclosure. A part of me appreciated her exuberance and her hopeful anticipation, and I believed she might indeed feel happier and freer after her surgery because I had witnessed such outcomes before with other male-to-female transsexuals. On the other hand, a

part of me worried that Lana was being unrealistic about the likely outcome of her vaginoplasty. This surgery would not make her a “complete woman”—if by that phrase she meant a biological woman—and it didn’t seem likely that many men and women would start desiring her because she felt more “complete” and “free.” Of course, she hadn’t said that she actually *believed* this would happen, but her elaboration of her Rorschach response suggested to me that it might be an unconscious fantasy. Finally, although I did not agree with Lana’s previous roommate that she was an “ugly woman,” I thought it unlikely she would easily pass for a biological woman or that her vaginoplasty would increase the likelihood she could do so. I worried that Lana would be very disappointed in her surgery if she didn’t realize all this beforehand. So after a pause, I gently said, “Lana, I hope this doesn’t seem insulting, because I understand how much you’ve always wanted to be a woman. But you know, don’t you, that even after your surgery it won’t be the same as if you were born a biological woman? And even if you feel better and freer and more beautiful—which I think could definitely happen—some people may recognize you as a transsexual woman and not think of you as a biological woman. And given societal hang-ups, that also means fewer people will be interested in being romantically or sexually involved with you.”

When I finished speaking, I saw shock and pain on Lana’s face, and she was silent for five to ten seconds. Then she began to weep, saying,

I’m sorry. I know what you’re saying is completely true, but it’s hard to think about. Dr. K said something like this to me six months ago, but I guess I didn’t let it sink in then. I didn’t realize, but I think I’ve been engaging in some magical thinking. I know a lot of people read me as trans now, and of course, that will probably be true after the surgery too.

I sympathized with how much Lana wanted to be a biological woman and how difficult it was to have a body that didn’t match her gender identity. She grew calmer and looked at me intently as I spoke. I said I did believe the surgery could help Lana feel better about herself and be happier, but that it was important to realize that it also had limits. She was taller than most biological women, had a squarer jaw, bigger wrists, and a lower voice. She could continue to work on feminizing her voice and appearance, but with increased societal awareness of transgender people, there might be more and more people now who would think, “I wonder if that person is a transsexual.” Lana winced a bit when I said that, but then sighed and said, “Of course, you’re right. That’s the way it is now, and that’s the way it’s going to be after the surgery. I wish it were different, but it’s not. Some trans kids now are getting hormones when they’re really young, and they pass better as adults because of that. But that didn’t happen with me. Still, I do think the surgery is worth doing, because it will change how I feel about myself. I’ll be happier with *me* and that’s what’s most important.” I agreed that how Lana felt about herself was the most important outcome.

I then asked Lana if she had a sense of how often she “passed” as a woman now. She said it was hard to know, but that sometimes she was aware of people looking at her intently when she was in public, and she was pretty sure they were attempting to make sense of her gender. I asked how she felt about such stares, and she said, “It’s hard, but I can live with them. And I understand why people are curious.” I then shared the following thoughts:

Lana, of course people are curious about you. But I also wonder if another part of what you see is that they are struggling with their own ideas about gender. The contribution that you and other transgender people make to the world is that you help us think about gender in a new way. I know that my work with transgender people has completely changed the way I see the world and how I think about what it means to be a man and a woman, and I’m grateful for that. In a way, your courage in living as a transgender woman is a kind of ‘ministry’ to the world, and if you completely passed you wouldn’t have the same kind of impact. People wouldn’t be challenged to stop and think. I know people have all kinds of reactions to transgender people, and I think that’s partly because you defy our usual ways of thinking about gender. I understand why you might not always want to have this job, and you’ll need places to take breaks from it. But I think some piece of it will always be there for you—even if you don’t want it to be—and you’ll need support from other transgender and supportive cisgender people to keep dealing with this and thrive.

Lana thanked me and said she was deeply touched by what I had said and wanted time to think about it. She also expressed her surprise that we had gotten to this important discussion through one of her Rorschach responses. I told her this is why I used psychological testing in my SRS assessments, and that tests often open up things that might not otherwise come out through talking. We agreed to meet a week later to continue our assessment.

Assessment Intervention Session

Of course, I was eager to see how Lana was doing when she arrived for our next session, and I was pleased to see her looking content and poised. She thanked me for my honesty in the previous session and said that our discussion had provoked a lot of thoughts that she had talked over with Dr. K. I asked if she would share some of those thoughts, and Lana summarized,

As I said last week, I think a part of me has been engaging in magical thinking about what the surgery will do for me. I know it will make me feel more like a woman and give me more of the body I feel I should have, but as you said, it’s not going to change how other

people view me very much. I do stand out from biological women, and while I hope to improve that more, you were right that a lot of people realize I am a transsexual woman. So that means I want to claim *that* identity and accept it and not try to be something I'm not. Otherwise, I'm always going to be worrying about passing and I'll be scared and miserable when I don't. Our talk has helped me change my ideas of how I will live after my surgery, and I'm really grateful for that.

I asked Lana to say more about her new ideas, and she said,

I was starting to think that I might move to another city where no one knew me as a man, cut off all my old friends, and just start over as woman. But now I see that was part of the magical thinking—that I could go somewhere and be seen as a biological woman and not have to think about being transgender. Instead, when I think about living as a transsexual woman, I want to stay right here, and keep my friends, and get more involved in fighting for transgender rights. And I still want to perform in public, but I'll do so as an open, proud transgender woman.

I was really impressed with the thinking Lana had done in the prior week, and I said so. Also, the reservations I had about whether she was unrealistic about her likely surgical outcomes were gone. After we talked further, I told Lana that I had one more thing I wanted us to do for the assessment, and that I thought it would be relevant to her question of what would make her happier after the SRS. She said she was very curious and wanted to know more. And so I moved on to a step in TA called an "assessment intervention." I had tentatively prepared what I would do if Lana and I got to this step, so let me first explain my thinking.

As I held Lana's assessment question in mind (about how to be happy after her surgery) along with her test results, I thought about the indications that she possibly covered up underlying shame and self-doubt with overconfidence. If these test results were accurate, they were relevant to Lana's happiness, as shame might keep her from being satisfied with her surgery, and any overcompensation for shame could interfere with her social relationships. In an attempt to explore these findings and open a discussion about possible shame, I asked Lana to do a test called the Thurston Cradock Test of Shame (TOS; Thurston & Cradock, 2009). This choice was part of an assessment intervention in that I had a previous idea based on the standardized testing of what Lana might do with the TOS, and I hoped it might lead to a discussion of test findings that otherwise might be difficult for Lana to hear. The TOS consists of 10 cards with drawings on them of scenes relevant to shame. For example, one drawing shows a baseball player who has just struck out at bat and lost the game for his team; another shows a man who comes upon his co-workers gossiping at the water cooler (possibly

about him); and yet another shows an adolescent girl examining a series of pimples on her face in a bathroom mirror. I selected these three and a few other cards and asked Lana to tell me a story to each that fit with the drawing. I quickly noticed aspects of her stories that were consistent with the hypotheses I had developed from the MMPI-2 and Rorschach results. For example, this is Lana's story to the picture of the girl looking in the mirror, with my prompts interspersed:

This is a girl who is upset because she has a date with a boy she has been wanting to go out with, and the day before the date she suddenly develops six really bad pimples. She's looking in the mirror thinking about whether she should cancel the date. [SF: What is she thinking and feeling?] She's a little upset, because she really likes this boy and thinks he is attractive. And at first she thinks about making up some excuse and calling him to cancel the date. But then, she realizes that this is a chance to find out what kind of person he really is. If he still likes her with the pimples, then it's because he appreciates her intelligence and her personality. If he never calls her back, then he must be a shallow person. And so she decides not to let the pimples bother her and doesn't even make a big effort to cover them up and goes on the date. [SF: What happens after?] They have a really good time and he kisses her at the door. And she goes to bed thinking, "He didn't care about the pimples! He passed the test!"

Her other stories were equally positive, and I thought that several of them verged on being unrealistic. For example, in Lana's story, the man who comes upon his co-workers gossiping at the water cooler hears them talking about how much they like and admire him. To my eye, the co-workers' faces look somewhat arrogant in the drawing.

After several cards, I stopped, and we had the following discussion:

SF: *Let's stop here and talk. Anything you notice about your stories?*

L: *Not really. How about you?*

SF: *Well, I was struck by these cards showing three situations where people might feel insecure or bad about themselves, and in your stories all the characters are—*

L: *Self-assured!*

SF: *That's a good word. Do you relate to that?*

L: *Well, I can have my moments of insecurity, but most of the time I'm pretty confident. Some of my friends even say that I'm pushy.*

SF: *That's interesting. What do you think?*

L: *I think that I spent a lot of my life not knowing what I wanted and now that I'm clear I don't want to waste time. My motto is, "If you want something, you have to go for it. No one is going to do it for you." I think that's the key to happiness. Don't you agree?*

SF: *I do think being your own advocate is really important. And I'm impressed by your ability to do that. I'm also interested in the moments of insecurity you mentioned. Would you tell me more about those?*

L: *Well, I try not to focus on them, but they're probably there all the time, and they used to stop me more. Working with Dr. K has helped a lot.*

SF: *And can you think of a situation where they come up?*

L: *Well, like I said last week, when I'm singing in public. If I let myself, I can start worrying about how people see me, or about my appearance, or about whether my songs are any good. So I just try not to go there.*

SF: *That makes sense, especially when you're performing! But I wonder if there would be anything to gain by exploring those insecurities at another, more convenient time.*

L: *(smiling) Well, they might make for some good song lyrics! But do you see anything else?*

SF: *Well, as a psychologist, I know that when people push feelings to the side, they sometimes pile up and come back and bite them in the butt later. I wouldn't want that to happen to you after your surgery. Also it sounds like if you aren't aware of those feelings, it could lead to others seeing you as pushy.*

L: *Hmmm . . . I see that.*

SF: *And maybe this is just me, but I think feelings of insecurity are pretty human and normal, as long as they don't take over. The road to happiness is not necessarily to be some kind of "superwoman" who never feels insecure.*

Lana agreed again, and I suggested an experiment with the TOS cards. I asked Lana to retell stories to several of the cards we had previously used, and this time to let the characters feel and stay with any insecurity that came up. This led to a very interesting shift, visible in the end of her story to the card depicting the girl looking at the pimples:

L: *. . . the girl isn't sure whether to cancel the date or not, because she's not sure that she'll be relaxed enough to be at her best. [SF: And how does it end?] She calls a friend and talks it over with her, and after discussing it she decides to go on the date. She still feels a little unsure, but she thinks she'll be able to manage it okay.*

SF: *How was that?*

L: *Good. I get what you meant about it being more human.*

SF: *Good, I'm glad. And did you notice anything else?*

L: *I'm not sure . . .*

SF: *In this story the girl gets help from a friend. In the other ones, people handle everything by themselves, or everything is so good they don't need help.*

L: *I didn't see that. That's like when I was thinking of cutting off all my friends and moving away. I don't want to do that! I need my friends.*

- SF: I'm glad you know that, because I think so too. Everyone needs support to be happy. Do you see how this relates to your question of what else you need to be happy after your surgery?
- L: I do, and I'm really glad we talked about this. And I just realized—I am definitely going to keep seeing Dr. K after my surgery. I think that will really help me.
- SF: I completely agree.

Summary/Discussion Session

A week after the assessment intervention session, Lana and I met to discuss the assessment results in more detail and to address her assessment question. Typically in TA, I brief referring therapists and get their input prior to such summary/discussion sessions (Finn, 2007). And very often, referring therapists are invited to attend such sessions to support their clients. In my SRS assessments, because my evaluation is supposed to be an independent review, I don't involve referring therapists in that same fashion, and Lana and I met alone. When I checked in with Lana at the beginning of the session, I was once again impressed with how much inner work she had done since the last session. She had talked to Dr. K about what we had discussed, and especially about her needing others to be happy, and she had asked Dr. K to keep working with her after her surgery. As I expected, Dr. K agreed. Lana thanked me again for the previous session and for all the work we had done together.

Because I suspected it would be on Lana's mind, I began the session addressing whether I felt comfortable writing the second referral letter for her SRS application. I told Lana that if she felt clear to go ahead with the surgery, that I would wholeheartedly support it. She sighed and smiled, and I paused for a moment and smiled back. I then explained my thinking: (1) her desire for SRS was based on gender dysphoria and not some mental disorder; (2) she had good knowledge of the surgery and a realistic appraisal of its outcome; (3) she had taken the necessary steps recommended by the *Standards of Care* to prepare for the surgery (such as living as a woman for over a year); and (4) she had sufficient psychosocial support for after the surgery. I also told Lana that I could write Dr. X that she had honestly and deeply explored her desire for gender reassignment and that because of this I had no reservations about recommending her.

Lana told me that she did indeed feel clear about going ahead, and she was very happy to have my support. She said, "I learned things about myself that I never imagined, and now I feel even more certain that I want to have my surgery." We talked a bit about what would be contained in my referral letter to Dr. X, and I said that I would like Lana to review it before I sent it. We agreed that I would also send a copy to Dr. K. I asked Lana how she felt knowing that I could recommend her, and she said, "Thrilled and excited, and like I am nearing the end of a long road."

I next turned to Lana's assessment question, "Is there anything else I need to do to be happy as a complete woman?" As I read it aloud, we both smiled at the phrase "complete woman," remembering our discussions of what the vaginoplasty could and could not do for Lana. She immediately spoke up and said, "Can I reword that? How about 'Is there anything else I need to do to be happy as a transsexual woman?'" I nodded and suggested we answer this question together based on what we had learned during the assessment; I then gestured for Lana to go first. She gave a lovely summary about needing to be realistic that she might "pass" in public on some occasions, but that she didn't want to be crushed if this didn't happen. Lana said she was embracing a new identity of being a "third gender," and that she looked forward to becoming more politically involved in the trans community. She also talked about wanting to be aware of fear and insecurity and to lean on others instead of pushing such feelings aside and plunging ahead. She said, "I love how strong I am, but I also want to embrace my softness. After all, isn't that also a part of being a woman?"

I added to Lana's summary by showing her the results of her MMPI-2 and briefly going over the Rorschach results. I emphasized that she was a well-functioning "sturdy survivor" with no major psychological difficulties, and that there were some indications of underlying shame and insecurity. As soon as I said this, Lana said, "Ever since we talked about that, I've been more aware of how I run past such thoughts and feelings." I asked for an example, and she told of having seen several beautiful women shopping over the weekend and having caught herself "putting down" her own appearance afterward. I asked Lana what she felt when she did this, and she said, "I noticed it because I started to feel a bit depressed. But then when I caught it, I was able to stop it." I congratulated her and asked, "And if you don't put yourself down, but leave room for other feelings when you think of those beautiful women?" Lana paused and thought, then teared up and said, "I feel sad." I gestured for her to go on, and she continued, "However much I want, I'll never be one of those women, because I was born in a male body." "Yes," I replied gently, "and that is a loss. One you can cope with, but nevertheless a loss." Lana thanked me for acknowledging that, and then laughed and said, "I just did it again, didn't I? I was all ready to push those sad feelings away on my own. But with your support, I got to another level that is important." I agreed and said, "And this loss is one you'll continue to need support about." Lana agreed and reaffirmed her plan to keep working with Dr. K after her surgery.

Shortly after this, as our session moved to a close, I asked Lana for feedback about her experience of the assessment. She said,

To be honest, although I understood why I had to get a second letter, at the beginning there was a part of me that resented having to spend the time and money seeing you. I thought I was all ready for my surgery, and that this was just a hurdle slowing me down. Now, I can't thank you enough. As I said, I learned really important things about myself and those are going to help me after my surgery. In fact, they're

already helping me. When I talk to other people, I'm going to tell them how worthwhile this process is.

I told Lana I was very happy to hear this and that I had really enjoyed working with her and had been inspired watching her courage during the assessment process. I told her I would write my referral letter within the next week and seek her approval before sending it. Lana also asked me to communicate the assessment findings to Dr. K. We then said good-bye, with Lana promising to keep in touch as she went ahead with her next steps. After she left, I sat for 10–15 minutes pondering my work with Lana and admiring her mix of “stubbornness” and openness.

Referral Letter

Figure 21.1 presents excerpts of the referral letter I wrote to Dr. X recommending Lana for SRS. Lana reviewed this letter and made a few small factual corrections to the background information. A month after I sent the letter to Dr. X, Lana sent me an email telling me that she had been accepted for SRS and was scheduled to go to Canada six weeks later. She was bringing a friend with her for support, and she said she would contact me after she was back in town for a follow-up appointment.

Figure 21.1 Excerpts From Letter Referring Lana for SRS

Dear Dr. X,

I am writing to recommend Ms. Lana Sterling for Sex Reassignment Surgery at your clinic. Lana first consulted me in January 20XX, at the recommendation of Dr. K, with whom she has been working in psychotherapy for 16 months. Dr. K recommended me because of my extensive experience evaluating and preparing transgender clients for medical intervention. I conducted an independent evaluation of Lana in keeping with the *WPATH Standards of Care*, and I can strongly recommend Lana to your program. Let me summarize the basis for my recommendation.

Gender Dysphoria

Lana described a lifelong desire to be a woman, which she had repeatedly denied in an attempt to fit into the world around her. Finally, due to her intense gender dysphoria and a growing sense that “time was running out,” Lana began working with Dr. K in psychotherapy 20 months ago. This began a slow and gentle process of Lana’s coming to terms with her female gender identity. With Dr. K’s assistance, Lana has changed her legal status from “M” to “F” and has been living full time as a woman for 13 months. She has come out to her children from a former marriage, and they are now accepting of her current gender. Over the last year, Lana has received feminizing hormone therapy from Dr. N, and is happy with the way her body has changed. She has researched SRS extensively, and now feels she is ready to undertake vaginoplasty.

(Continued)

Figure 21.1 (Continued)

Absence of Serious Mental Disturbance

As part of my assessment of Lana, we collaborated on several standardized psychological tests, the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) and the Rorschach inkblots (Comprehensive System scoring). I also spent over eight hours talking to Lana about her life and her current functioning. On the basis of all these sources of information, I have concluded that Lana has no serious mental disorder, including psychosis, personality disorder, depression, or body dysmorphic disorder, and that her desire to change her gender is due to gender dysphoria and a desire to make her body more congruent with her gender identity. Although Lana has had some periods of depression in the past (not at all uncommon, as you know for transgender individuals), she reports that she currently feels calmer and more content than ever in her life, and the test results bear this out.

Psychological Strengths

The testing also revealed that Lana is a sturdy, determined woman with many psychological strengths. She is intelligent, thoughtful, and insightful and has a great deal of creative talent as a musician/songwriter. As you surely know, some individuals seeking SRS are reluctant to explore their multifaceted feelings about such a change for fear that they will be judged unsuitable for surgery. Of all the people I have assessed for gender reassignment, Lana stands out as having looked honestly at her motivations and feelings about SRS and as having confronted a number of deeper issues. Whenever we met, I often found that I had learned a great deal from Lana and her self-exploration.

Stable, Responsible Life

Lana currently works as a medical technician at Smith Healthcare, a position she has held for eight years. She earned and saved the money for her vaginoplasty herself and has also paid for her hormone therapy, for electrolysis, and for speech therapy. Her medical insurance covers her psychotherapy with Dr. K, and Lana plans to continue working with her after her SRS. Lana was very responsible during our sessions, coming to scheduled appointments, paying her bill on time, and “working” psychologically in between our meetings. Lana does not use drugs and drinks only occasionally. I have no doubt that Lana will be able to reliably engage in the post-surgical self-care required.

Social Support

Lana attends a transgender support group regularly and plans to do so after SRS. She has good friends she spends time with regularly, and often plays together in public with other musicians. As mentioned earlier, she plans to continue working with Dr. K. During our work together, I saw Lana take steps to consolidate her identity as a transgender woman, and I will not be surprised if she turns out to be a leader in the transgender community.

In summary, I recommend Lana Sterling to you for SRS without any reservations. She is well prepared for and has a realistic understanding of what the vaginoplasty can do for her. In my judgment she has an excellent prognosis for a successful post-surgical adjustment.

Please feel free to contact me if you have any questions.

Sincerely,
Stephen E. Finn, Ph.D.
Licensed Psychologist (TX #23064)

Follow-up

As it turned out, Lana and I didn't meet again until seven months after her successful vaginoplasty. We did communicate briefly when she went to Canada for her surgery. (I sent a card wishing her well, and she sent an appreciative email in return.) When she scheduled the follow-up appointment, she explained that she had thought of contacting me many times, but that "time, money, and life" had gotten in the way. When she arrived, I was struck by how "centered" and happy she seemed, and she spent the first part of the session filling me in on the surgery, her recovery (which had gone well but was challenging), and her current life. The biggest news was that she had a new romantic relationship with another post-surgical M-F transsexual! "Kendra" was a successful pilot for one of the major airlines, and she and Lana had taken several wonderful trips over the last several months. The two of them were discussing living together, and Lana was very excited about having found a partner. She was continuing to see Dr. K regularly, and told me that she was very pleased with her surgery. She said she was "passing" at times and embracing "third gender" status when possible/necessary.

Towards the end of the session, I asked Lana for feedback about the assessment we had done, and she said she considered it "one of the most important things" she could have done prior to her surgery. She said she especially appreciated my confronting her unrealistic fantasy of being a "complete woman" after the surgery, as well as how kind and respectful I had been. I told her how much of a privilege it had been to assist in her personal growth, and we parted with a spontaneous hug and my wishing her much happiness.

Conclusion

Is it possible to conduct screening evaluations for Sex Reassignment Surgery in a way that is professionally responsible, yet also respectful of the dignity and humanity of the client applicant? I believe it is, and I have tried to demonstrate in this chapter how the principles and techniques of Therapeutic Assessment lend themselves to this enterprise. Interestingly, I developed Therapeutic Assessment during a period of my life when I was working regularly with transgender clients and assessing some of them for medical interventions. Writing this chapter has given me a chance to reflect on how this work impacted the ways I do assessment. I now see that my assessments of transgender clients helped me develop my ideas about Therapeutic Assessment and were foundational in my articulating the core values of this new assessment paradigm. Because I had empathy for gender-variant clients, in part from my own experiences as a gay man, I felt compassion for those clients who sought my help, and I found I had to develop my own way of doing screenings for medical interventions that differed in important ways from the way other colleagues I consulted with approached this work. Happily, this was also an era in which political awareness was growing about the rights and struggles of transgender clients (APA, 2008a),

and this awareness has led to major changes in the *WPATH Standards of Care* and in the diagnostic nomenclature used with these clients (APA, 2013). The current *Standards* are more collaborative than previous editions, and the *DSM-5* terminology is less pathologizing. Also, other experts in assessing transgender clients now articulate principles and procedures that are very much in line with those I developed. For example, I highly recommend the book I referenced earlier by Lev (2004) for those of you wanting to read more in this area.

As I told Lana, working with her and other transgender clients has greatly changed the way I view and think about the world. For example, I have an acute awareness of how unnecessarily gendered much of the world is, and I have used that awareness to good result. To give a simple illustration, in my office building there are two “one-seater” restrooms in the lobby that for years were labeled as being for “Men” and “Women.” This created an all-too-common problem that clients would be waiting for the “appropriate” restroom, while the other remained unoccupied. One day, in one of our business meetings for the building, several colleagues and I lobbied to remove the gender signage from the bathrooms. Since only one person at a time could occupy each restroom, why did we need to restrict them according to gender? I was surprised by the resistance shown by several professionals in the building, who carefully explained to me that it would be offensive to women clients to see a urinal next to the toilet in the “male” bathroom! I was also told that women needed their own restroom because “they take longer than men,” and when I gently pointed out that women’s being able to use the second bathroom would mean they had to wait for less time, I was met with blank stares. When we renovated the bathrooms a year later, the consensus was to try nongendered restrooms, and one of the colleagues who was against the change has since told me that it has made her life better.

Writing this chapter has also given me a chance to reflect on how the assessment I did with Lana particularly impacted me. I believe the part that touched me the most was the work Lana and I did about “shame covered by confidence.” Seeing this dynamic in Lana helped me identify it in myself and has aided me in working on my own counter-dependence. As a gay man who grew up in a small rural town in the 1960s and 1970s, I developed a great deal of shame about my sexuality. I came out in college in the 1970s and gradually developed a proud, confident, gay “sturdy survivor” persona. This served me well, but it also impacted my personal relationships. After Lana and I worked together, I was more aware of my tendency to hide my self-doubt and insecurities, or as she described, to “just not go there” when such feelings came up. Like Lana, I have needed reminding that I can turn to others for support, and her articulating that lesson drove it home again and has helped make my life richer and happier.

In closing, I hope that this chapter will inspire other assessment psychologists to get training in working with transgender clients and to incorporate Therapeutic Assessment into screening assessments required for medical interventions.

Practical Points

- Read the resources in the annotated bibliography at the end of this chapter. They give an excellent overview of research on transgenderism and summarize the political, social, and professional issues involved in working with transgender clients.
- Consider attending the yearly summit sponsored by the Center of Excellence for Transgender Health (www.transhealth.ucsf.edu), where you can take part in continuing education workshops, hear summaries of the latest research, and meet a wide variety of transgender individuals and the professionals who work with them. The Center for Excellence also publishes treatment protocols for professionals working with transgender clients.
- Look for and participate in continuing education programs on working with gender-variant clients. The American Psychological Association and some state and local psychological associations sponsor these workshops from time to time.
- Watch movies that feature transgender characters to get a better sense of what it is like to be transgender. Some that I recommend are *Ma Vie en Rose [My Life in Pink]* (1997), *Southern Comfort* (2001), and *Transgeneration* (2005).
- If you live in or are close to a large city, visit a support group for transgender individuals or for their friends and families, and let them know that you are wanting to learn more about what it is like to be transgender. Local chapters of PFLAG (<http://community.pflag.org/page.aspx?pid=212>) often organize support groups for families and friends of transgender people. If there are no support groups in your area, visit one of the online forums/groups; many are listed at <http://iamtransgendered.com/SupportGroups.aspx>.
- Get consultation and supervision from other mental health professionals who have experience working with and assessing transgender clients. If there are none in your area, you can locate experts through the website of the World Professional Association for Transgender Health (www.wpath.org).
- As you take any of the steps above, do explore your own reactions, feelings, beliefs, and thoughts, no matter what they are. Because of the way gender is conceptualized and treated in traditional Western cultures, it is very likely that you will experience a variety of reactions.

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Comment: This slightly dated but excellent report commissioned by the APA gives an excellent summary of how psychologists can support transgender individuals.
- Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender variant people and their families*. New York, NY: Haworth Press.

Comment: This comprehensive books gives an excellent summary of the research and issues relevant to working with gender-variant people and spells out a strengths-based approach for mental health professionals treating such clients.

World Professional Association for Gender Health (WPATH). (2012). Standards of care for the health of transsexual, transgender, and gender nonconforming people, version 7. *International Journal of Transgenderism*, 13(4), 165–232. doi: 10.1080/15532739.2011.700873

Comment: Although this document is criticized as paternalistic by some transgender rights groups, it lays out the standards of care that many medical professionals adhere to in conducting medical interventions with transgender individuals. Every mental health professional working with transgender clients needs to be familiar with these guidelines.

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