



RESPONDING TO TRANSGENDER VICTIMS of Sexual Assault

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Transgender victims, like all victims of sexual assault, want and deserve to be respected, heard, believed, served, and supported. This guide will help you do just that.

- [About This Guide](#) describes why the guide is necessary and offers a list (by no means exhaustive or authoritative) of common transgender-related terms.
- [Transgender 101](#) covers the basics of what it means to be transgender. If you need a general understanding of transgender-related issues, read this section first.
- [Sexual Assault in the Transgender Community](#) reveals the quite high rate of sexual assault within the community and also covers community ramifications.
- [Tips for Those Who Serve Victims](#) is where you'll find provider-specific advice on how best to serve transgender victims of sexual assault.

Whether you are a health care provider, law enforcement officer, emergency medical personnel, sexual assault advocate, therapist, or support group facilitator, this guide will help you deliver culturally sensitive, respectful care when working with transgender victims and their loved ones.

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Message From the Director

People who are transgender or gender non-conforming come from all walks of life. They represent all ages, cultural and ethnic backgrounds, and socioeconomic status, and they live in communities throughout the Nation. As our country becomes more open to diversity—as demonstrated by the gradual acceptance of lesbian, gay, bisexual, and transgender (LGBT) populations—transgender individuals are becoming more visible. When they are victimized by crime, they need and deserve the same level of skilled, compassionate care as other victims, but that right is not yet a reality.

Members of the transgender community are among the most misunderstood and marginalized of populations, leaving them vulnerable to sexual violence. This vulnerability, coupled with past discrimination, stereotypical perceptions, and other barriers to service, means lost opportunities for justice and healing. Yet another concern is that frequently, victims must explain to service providers what it means to be transgender in order to receive culturally competent care. When faced with this lack of understanding, many victims forgo seeking assistance out of fear, mistrust, or frustration. But they urgently need our help.

Historically, many transgender victims of crime have had limited or no access to culturally competent services to prevent and address the violence against them.¹ Through a 2009 cooperative agreement with FORGE, Inc., OVC funded the development of *Responding to Transgender Victims of Sexual Assault*, an online guide to help educate those who respond to sexual assault victims about what it means to be transgender and how to provide these victims with appropriate, accessible care. This groundbreaking resource reflects the perspective of the transgender community, which has gone unheard in mainstream victim assistance for far too long. It is our hope that professionals representing many victim-serving disciplines will find the guide useful in developing community collaborations and protocols to ably serve transgender victims of sexual assault.

The guide presents a wide array of information in a user-friendly electronic format that allows practitioners to pick and choose the information that is most useful to them, from basic information about the transgender experience to specific guidance for sexual assault service providers and advocates, law enforcement officers, medical and mental health care providers, and support group facilitators. It includes practical tools to promote understanding and support of transgender victims, such as preferred language terms. Everyone is encouraged to review the guide's core resource, "Transgender 101," to gain a basic understanding of this population before accessing the educational provider-specific sections.

We hope that you will find this guide to be invaluable in preparing you to serve transgender victims of sexual violence, as well as helping to build more enlightened communities. We welcome your ideas for additional resources to enhance our collective cultural competence as we strive to serve *all* victims of crime.

Sincerely,
Joye E. Frost
Director

¹ National Center for Victims of Crime and National Coalition of Anti-Violence Programs, 2010, [Why It Matters: Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender, and Queer Victims of Hate Violence & Intimate Partner Violence](#), Washington, DC and New York, NY: National Center for Victims of Crime and National Coalition of Anti-Violence Programs.

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About This Guide

Why This Guide?

For most people, it is normal to be excited or curious when meeting someone with an identity or experience significantly different from their own. This can often spark a desire to ask personal questions with the intention of learning more. While this is an understandable interest, it is important to remember that transgender individuals are asked these questions frequently. Even if well-intentioned, some questions can feel invasive, inappropriate, or even hostile. This is especially true when the person is trying to access care.

A common concern voiced by transgender individuals is that they have to describe what it means to identify as transgender in order to receive sensitive care and services. For example, 50 percent of transgender individuals who participated in the National Transgender Discrimination Survey (NTDS) reported having to provide basic information about their transgender identities, experiences, or bodies before they were given medical services.¹ As a result, many transgender individuals avoid accessing routine and emergency care out of fear or because they don't want to have to educate their providers. If you demonstrate preexisting knowledge of transgender identities and experiences, transgender individuals may feel more comfortable when accessing care, which may increase the success of your services.

Another all-too-common complaint relates to having experienced prejudice, discrimination, or violence, even when accessing medical and social services. According to several studies and surveys, for example—

- Fifty-three percent of transgender respondents to NTDS have been verbally harassed or treated disrespectfully in places of public accommodation, and 44 percent have been denied service because of their transgender identity. Twenty-two percent of respondents who have interacted with law enforcement officers have been harassed by them, 20 percent have been refused assistance, 6 percent have been physically attacked by an officer, and 2 percent have been sexually assaulted by an officer. Transgender people of color faced higher rates of prejudice and violence, with up to 38 percent reporting harassment by officers.²
- Seventy-seven percent of transgender people have felt physically unsafe in public.³
- Twenty percent of transgender people have experienced discrimination in a social service agency, from both clients and staff.⁴

On top of these high rates of discrimination and prejudice, transgender individuals also experience high rates of sexual violence. According to several studies, more than 50 percent have been sexually assaulted at some point in their lives.⁵

Because transgender people make up a relatively small portion of the population (approximately 0.3 to 3 percent),⁶ service providers may wonder about the cost-benefit ratio of providing additional training or

modifying practices to meet transgender victims' needs. We believe that the concept of universal design—borrowed from the disability rights movement—applies. If the physical world is designed in accessible ways, the structures will better serve all individuals, whether they have disabilities or not. Likewise, if you construct service delivery systems to serve the most marginalized individuals effectively (e.g., transgender clients), these systems better serve all clients. A little effort devoted to increasing your cultural competency regarding transgender victims of sexual assault will have positive, unanticipated results for non-transgender victims as well.

Most professionals already possess what is required to provide victims of sexual assault with respectful and appropriate care:

- **Knowledge:** Knowledge about what is required to provide the service the victim is seeking or needs.
- **Skills:** Ability to ask appropriate questions, listen to the victim's responses, and have those responses shape the services being provided.
- **Attitudes:** Belief that being a professional means serving all victims with respect and fairness, even if that requires (temporarily) ignoring personal beliefs, judgments, and emotions.

With an enhanced understanding of transgender-related issues, professionals and providers who serve victims of sexual assault can be sources of support and care for all victims, including individuals in this high-risk population.



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Information in the Guide

This guide compiles information from multiple quantitative and qualitative datasets as well as collected experiences from transgender survivors who have navigated sexual assault services and from providers who have worked with transgender survivors.

Primary data are largely based on several key studies:

- FORGE's 2004 "Sexual Violence in the Transgender Community Survey" (n=254).
- FORGE's 2011 "Transgender Individuals' Knowledge of and Willingness to Use Sexual Assault Programs" survey (n=1,005).
- FORGE's 2011 "Assessment of Sexual Assault Programs' Efforts to Welcome Transgender Survivors and Appropriately Serve Them, Including Training Preferences" survey (n=310).
- National Center on Transgender Equality and National Gay and Lesbian Task Force's 2011 "National Transgender Discrimination Survey" (n=6,400).

The guide provides practical information supported by the experiences of transgender survivors and some specific challenges that victim service providers may encounter. When possible, information is supported by cited research, which is notably sparse.



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Language

The most important information to know about language in this publication is that **no single term or definition for any given concept is the only term or definition.**

Instead of rigidly following the terms and definitions found here, listen to what the people you are serving say, and mirror what they say.

Keeping this in mind, the following are working definitions for this guide and are not intended to be universally accepted or applied. Do not "correct" victims you are serving if their self-definitions differ from what is found below.

Binary gender

The socially constructed concept that there are only two genders: male and female.

Cisgender (or non-transgender)

Non-transgender individuals who are comfortable in the gender they were assigned at birth.

FTM, or female-to-male

An individual who was assigned female at birth but who may now identify as male or who may have taken medical, legal, or social steps to present in more masculine ways.

Gender expression

How a person expresses gender through clothing, grooming, speech, hair style, body language, social interactions, and other behaviors.

Gender identity

An individual's internal sense of being male, female, or another gender (not necessarily visible to others).

Gender non-conforming

A person who does not adhere to traditional binary gender identity, roles, or expression.

Gender vector

The direction a person's gender may be moving, for example, toward a more feminine or a more masculine identity or expression. The term "gender vector" acknowledges that gender is not necessarily binary (or does not have an end point) and that many peoples' identities evolve over time.

MTF, or male-to-female

READ MORE

In this e-pub*—

- Five Keys to Service: [Don't Categorize; Use Your Client's Terms](#)

*Clicking these links will take you to other sections in this e-pub. To return, hit your browser's "back" button.

READ MORE

- [101 Trans Identity Words](#)

An individual who was assigned male at birth but who may now identify as female or who may have taken medical, legal, or social steps to present in more feminine ways.

Pronouns

Words that can be used to refer to an individual in place of their name. Common masculine pronouns include he, him, his; common feminine pronouns are she, her, hers. Some transgender individuals use gender-neutral pronouns (e.g., ze, s/he, sie, hir), and the singular use of "they" is growing in popularity.

Questioning

An identity or a process of introspection whereby a person learns about their gender identity. This process can happen at any age or at multiple times throughout one's life.

SOFFA

An acronym for significant others, friends, family, and allies. Everyone is a SOFFA to many others. Everyone has a SOFFA circle—the people around them who are a part of their life.

Transgender, or trans

An umbrella term that encompasses a wide range of people whose gender identity or expression may not match the sex they were assigned at birth. "Trans" is used as frequently or more frequently than "transgender."

Transition

Process and time within which a person goes from predominantly being seen as one gender to predominantly being seen as another gender.

READ MORE

Gender Neutral Pronouns.

FORGE's quick reference guide to the more common traditional and gender-neutral pronouns.

In this e-pub*—

- Transgender 101: [Pronouns](#)

*Clicking these links will take you to other sections in this e-pub. To return, hit your browser's "back" button.

TRANSGENDER

The term "transgender" was coined in the 1970s by Virginia Prince. Prince recognized that some people do not want to take medical steps (hormones or surgery) to live in a gender not assigned at birth and that some peoples' identities are not captured by the words "transsexual" or "transvestite" (a word no longer in common use). She created the word "transgender" to encompass those who don't have words to adequately describe their experiences and identities. She acknowledged that living as male or female is not linked to medical actions and that people's identities and choices about how to embody gender are complex.

At the time, "transgender" described people who fell between genders and who did not want surgical intervention to "change sex." Today, it is an umbrella term that encompasses a wide range of people whose gender identity or expression may not match the sex they were assigned at birth. FORGE uses "transgender" and "gender non-conforming" to cover hundreds of gender identities, histories, experiences, and expressions, including—

- People who have transitioned from one gender to another (many who transition move from identifying as "transgender" to identifying as either male or female).
- People who intend to transition from one gender to another but have not yet taken any or many steps to do so.
- People who choose to use hormones and surgery and those who use neither.
- People who use hormones for a short while, or may opt for one or more surgeries (e.g., breast augmentation or mastectomy, facial feminization, gender reassignment surgery).
- People who identify as a gender other than male or female.
- Cross-dressers and others who identify as one gender but sometimes dress in clothing usually worn by another gender.
- People who perform as another gender (professionally or not), such as drag performers (both female and male drag).
- People who do not visibly conform to gender stereotypes (whether they want to conform or not).

Although this guide primarily uses the term "transgender," FORGE presumes that many individuals more closely align with other terms (see FORGE's [101 Trans Identity Words](#)).

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FORGE is widely viewed as the national expert on transgender trauma and violence. Founded in 1994, FORGE's work has evolved from general support of transgender individuals and loved ones to incorporating the Transgender Aging Network in 2000 to extensively focusing on anti-violence issues since 2004. FORGE has been federally funded since 2009 to provide training and technical assistance to victim service professionals on how to better serve transgender survivors of sexual assault, domestic violence, stalking, dating violence, and hate crimes, and to provide direct services to transgender survivors of sexual assault. It is also a partner in the federally funded National Resource Center on LGBT Aging, funded through the Administration on Aging.

FORGE is an active member of the National Coalition of Anti-Violence Programs, the New Beginnings Initiative working on federal LGBT improvements, and the LGBT Aging Roundtable. It actively partners with other anti-violence agencies, statewide coalitions, and transgender/LGBT organizations to enhance the collective work of reducing violence and harm against transgender individuals and improving the cultural competency of professionals working with transgender victims. FORGE maintains a rich selection of free online trainings, fact sheets, publications, and other materials on [its Web site](#).

Multidisciplinary Advisory Council

FORGE is grateful to the dedicated professionals across the country who served on the Multidisciplinary Advisory Council, which reviewed early drafts of some portions of this guide:

- Avy A. Skolnik—Ph.D. graduate student with extensive experience in transgender anti-violence issues, New York, NY.
- Debra K. Donovan, R.N.—Sexual Assault Nurse Examiner, Sexual Assault Treatment Center, Milwaukee, WI.
- Wendy J. Murphy, J.D.—Attorney, New England School of Law, Boston, MA.
- Curt Rogers—Executive Director, Gay Men's Domestic Violence Project, Boston, MA.
- Cpl. Michael G. Hemond—Law enforcement officer, Burlington Police Department, Burlington, VT.

Consultants

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- Eli R. Green, M.A., M.Ed.—Editor.
- Iore m. dickey, Ph.D.—Data analyst and principal investigator.
- Mary Woodruff—Librarian and citation expert.

Demonstration project sites

FORGE is indebted to the four demonstration sites also funded under this project, which provided it

with deeper insight into the challenging issues of working with transgender victims of sexual violence and which continue to work diligently to improve service provision and healing for survivors within their communities. The four communities are—

- Iowa City, IA.
- Boulder, CO.
- The State of Maine.
- Boston, MA.

Survivors and providers

This guide would not be possible without the thousands of transgender survivors and loved ones who courageously shared their stories and experiences and the hundreds of victim service providers who reached out for technical assistance or shared their challenges and successes in working with transgender victims.

Office for Victims of Crime

FORGE is grateful to OVC staff for their dedication to improving the respectful, competent treatment of transgender survivors of sexual assault and for the funding needed to develop this guide. FORGE particularly wants to thank—

- Joye Frost, Director.
- Kathleen Gless, Victim Justice Program Specialist.

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The Office of Justice Programs (OJP) provides federal leadership in developing the Nation's capacity to prevent and control crime, administer justice, and assist victims. OJP has six components: the Bureau of Justice Assistance; the Bureau of Justice Statistics; the National Institute of Justice; the Office of Juvenile Justice and Delinquency Prevention; the Office for Victims of Crime; and the Office of Sex Offender Sentencing, Monitoring, Apprehending, Registering, and Tracking. More information about OJP can be found on its Web site.

[U.S. Department of Justice](#)

Eric H. Holder Jr., Attorney General

[Office of Justice Programs](#)

Karol V. Mason, Assistant Attorney General

[Office for Victims of Crime](#)

Joye E. Frost, Director

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- [A National Protocol for Sexual Assault Medical Forensic Examinations](#)

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¹ J.M. Grant, L.A. Mottet, J. Tanis, J. Harrison, J.L. Herman, and M. Keisling, 2011, [*Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*](#), Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force, accessed February 4, 2011.

² Ibid.

³ J.H. Herbst, E.D. Jacobs, T.J. Finlayson, V.S. McKleroy, M.S. Neumann, and N. Crepaz, 2007, "Estimating HIV Prevalence and Risk Behaviors of Transgendered Persons in the United States: A Systematic Review," *AIDS Behavior* 12(1):1–17.

⁴ S. Minter and C. Daley, 2003, *Trans Realities: A Legal Needs Assessment of San Francisco's Transgender Communities*, San Francisco, CA: National Center for Lesbian Rights and Transgender Law Center.

⁵ FORGE, 2005, Sexual Violence in the Transgender Community Survey, unpublished data; G. Kenagy, 2005, "The Health and Social Service Needs of Transgender People in Philadelphia," *International Journal of Transgenderism* 8(2/3):49–56; G. Kenagy and W. Bostwick, 2005, "Health and Social Service Needs of Transgendered People in Chicago," *International Journal of Transgenderism* 8(2/3):57–66.

⁶ G. Gates, 2011, [*How Many People Are Lesbian, Gay, Bisexual, and Transgender?*](#), Los Angeles, CA: Williams Institute, accessed March 20, 2013; L. Conway, 2002, [*"How Frequently Does Transsexualism Occur?"*](#) accessed March 20, 2013.



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Transgender 101

It is a widely held social belief that gender is a binary concept and that there are only two sexes: male and female. Although most individuals strongly identify as either male or female throughout their lives, some don't identify as either, some identify as both or more than two genders, and others move from one gender to another in the way they identify, present, or express themselves.

Transgender 101 examines the transgender population in general, covering the estimated [number of transgender people](#) in the United States, who makes up the [transgender community](#), and [specific issues associated with transgender people](#). Review this section to improve your understanding, thereby improving your services.

WHAT'S THAT MEAN?

- [Transgender](#)



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The Numbers

During the 2010 U.S. Census, when asked to identify their sex, 51 percent of the population selected "female" and 49 percent selected "male."¹ These are the only two options offered, which does not allow individuals to note whether their current identity is consistent with the sex they were assigned at birth or whether "male" or "female" is an accurate description of their identity. As a result, most estimates of the size of the transgender population are educated guesses. The most common estimates range from 0.3 percent of the population to 3 percent.²

For the most part, these estimates refer only to people who intend to or who have already transitioned from one gender to another, which does not reflect the experiences of all transgender people. For example, "transgender" can include those who cross-dress or who transcend traditional societal norms about gender expression. Tri-Ess, an international social and support group for heterosexual cross-dressers, their partners, the spouses of married cross-dressers, and their families, believes that one in five heterosexual men cross-dress at some point in their lives.³ In addition, a growing number of individuals—particularly youth—are expressing their gender in more creative, non-conforming ways:

- Goths of all genders may intentionally cross traditional gender stereotypes, wearing makeup, fingernail polish, long trench coats, and/or wide-bottomed pants that look similar to skirts. This population is rarely counted within transgender prevalence statistics.
- Some male musicians bend gender, wearing makeup, long hair, or accessories such as scarves and jewelry typically worn by women in Western culture.

Also not included in the U.S. Census reports are intersex individuals. The Intersex Society of North America defines intersex as "a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male."⁴ It is estimated that between 0.5 and 1 percent of the population have a medical condition that falls under the intersex umbrella.⁵



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The Transgender Community

"Transgender community" is a term used to describe the diverse people who experience incongruence between the sex they were assigned at birth and their internal gender identity, who experience binary gender as restrictive or inaccurate, who do not conform to cultural expectations of binary gender, or who love someone who is transgender (e.g., partner, family member, loved one).

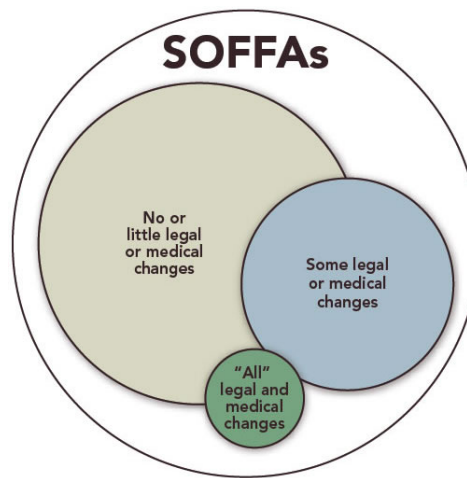
The community includes transgender people of all ages, races, ethnicities, religions, and socioeconomic backgrounds and also comprises a wide variety of gender-related experiences. Some transgender people identify very strongly as a gender other than what they were assigned at birth, while others identify as being beyond, between, or a combination of genders.

Due to media (mis)portrayals and a general lack of education about transgender people, false stereotypes and assumptions persist. For example, some believe that to "be transgender" someone must medically transition (i.e., hormones and/or gender reassignment surgeries). This is untrue. Transgender identity is not defined by a person's desire for medical interventions but on their experience that their gender identity is incongruent with the biological sex they were assigned at birth.

Another inaccurate assumption about transgender people is believing that all transgender individuals "feel trapped in the wrong body," seek medical transitions from one gender to another, and/or want to change their legal documentation to a new name and gender. This is true for some within the community, but it is not true for all.

The largest subset of the transgender community is made up of mostly non-transgender people referred to as "SOFFAs" (significant others, friends, family, and allies). These people can be subject to the same prejudices, curiosity, discrimination, and even violence as their transgender loved ones. Because each transgender person has dozens of SOFFAs, they make up the largest part of the community. Exhibit 1 illustrates the likely proportions within the transgender community who have particular identities or who have made particular choices.

Exhibit 1. The Community



The term "transgender community" can be misleading. As with every other community, only a fraction of transgender people are actively involved in community activities or are connected to other transgender people. Like everyone else, transgender people belong to a veritable cornucopia of communities in which they may or may not be active—their child's school, the religion in which they were raised, their cultural and ethnic communities, their neighborhood watch, a professional networking group, and so forth. Just as a devoted Girl Scout when age 10 may have no ongoing involvement with the organization at age 35, some transgender people view their gender identity as an issue for which they once sought support, but which no longer has much day-to-day relevance. Others actively shun the transgender community, afraid that being seen with other transgender people will draw unwanted attention to themselves.

Those who are active within organized transgender events, organizations, or the transgender or LGBTQ (lesbian, gay, bisexual, transgender, and queer) community can be broadly divided into three groups:

1. **Information seekers.** Probably the largest portion of transgender people consists of those who are new to organized transgender communities. These individuals may have thought about their own gender identity for decades, but have only recently decided to take action, get more information, and connect with other transgender people. They may seek this information through the Internet, books, in-person groups, social service providers, LGBT community centers, or mental health professionals. Information seekers often spend several years involved in transgender groups, especially if they decide to transition (to move from living as one gender to living as another). They rely on their information sources for ongoing advice and support. Then, when their new lives are better established, they may move on to other issues and activities.
2. **Long-term engagers.** These are people for whom a transgender identity remains an important part of who they are or who value the continued connection with other transgender individuals. Some lost their prior support circle during gender transition and/or feel most comfortable surrounded by other transgender people who have had similar experiences. People who cannot complete a gender transition due to family, work, medical conditions, or other reasons often spend years participating in the same groups and activities as a way of coping with those challenges. People in this category may maintain active involvement in social support groups, attending drag or performance events, regularly posting on blogs or interacting with others via listservs, and attending balls or other organized activities.
3. **Activists.** These are the people who work for social change and who want to ease the way for newer transgender people through mentoring, training professionals, participating in public education efforts, or organizing social or political events.

There is also great diversity among transgender support groups, which are designed to provide information, advice, and peer role models. Some of these groups, however, are aimed at just one segment of the transgender community. Groups may cater only to male-to-female (MTF) or to female-to-male (FTM) transgender people, for instance, while others may welcome only cross-dressers or only those who have had genital surgery. Very large communities may have separate groups based on race or another demographic variable, such as gender non-conforming poets or transgender individuals

involved in the sex trade. Some include SOFFAs, while others are for transgender people only. Some localities have transgender organizations with a specific focus, such as advocating for transgender health services or sponsoring an annual conference.

Not all transgender individuals meet in person, which could be due to personal preference or because no transgender group is available in the area. The Internet has vastly improved the ability of transgender individuals and SOFFAs to access key information and connections through a nearly infinite number of listservs, chat rooms, social media, blogs, and other virtual gatherings. Many of these have a narrow focus, such as transgender parents or heterosexual female partners of FTMs. Some are locality-based and serve as the primary communication channel for transgender and SOFFA individuals in a given area or state.

Some transgender and SOFFA individuals participate in structured and informal social activities with others in the transgender community in addition to, or instead of, attending support groups. People who participate in these activities may know each other from in-person meetings or from online venues, or they may attend more anonymous social events like drag balls. Often, people want to enjoy traditional forms of entertainment (e.g., dining, sporting events, theater, coffee, lectures) and prefer to do so in a group of other transgender and SOFFA individuals.

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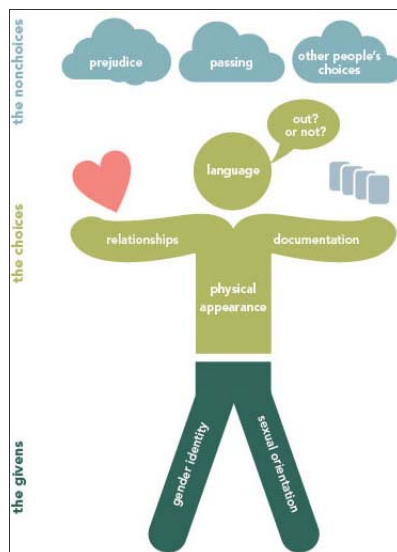
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Transgender-Specific Issues

This section covers the givens, choices, and nonchoices that help shape individual transgender people's lives (see exhibit 2). It will help you identify what you may need to know about any given transgender client to provide successful services. Perhaps more importantly, it should help determine what does not need to be known (even when well intentioned).

Exhibit 2. Givens, Choices, and Nonchoices.





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Transgender-Specific Issues

The Givens

People may conflate the terms "[gender identity](#)" and "[sexual orientation](#)." This section describes the two to help clarify the differences and also provides a few [caveats](#).

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Transgender-Specific Issues

The Givens: Gender Identity

"Sex" is what you are assigned at birth, generally based on whether you have a penis or a vagina. "Intersex" or "disorders of sexual development" are the current terms for people whose genitals and/or internal reproductive organs do not clearly fit into one of the two binary classifications and/or who have chromosomal structures other than XX or XY.

"Gender identity" is your internal sense of whether you are male, female, or another gender and is not necessarily visible to others. Because gender identity is internal—how a person sees themselves—it is impossible to know someone's gender identity without overtly asking them, which is not always appropriate when providing services to them.

For most of the general population, sex and gender identity align—the sex assigned at birth matches the gender with which they identify. Transgender people, however, have a gender identity that does not match the sex they were assigned at birth.

Everyone has a gender identity, and transgender people may have more than one. Some will align with the word transgender, although a growing number either never considered themselves transgender or do not embrace the term. For example—

- Many individuals who have transitioned from one gender to another state their gender identity as simply male or female, with some never viewing themselves as another gender. These individuals may describe a gendered past that matches their current gender identity.
- Others state that they were transgender before and during transition to another gender, but not after.
- Still others view being transgender as a medical condition, which hormones and/or surgery can correct, and no longer identify as transgender after they have medically transitioned.

FORMS OF IDENTITY

- **Self identity:** Who I say I am to myself.
- **Ascribed identity:** Who you say I am without my confirmation.
- **Disclosed identity:** Who I tell you I am.
- **Perceived identity:** Who I think you believe that I am.

READ MORE

In this e-pub*—

- Transgender 101: [The Choices](#)

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Transgender-Specific Issues

The Givens: Sexual Orientation

"Sexual orientation" describes a person's attraction (physical, emotional, spiritual, or sexual) to other people of one or more specific genders. The most common sexual orientations—among transgender and non-transgender people alike—are heterosexual, gay, lesbian, bisexual, queer, and asexual (i.e., not sexually attracted to others). However, just as with gender identity, there are countless individual identities for sexual orientation. Although gender identity and sexual orientation are often conflated and confused, it is important to remember that sexual orientation is distinct from gender identity.

READ MORE

In this e-pub*—

- Tips for Those Who Serve Victims: [Sexuality](#)

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The Givens: Caveats

What people call themselves may not, to an outsider, reflect their behavior. For example, a woman who says she is heterosexual may have a female partner; and a person who has a male gender identity may dress and appear female. There are many reasons a person's identity and behavior may not line up the way others might expect, including the following:

- **Cultural relevance.** Many of the terms commonly heard are terms used predominantly by white people.⁶ These terms may have little meaning in some cultural contexts or may not resonate for an individual with a non-Western cultural background.
- **Concerns regarding personal safety or autonomy.** Claiming a particular term may put one's physical safety, access to resources, and/or social support in jeopardy.
- **Denial** (e.g., "I'm not really transgender").
- **Wishful thinking or intention** (e.g., dressing in clothes designed for teenage girls to appear younger).
- **Opportunity** (e.g., the male-to-female transgender person doesn't dress as a woman outside of the house until she retires from the job where everyone knows her as a man).

READ MORE

In this e-pub*—

- Transgender 101: [Language](#)

*Clicking these links will take you to other sections in this e-pub. To return, hit your browser's "back" button.

Remember—

- Everyone has a sexual orientation: heterosexual, gay, bisexual, lesbian, asexual, queer, or something else.
- Everyone has a gender identity: female, male, genderqueer, transgender, Two-Spirit, stud, femme, or something else.⁷

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Transgender-Specific Issues

The Choices

It is important to know whether and when it is necessary to know a person's **identity** (how someone thinks of themselves or what is inside), and when it is key to know their **behavior** (how a person acts or the choices they make). The difference between identity and behavior will become clearer in this section, which explains the many choices that transgender people may make. Although the word "choice" is sometimes controversial within transgender circles, every individual (transgender and non-transgender) makes daily and long-term choices about how they will present themselves to the world and how they will live their lives.

One choice that transgender people make is whether they will transition. "Transition" occurs when a person goes from predominantly being seen or identifying as one gender to predominantly being seen or identifying as another gender (e.g., male to female, female to male, female to gender non-conforming). Transition can involve one or more of the following aspects:

- **Social transition.** Coming out and creating a personal environment in which a person's gender identity is known and, ideally, respected by others, such as friends, family, and coworkers.
- **Medical transition.** Using hormonal and/or surgical interventions to more closely align one's body with one's gender identity.
- **Legal transition.** Changing identity documents to have a name and/or gender marker that reflects one's current identity.

Many transgender people never transition, either because they desire no physical changes, are content to have the world see them in a way that differs from how they identify internally, or they cannot transition due to work, family, health, or financial reasons.⁸ Some transgender people simply ease into a more neutral or gender non-conforming presentation without undergoing a transition that will be noticed by others.

Some transgender individuals strongly state that transition is not a choice—that they must transition or they will die. Although this is true for some (e.g., they exhibit suicidal thoughts or behaviors), transition is a process of making choices. Some choices may be more feasible than others due to finances or living situations. Some choices may directly affect others and thus require more joint decisionmaking, negotiation, and compromise.

For those who do transition, the process is usually public. Transgender individuals, and possibly their loved ones, may be subject to a tremendous amount of curiosity, questions, judgment, and, in some cases, hostility.

Transgender people may transition at any point in their lives. Transitioning in mid- to later life—often when children move out, the person retires, parents die, or there is a health scare—is common.⁹ In

some cases (e.g., those involving hormone use), transition mirrors certain aspects of puberty, such as body changes and mood swings. People who are transitioning may experiment with different clothing styles and roles, some of which may strike loved ones and other observers as age inappropriate or even offensive. They may start negotiating changes in all aspects of their lives, including family, work, and social relationships. For all these reasons, others may view them as being self-centered, which can create challenges for any relationship.

Once someone has taken all of the steps they want to take, they may no longer see themselves as transgender, instead identifying simply as female or male. They may never disclose their gender history to others, including health care providers, new spouses, or children, because they do not view it as relevant.

The rest of this section covers many of the social, medical, and legal choices that transgender people make in more detail:

- [Language.](#)
- [Physical appearance.](#)
- [Relationships.](#)
- [Degree of "outness."](#)
- [Documentation.](#)

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Transgender-Specific Issues

The Choices: Language

This section describes language-related choices:

- [Gender identity.](#)
- [Names.](#)
- [Pronouns.](#)

Gender identity

There are hundreds of gender identities, with each term carrying numerous meanings. It is unlikely that two people (transgender or non-transgender) would define their gender identities in exactly the same way. For example, how people define "female" varies greatly from person to person. Definitions may differ based on where in the country or world someone lives, the types of familial relationships they have had with females, their age, their ethnic influences, and many other factors. Remember: Victims are always experts in their own language preferences. Listen carefully to the words that victims use to describe themselves and their bodies and reflect those words back to them.

READ MORE

In this e-pub*—

- Transgender 101: [Documentation](#)
- Five Keys to Service: [Don't Categorize; Use Your Client's Terms](#)

*Clicking these links will take you to other sections in this e-pub. To return, hit your browser's "back" button.

Here are just a few terms that transgender people may use to describe their identity:

- Genderqueer.
- Hybrid.
- Man of transgender history.
- Stone.
- Stud.
- Transensual femme.
- Transwoman.

For more, but by no means all, identity-related terms, see FORGE's [101 Trans Identity Words](#). Note that the preferred language of some victims may be perceived as offensive to others, so be careful to use the language preferences of each individual.

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Names

Generally, with some gender-neutral exceptions, many first names are considered either male or female. Some transgender people decide to adopt a name different from the name they were given at

birth, usually in accordance with their gender identity. As with anyone who has changed names, transgender people may or may not have changed their name legally or consistently.

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Pronouns

Most people in the United States only know of two sets of singular pronouns: masculine (he, him, his) and feminine (she, her, hers). The majority of transgender individuals use masculine or feminine pronouns and prefer others to consistently use those pronouns for them as well. Others feel limited by only masculine or feminine pronouns and create or adopt a vocabulary to better represent themselves. Some of these individuals prefer gender-neutral pronouns, such as ze, s/he, sie, hir, and they/their. Others use different pronouns in different settings. Still others prefer to intentionally not adhere to any one set of pronouns.

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READ MORE

[Gender Neutral Pronouns](#)

In this e-pub*—

- Tips for Those Who Serve Victims: [Preferred Language](#)
- Five Keys to Service: [Don't Categorize; Use Your Client's Terms](#)

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Transgender-Specific Issues

The Choices: Physical Appearance

This section describes choices related to physical appearance:

- [Gender expression.](#)
- [Hormones.](#)
- [Surgery.](#)

Gender expression

Gender expression, as opposed to gender identity, is what is on the outside. It is how people express their gender to others.

All people make daily choices about what clothes to wear; whether and how to use or not use accessories, jewelry, and/or makeup; and how their hair is cut or styled. Most people have a specific look or style that is personally comfortable. This may also include how individuals walk, sit, or carry themselves.

In the United States, women and men often are expected to make appearance-related choices from mutually exclusive sets of options. For example, although women may wear feminine-tailored clothing, use makeup, have a feminine hairstyle, and act "femininely," these gender expressions are very rarely considered acceptable for men. Other examples include separate women's and men's clothing departments, jewelry and watch display cases, and hygiene-related store shelves.

A growing number of non-transgender individuals are breaking traditional gender norms. Male goth youth, for example, wear eyeliner and fingernail polish; business women wear pantsuits without makeup or jewelry; metrosexual men use moisturizing products and get manicures. Although gender expression is less rigid with each passing year, in large part expectations to conform to the stereotypes remain in place.

Transgender people may decide to consistently present as male or female in alignment with societal norms. They may also deliberately choose both male and female gender expressions and thus have mixed, gender non-conforming, or genderfluid presentation. Some are more fluid about their gender expression, which they may change from day to day, hour to hour, or setting to setting either because they feel they have to (e.g., an individual chooses not to transition at work) or because they want to.

Some transgender people express gender in very traditional or overt ways to better "pass" as the gender with which they identify. For example, a male-to-female (MTF) transgender person may always wear skirts and stereotypically feminine blouses, paired with matching earrings and pristine makeup.

WHAT'S THAT MEAN?

- [FTM](#)
- [MTF](#)

A female-to-male (FTM) individual may wear a pressed oxford shirt and tie, dress pants and buffed shoes, and neatly trimmed short hair. In these cases, there is an intentional effort to send very clear, gendered messages to others.

Often, as people are in the process of figuring out what feels most comfortable for themselves, they may experiment with styles and looks. They may later relax into more comfortable clothes, or clothes that reflect their own personal sense of style, rather than basing their choices on rigid cultural norms.

Body image can play a role in how people express their gender. Transgender people generally have an even more uncomfortable or negative relationship with their bodies than non-transgender people. Some create a literal armor to hide or alter their bodies or to create a different bodily contour:

- Some FTMs (or other people on the trans-masculine spectrum)—
 - Bind their chests.
 - Wear baggy or multiple layers of clothing to help flatten the appearance of their chest.
 - Wear self-made or store-bought penile prosthetics.
 - Use prosthetics to allow them to urinate while standing.
 - Slouch or intentionally gain weight to add mass to their midsection, altering their feminine contour.
- Some MTFs (or other people on the trans-feminine spectrum)—
 - Use breast or hip forms to create a more feminine contour.
 - "Gaff" or "tuck" (i.e., pull back their genitals to create a smoother line).
 - Wear wigs.
 - Dress in a highly stereotypical feminine way to create an outward appearance of undeniable femaleness.

Safety can also be a major component of how gender is expressed. More detail about safety is found in the [Passing section](#) of this e-pub.

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Hormones

Some transgender people—but by no means all—use hormones as part of their medical transition. According to the National Center for Transgender Equality's (NCTE) groundbreaking study of 6,450 transgender individuals, 62 percent of respondents have had some hormone therapy and 23 percent hope to have it in the future.¹⁰ Hormones are available in injectable, pill, patch, and gel/cream formats.

Hormones help shift bodies into a more traditionally masculine or feminine form. Using testosterone, for example, can deepen the voice, activate facial and body hair growth, redistribute fat, cause the clitoris to enlarge, and may stimulate male pattern balding. Vaginal tissue typically becomes more fragile and less elastic and may not lubricate easily. The vaginal opening may become smaller and tighter, especially if the person does not use their vagina for consensual sexual penetration. Testosterone use usually, but not always, results in the cessation of menstrual cycles and renders the individual infertile. Using estrogen, progesterone, and anti-androgens can cause breast growth, reduce body hair, redistribute body fat, soften the skin, cause some loss of muscle mass, and increase the risk of blood clots, particularly following surgery and in people who smoke. Although mood swings are a typical side effect of hormones in the first few years of use, people who use them frequently report that hormones make them calmer and happier.¹¹

Because some of the changes from hormone use are permanent, some transgender people stop using hormones once they have achieved specific physical goals. Others stop for health reasons or because they become unable to afford hormones (which may not be covered by health insurance, even for those who have insurance). Others continue lifelong use, which is generally recommended for anyone who no longer generates their own hormones due to a hysterectomy (removal of the ovaries and uterus) or orchiectomy (removal of the testes), or due to age (when hormone levels naturally decline).

People can acquire hormones from a health care provider or clinic—the safest method—but they may also get them on the street, from friends, or online (frequently without any medical supervision or monitoring). Non-physician prescribed hormones are relatively common due to a lack of access to

health care, an inability to afford physician visits and routine laboratory tests, a preference not to see a physician, or a preference to avoid or an inability to afford psychotherapy, which a physician may require prior to prescribing hormones.¹²

SILICONE

Some MTFs inject silicone to feminize their bodies. Silicone use is particularly prevalent among MTFs involved in the sex trade because it creates a feminine appearance without the use of hormones, which may limit erectile function and reduce their employment options.¹³

Although injected silicone has an immediate outcome, it also carries many serious health risks, including migration of the silicone away from the desired area, systemic illness, and even death.¹⁴ In addition, because injection often happens in peer-based group settings and in less-than-sterile environments, needles may be re-used or shared, increasing the risk of acquiring HIV, hepatitis, and other blood-borne infections.

Note: FTM may also use silicone to alter the shape and contour of their bodies.

If people acquire hormones through a health care provider, that provider should monitor the individuals' laboratory results and physical wellness. Many providers adhere to a standard of care to guide their treatment of transgender patients, which requires that a mental health professional also be involved.¹⁵ Most standards of care require that transgender clients participate in therapy for a time, typically 3 months to 1 year, after which the mental health care provider will write a letter stating that the client is ready to start medical treatment. This "gatekeeping" model can create additional challenges. For example, transgender people who visit mental health professionals may omit certain details about their lives out of fear that they will be denied the letter required by the standard of care. Past traumas, current mental health issues, or drug or alcohol use are generally known to have been used as justification for withholding these letters. A growing number of LGBT community health clinics and individual providers, however, are moving from standards of care to informed consent models of care, giving both transgender patients and providers more flexibility, autonomy, and control over the health care process.¹⁶

The risks associated with medically supervised hormone use are in line with the risks of many other medications. Routine monitoring, moderate dosing, a healthy lifestyle (e.g., exercise, healthy diet, adequate rest, low-to-moderate stress), and well-managed medical conditions (e.g., diabetes, high blood pressure, other common or rare conditions) help to minimize the risks associated with hormone use.

Economics, access to medical care, and access to physicians who are willing to prescribe hormones often influence how and whether people obtain hormones as a part of their medical transition.

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Surgery

Non-transgender people frequently believe there is one "transgender surgery," which involves the genitals. The reality is that there is no "one" surgery and that multiple options or combinations of surgeries can help people change their bodies to be more closely in line with their gender identity. As with hormone use, health care providers operating under standards of care may require their transgender clients to participate in therapy before surgery. In fact, surgeons specializing in gender-related surgeries often require letters from two mental health professionals rather than just one.

The following data on surgeries were taken from the National Transgender Discrimination Survey conducted in 2011¹⁷:

- The most common **FTM surgeries** are mastectomy or chest reconstruction (41 percent) and hysterectomy (20 percent). Few have phalloplasty (construction of a penis) (2 percent) or other genital surgery (e.g., metoidioplasty and/or construction of testes) (3 percent) because of their high cost and frequent complications, and dissatisfaction with the results.
- **MTF surgeries** can involve breast augmentation (18 percent), facial feminization surgery (e.g., creating a less prominent brow or chin, shaving the Adams apple), vaginoplasty (creating a vagina) (20 percent), and/or removal of the testes (21 percent). Because of the danger of

attracting anti-transgender violence in public, some transgender women consider breast augmentation and facial feminization surgeries higher priorities than genital surgery.

Genital surgery, as noted above, is far more common for MTFs than FTMs. The difference in function and aesthetics may be among the reasons for this disparity, as well as the difference in cost for vaginoplasty (cheaper) versus phalloplasty (much more expensive).

On rare occasions, some transgender people who have been unable to access surgeries due to cost and/or surgeons' refusals to operate have attempted self-surgery to remove their breasts, penis, or testicles.

Contrary to popular belief, many transgender people do not feel the need to surgically alter their bodies. For that reason, combined with prohibitive costs, lack of access, and worries about functionality and aesthetics, FORGE believes that most transgender people do not have gender-related surgery. This underlying belief is supported by the National Transgender Discrimination Survey's broad sample of transgender individuals and their experiences and desires with/for surgery.¹⁹

NON-SUICIDAL SELF-INJURY

Cutting, or non-suicidal self-injury (NSSI), as a way of coping with abuse and stress is common among transgender people. In a study of 977 individuals, almost 42 percent had a history of NSSI, as compared to 4–38 percent in the non-transgender population. FTMs had substantially higher rates of NSSI. Of transgender people who were prevented from transitioning (denied letters for hormones or surgery), 50 percent had a history of NSSI.¹⁸

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The Choices: Relationships

As with any person, transgender people can be celibate, involved in a partnership, or have multiple partners at any given time. Partners may be with a transgender person throughout their gender journey (exploration and/or transition), or they may enter the transgender person's life later on.

Partners of transgender people may or may not have sexual orientations that are congruent with their partner's gender. For example, an FTM who was once part of the lesbian community as a butch may have strong social ties to the lesbian community and have a partner who identifies as a lesbian. The female partner may maintain a lesbian identity, while the FTM partner may now identify as straight or bisexual. Similarly, an MTF who was married to a woman throughout her transition may remain married. Post-transition, the MTF may now identify as lesbian, while the MTF's wife may still identify as heterosexual.

Genderqueer or gender non-conforming individuals and their partners may have already created language to encompass their gender non-conformity and may feel similarly empowered to develop creative and unique terms to describe their sexual orientation. Some younger people are reclaiming the word "queer" and using it as a positive term to describe their sexual orientations (regardless of their partners' gender), or they use terms that transcend traditional partnership language, such as friends with benefits, heteroflexible, pansexual, and polyamorous.²⁰

Sexual attraction or behavior is nearly always an area that partners address when one person socially or medically transitions. Navigating the changing dynamics of a partnership can be complicated in the best of scenarios, and it may become even more difficult if one or both partners' attraction changes.

WHAT'S THAT MEAN?

- [FTM](#)
- [MTF](#)

READ MORE

In this e-pub*—

- Tips for Those Who Serve Victims: [Relationships](#)

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The Choices: Degree of "Outness"

Mainstream society has begun to acknowledge and become more accepting of LGBT (lesbian, gay, bisexual, and/or transgender) people. Consequently, some LGBT people have felt more comfortable sharing their sexual orientation and/or gender identity with others.

To be out means that people know about a person's gender identity or history, sexual orientation, or both. Although many studies of gay and lesbian individuals have found that being out can lead to greater self-acceptance and self-empowerment,²¹ it is unclear if "outness" carries the same positive benefits for transgender people.

The choice to disclose gender history or transgender status is often on a need-to-know (or want-them-to-know) basis:

- Many transgender individuals who transition from one binary gender to another may not feel any need to disclose their gender history to others.
- Others may choose to disclose specific pieces of information about their history but not all of their history. For example, someone may be extremely out about being trans but may rarely discuss their surgical or genital status.
- Transgender people may be out to some people and not to others based on preference or necessity. For example, they may selectively disclose their gender history to new friends, coworkers, in-laws, and others once those relationships are well established.
- If transitioning on the job, people may need to disclose their intentions to direct supervisors or to the human resources department. In some companies, this process creates a safer environment for transition; in others, it may create more friction and challenges. Regardless of who is officially told, however, other current employees will likely know after the transition.
- People who have gender non-conforming identities may want others to know about it and will regularly let people know, either verbally or visually (i.e., through their appearance).
- Individuals who transitioned many years ago may become so accustomed to their lives and gender that they legitimately forget to disclose this information.

Sometimes, being out or not is not a choice. Transgender people who have not had genital surgery and must disrobe in urgent care settings may not have any control over disclosure. At other times, transgender people are accidentally or intentionally outed by someone who knows their gender history—whether their intentions are benign or malicious. Outing may also happen when transgender people have to produce documents that have their former names and/or gender markers on them, such as driver's licenses or health insurance cards.

READ MORE

In this e-pub*—

- Tips for Those Who Serve Victims: [Disclosure and Confidentiality](#)

*Clicking these links will take you to other sections in this e-pub. To return, hit your browser's "back" button.

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Transgender-Specific Issues

The Choices: Documentation

Changing name or gender on identity documents can be complex; there are more documents involved than you think. Even transgender people who want to change all of their documents are likely to have some discrepancies between documents because of state or agency laws prohibiting changes, prohibitive fees, not knowing that a particular document exists, or other reasons. It may also be impossible to change some documentation; for example, if another person owns that document (e.g., a nephew is listed in his uncle's will). Some states do not allow legal gender changes unless a person has undergone a particular surgery, further limiting transgender people's ability to change documents if they do not plan to have or cannot afford surgery.²²

Some states (or cities) will not change a birth certificate under any circumstances, others will change the name only and never change the sex, and still others will allow individuals to change both their name and sex. Some locations will amend birth certificates to add the new information, but will not remove previous information. Likewise, laws regarding changing name and sex on driver's licenses or identification cards vary by state.

Some transgender individuals may not want to change their documents or may have an identity that doesn't lend itself to changing documents (e.g., a person who cross-dresses on the weekends, or a bigender individual who moves between genders).

SOME DOCUMENTS TO CHANGE, OR NOT

- Driver's license or state I.D. card
- Car registration and insurance
- Credit and debit cards
- Credit reports
- Bank accounts
- Mortgage documents or leases
- Employment records
- Professional licenses
- Health and dental insurance
- Medical records
- Wills and care directives
- Durable powers of attorney
- School transcripts and diplomas
- Marriage license
- Children's birth certificates
- Military service records
- Veterans' Administration records
- Social Security records
- Birth certificate
- Passport
- Work visa
- Green card
- Government benefits cards
- Court documents, such as custody agreements or lawsuit paperwork



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Transgender-Specific Issues

The Nonchoices

Three areas that often have a profound impact on transgender lives are out of the control of transgender people:

- [Prejudice.](#)
- [Passing.](#)
- [Other people's choices or actions.](#)



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Transgender-Specific Issues

The Nonchoices: Prejudice

Societal prejudice against transgender people is pervasive. Rates of harassment, discrimination, and violence against transgender people are high, and most cities and states offer limited protection to transgender individuals who experience prejudice or violence.²³ Even in locations with protections, the existence of punitive laws only discourages discrimination, it does not prevent it. For example, transgender people may be leery of transitioning on the job out of fear of termination, even in states that have employment nondiscrimination laws, because cases of discrimination are legally hard to prove and expensive to pursue.

WHAT'S THAT MEAN?

- [FTM](#)
- [MTF](#)

MTFs are often nervous about being alone in public, concerned that they will be taunted, beaten, or even killed for simply walking down the street. FTMs may avoid locker rooms because they fear violence in these highly gendered and physically vulnerable spaces. Genderfluid individuals may not know when they will be confronted with "What are you?" proclaimed by a convenience store clerk.

Prejudice, harassment, and violence emerge in all aspects of life: on the job, in health care settings, in interactions with law enforcement, at home, at school, on the streets. When individuals are transgender and are members of other minorities, they are at even higher risk.

Slowly, transgender individuals are gaining more legal rights as well as greater societal understanding and acceptance. Unfortunately, prejudice against transgender individuals and their loved ones is still overwhelmingly powerful and is almost always outside of a transgender person's control.

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The Nonchoices: Passing

"Passing" refers to whether someone is perceived as female, male, or another gender. Everyone passes, regardless of whether the person identifies as transgender or non-transgender. Many transgender people strongly oppose the presumption that all transgender people want to pass as either male or female. For many, gender identity and expression is not about conforming; these individuals consciously and intentionally present their gender in ways that do not conform to one of only two genders.

WHAT'S THAT MEAN?

- [FTM](#)
- [MTF](#)

How a person is perceived by others is not always consistent. For example, it's not uncommon for a transgender person in a department store to be called "ma'am" by one clerk and "sir" by another. People's unconscious inability to categorize a person's gender creates discomfort, which some shift onto the transgender person.

In general, but with numerous exceptions, FTMs pass as male more often than MTFs pass as female—when they are clothed. Undressed, FTMs are more vulnerable to abuse and discrimination because fewer of them have had genital surgery than MTFs (5 percent versus 20 percent, respectively).²⁴

RAMIFICATIONS OF NOT PASSING

On the street—

- Violence
- Ridicule
- Questions
- Rudeness

On the exam table—

- All of the above, plus—
- Refusal of provider to treat
- Refusal of insurance to pay
- Assumption of provider that all health problems are transgender related
- Refusal of transgender individual to seek or accept health or personal care services

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The Nonchoices: Other People's Choices or Actions

SOFFAs (significant others, friends, family, and allies) go through a transition of their own as they gain more information, work through their feelings, and figure out how their loved one's gender identity, expression, and journey affect them. Unfortunately, the public nature of a gender transition often results in SOFFAs also going through their transition publicly. In some cases, SOFFAs may be included in early discussions about gender and choices, but they may also be informed right before or even after a transgender person has begun to make physical, social, medical, or legal changes. SOFFAs face many of the same questions, unsolicited opinions, and acts of discrimination that transgender people do. Some SOFFAs are asked invasive questions about a transgender person's body because the person asking thinks it may be more polite to query a partner, friend, or family member than to ask the transgender person directly.

Just as transgender people can make choices about their lives, SOFFAs can and do make independent choices as well. When learning of a loved one's gender identity or desire to transition, a SOFFA has several choices:

- Connect with the loved one, accept the knowledge, and work toward making necessary cognitive and other life adjustments to continue in the relationship.
- Actively resist or oppose the transgender person's gender identity or transition plans.²⁵
- End the relationship.

Fortunately, for everyone involved, many partners stay together, many families continue to love and care about each other, and friendships prevail through new and sometimes challenging times. Yet the hard reality is that no person can make a choice for someone else. The choice a SOFFA makes is not within the transgender person's control.

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Resources

FORGE offers [publications](#), webinars ([archived](#) and [upcoming](#)), and in-person [training events](#) for professionals who work with transgender people. If you need direct, customized technical assistance, information, and referrals, contact FORGE via [e-mail](#) or phone (414-559-2123).

You can also find out about transgender issues through the following:

- **Transgender groups and professionals.** Find a local transgender group or other professional who specializes in transgender issues. Ask them to come to your agency to provide an inservice or training event.
- **Search engines (e.g., Google, Yahoo, Bing).** Be careful what you read, as not all Web sites fact check before adding content, but there is a great deal of information you will find if you look. Be mindful, however, that what one article or Web site states as fact may not be true for your client.
- **Listservs.** Every day new listservs emerge that provide direct, fast, and focused answers to questions and concerns. Some of these listservs are specific to those who work with (or want to work with) transgender clients.
- **Conferences.** Profession-specific conferences are more and more frequently offering transgender-specific workshops. There are also many transgender-focused and transgender-sponsored conferences throughout the country. Most conferences offer programming for professionals in addition to providing workshops by and for transgender individuals and their loved ones.

Remember, if you are curious about transgender people, it is likely that other people in your organization are curious as well. When possible, offer learning opportunities to everyone in your workplace so that everyone has a shared knowledge set.

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² G. Gates, 2011, [How Many People Are Lesbian, Gay, Bisexual, and Transgender?](#), Los Angeles, CA: Williams Institute, accessed Jan. 24, 2013; L. Conway, 2002, [How Frequently Does Transsexualism Occur?](#) accessed Jan. 28, 2011.

³ Correspondence with [Tri-Ess](#).

⁴ Intersex Society of North America, [How Common Is Intersex?](#) accessed Jan. 28, 2011.

⁵ Ibid; A. Fausto-Sterling, 2000, *Sexing the Body: Gender Politics and the Construction of Sexuality*, New York, NY: Basic Books.

⁶ G.P. Kenagy, 2005, "Transgender Health: Findings from Two Needs Assessment Studies in Philadelphia," *Health and Social Work* 30(1).

⁷ Two-Spirit references historical multiple-gender traditions in some of the American Indian cultures of North America.

⁸ See Conway's [How Frequently Does Transsexualism Occur?](#) for more information on the difference between the rates of those who transition publicly in some way (e.g., medically) and the rough rates of those who do not.

⁹ L. Cook-Daniels, 2002, [Transgender Elders and Significant Others, Friends, Family and Allies \(SOFFAs\): A Primer for Service Providers and Advocates](#), paper presented at the 110th Annual Convention of the American Psychological Association in Chicago, IL, accessed March 20, 2013.

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¹¹ FORGE, 2003, "Trans+/SOFFAs and Mental Health: Survey Results," *Connectivity* 7(2–3).

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¹³ G. Kenagy and W. Bostwick, 2005, "Health and Social Service Needs of Transgendered People in Chicago," *International Journal of Transgenderism* 8(2/3):57–66; J. Xavier, M. Bobbin, B. Singer, and E. Budd, 2005, "A Needs Assessment of Transgendered People of Color Living in Washington, DC," *International Journal of Transgenderism* 8(2/3):31–47; T. Nemoto, D. Operario, and J. Keatley, 2005, "Health and Social Services for Male-to-Female Transgender Persons of Color in San Francisco," *International Journal of Transgenderism* 8(2/3):5–19.

¹⁴ J. Xavier, 2004, [*An Overview of U.S. Trans Health Priorities: A Report by the Eliminating Disparities Working Group*](#), Washington, DC: National Coalition for LGBT Health, accessed May 11, 2011.

¹⁵ See the World Professional Association for Transgender Health's "[Standards of Care](#)."

¹⁶ The three largest LGBT health centers follow informed consent protocols. See Fenway Community Health Center's "[Protocol for Hormone Therapy](#)," Tom Waddell Health Center's "[Protocols for Hormonal Reassignment of Gender](#)," and Howard Brown Health Center's [THInC](#) program.

¹⁷ Grant et al., [*Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*](#).

¹⁸ I.m. dickey, 2010, Non-suicidal self-injury in the transgender community, unpublished dissertation, University of North Dakota, Grand Forks.

¹⁹ Grant et al., [*Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*](#).

²⁰ A heteroflexible person is primarily oriented to people of the "opposite sex" but may be open to relationships with individuals of any sex or gender. Pansexual differs from bisexual in that it does not imply there are only two genders. Polyamorous individuals are capable of loving more than one person at the same time. Polyamory is consensual non-monogamy, which may result in different types of relationships.

²¹ R. Savin-Williams, 1989, "Coming Out to Parents and Self-Esteem Among Gay and Lesbian Youths," *Journal of Homosexuality* 18:1–2; I. Meyer, 2003, "Prejudice, Social Stress, and Mental Health in Lesbian, Gay, and Bisexual Populations: Conceptual Issues and Research Evidence," *Psychological Bulletin* 129:5; M. Eliason, 1996, "Identity Formation for Lesbian, Bisexual, and Gay Persons," *Journal of Homosexuality* 30:3.

²² For a state-by-state listing, see Lambda Legal's "[Sources of Authority to Amend Sex Designation on Birth Certificates](#)."

²³ Grant et al., [*Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*](#).

²⁴ Ibid. FTMs who are or have used testosterone tend to have an overtly male appearance (e.g., facial hair, fat redistribution, deepened voices), whereas MTFs, even those who use estrogen, progesterone, or androgen-blockers, may not have any outward signs of a stereotypically female appearance.

²⁵ Some SOFFAs who initially adopt this stance end up accepting or even celebrating the transition.



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Sexual Assault in the Transgender Community

This section discusses sexual assault as it affects transgender individuals, covering—

- [The numbers.](#) How many transgender people are sexually assaulted? Who are the victims? The perpetrators? How do hate crime and intimate partner violence factor in?
- [Gender identity and sexual assault.](#) Is gender identity a cause of sexual assault?
- [Chicken or egg?](#) Does sexual assault in childhood influence gender identity?
- [Community ramifications.](#) Does the relatively small size of transgender communities have an adverse effect on transgender victims?



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The Numbers

Statistics documenting transgender people's experience of sexual violence indicate shockingly high levels of sexual abuse and assault. One in two transgender individuals are sexually abused or assaulted at some point in their lives.¹ Some reports estimate that transgender survivors may experience rates of sexual assault up to 66 percent, often coupled with physical assaults or abuse.² This indicates that the majority of transgender individuals are living with the aftermath of trauma and the fear of possible repeat victimization.

This section covers statistics related to the following topics:

- [Victims.](#)
- [Perpetrators.](#)
- [Hate crimes.](#)
- [Intimate partner violence.](#)

Victims

Sexual violence has been found to be even higher in some subpopulations within the transgender community, including transgender youth, transgender people of color, individuals living with disabilities, homeless individuals, and those who are involved in the sex trade. For example, the 2011 *Injustice at Every Turn: A Report of the National Transgender*

Discrimination Survey found that 12 percent of transgender youth report being sexually assaulted in K–12 settings by peers or educational staff; 13 percent of African-American transgender people surveyed were sexually assaulted in the workplace; and 22 percent of homeless transgender individuals were assaulted while staying in shelters.³

READ MORE

- [Transgender Rates of Violence](#)
- [Transgender Survivors: Statistics, Stories, Strategies](#) (webinar)

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Perpetrators

Sexual assaults can be perpetrated by any individual; however, it is particularly startling when professionals who are in "helping" roles abuse their power and sexually assault individuals they are supposed to be serving. Fifteen percent of transgender individuals report being sexually assaulted while in police custody or jail, which more than doubles (32 percent) for African-American transgender people. Five to nine percent of transgender survivors were sexually assaulted by police officers.⁴ Another 10 percent were assaulted by health care professionals.⁵

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Hate crimes

Sexual assault perpetrated against transgender individuals may be a component of an anti-transgender hate crime or may be linked to other demographic variables such as race. According to the National Coalition of Anti-Violence Programs (NCAVP):

Acts of hate violence, such as harassment, stalking, vandalism, and physical and sexual assault, are often supported by more socially sanctioned expressions of transphobia, biphobia, and homophobia and are intended to send a message to LGBTQ communities. . . . Many LGBTQ people also face substantial bias because they belong to other traditionally marginalized groups along other axes of identity such as race, class, incarceration history, immigration status, or ability. . . . membership in more than one traditionally marginalized community can increase targeting for severe violence.⁶

In the NCAVP 2009 report on hate violence, 50 percent of people who died in violent hate crimes against lesbian, gay, bisexual, transgender, and queer (LGBTQ) people were transgender women; the other half were male, many of whom were gender non-conforming.⁷ Sexual assault and/or genital mutilation before or after their murders was a frequent occurrence.

In 2009, 17 percent of all reported violent hate crimes against LGBTQ people were directed against those who identified themselves as transgender, with most (11 percent of all hate crimes) identifying as transgender women.⁸ The remainder identified as transgender men, genderqueer, gender questioning, or intersex.

Hate crimes are more prevalent against people of color. In 2009, 53 percent of LGBTQ hate crime victims were people of color.⁹ Of the 22 anti-LGBTQ hate crime murders documented by NCAVP that year, 79 percent of the victims were people of color.¹⁰ As noted above, 50 percent (11 individuals) of the 2009 murders tracked were transgender women; of those, 9 were people of color (82 percent). Of the other 11 murders of gender non-conforming people, 5 (45 percent) were people of color.¹¹

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Intimate partner violence

Many incidents of intimate partner violence include some form of sexual assault.¹² According to the 2010 National Intimate Partner and Sexual Violence Survey, "bisexual women experienced significantly higher lifetime prevalence of rape and other sexual violence by an intimate partner when compared to heterosexual women" and "significantly higher lifetime prevalence of rape, physical violence, and/or stalking by an intimate partner when compared to lesbian and heterosexual women."¹³ Some studies indicate that between 20 and 35 percent of LGBTQ couples experience domestic violence.¹⁴ According to another, 50 percent of transgender people surveyed had been hit by a primary partner after coming out as transgender.¹⁵ LGBTQ youth report a 30 percent incidence of dating violence, compared to 9 percent for heterosexual students.¹⁶

Only one in five LGBTQ victims of intimate partner violence or sexual assault get help from service providers.¹⁷

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Gender Identity and Sexual Assault

People may assume that being visibly transgender or having a transgender history is a direct cause of sexual assault. There is some truth to this: A number of murders of transgender people (particularly transgender women of color) have taken place when new sexual partners "discover" their sexual partners were assigned male at birth and/or have a penis.¹⁸ This should not be used to blame transgender victims of assault. It is more accurate to observe that anti-transgender bias motivated the assault—not the gender or genitals of the victim.

Some hate crimes and murders have included genital mutilation and sexual assault. One person reported a workplace rape related to the victim's transgender identity: "My close friend was sexually assaulted at work because he was trans. His job discouraged him to [sic] report it and fired him a week later."¹⁹ In other cases, perpetrators may be motivated by reasons that have nothing to do with the victim's perceived or actual gender.

READ MORE

- Transgender Day of Remembrance: When Violence Becomes Deadly ([fact sheet](#), [webinar](#))

When asked, "Was gender a contributing factor in the abuse/assault?" 29 percent of respondents to FORGE's 2005 survey said no, 42 percent said yes, 21 percent were unsure or didn't remember, and 8 percent gave other responses.²⁰ It is contextually important to note that some respondents appear to believe that sexual assault only happens to women or people perceived to be female:

All of the unwanted/persuaded sexual contact in my life has been directly because of my being seen as female-and-sexually-attractive, and this is a very strong contributing factor in my renouncing female identity altogether (no matter what declared orientation), as many straight men simply do not get the clue and assume that any personable demeanor is an invitation for their advances.²¹



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Chicken or Egg?

The vast majority of transgender sexual assault survivors who responded to FORGE's 2005 survey were first assaulted as children or youth.²² Many transgender people first realize they do not identify with their assigned gender when they are young.²³ This is not a coincidence and may make it harder for survivors to figure out which came first and whether one influenced, mediated, or even caused the other. Respondents came down on all sides of the question²⁴:

Being raped did not make me attracted to lesbians. Nor did it make me trans. Providers should know that and not say so or imply it. Even noting that many women who are abused "become" lesbians or that many lesbians have been abused in such a way is rather offensive and kept me from going to a gyn[ecologist] for some time.

I kept blaming things on trauma from the rape that were really trans-related. But, I can see how that could be a hard call to make dealing with a queer teenager that was raped at 8 years old.

I'm afraid to go anywhere for help, because they will say my transgenderism is related to abuse, or that I somehow egged it on by being a freak. I do not want to have it affect my ability to rightfully claim my own identity. I was transgendered before I was ever abused, but I don't think they will understand.

I don't know if this was a negative impact or not, but several of the mental health providers whom I saw suggested that my sexual and/or gender ambiguity was caused by the sexual abuse. I bought that at first. I don't believe that to be true anymore. I've healed from the sexual abuse—truly—and I remain sexually/gendered ambiguous. This is just who I am. Maybe more sensitivity in the fact that gender identity does not have to be a direct result of sexual abuse. It can just 'be' and should not just automatically be thrown in as being the same issue.

I understand that my gender dysphoria arises from the childhood abuse. I had researched this area fairly carefully, and if useful, I have literature suggesting abuse as a possible cause of gender dysphoria.

Studies have shown that lesbian, gay, bisexual, and transgender people are more likely to be sexually assaulted in childhood than heterosexual and non-transgender children.²⁵ It is unclear whether perpetrators were reacting to some gender-related cue and assaulted these children because of it, whether gender insecurity made the children more vulnerable, or whether the attack was meant to "teach the child a lesson."²⁶ One child abuse survivor said that gender identity was a factor in not reporting the abuser: "By me putting up with it, I thought it would help me to be 'normal,' not transgendered or lesbian."²⁷

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Community Ramifications

Some transgender victims of sexual assault show signs of posttraumatic stress disorder or skills deficits that may stem from the assault. These may include hypervigilance (being constantly on the lookout for danger); being easily or extremely startled by sudden sounds or movements; poor concentration; irritability or outbursts of anger; panic attacks; sudden intense emotions; flashbacks or hallucinations; dissociation (having a reduced awareness of one's self and/or the environment); disorientation; amnesia; confusion; isolation; denial; numbing; fatigue; headaches; self-harming behaviors such as cutting; addictions; and substance abuse. Where can they turn for support?

The Internet provides ample information about transgender health, gender transition, and social issues, and most medium- and large-sized communities have in-person support groups or informal social networks where transgender people can meet and exchange information and support. However, these local transgender communities are generally rather small. Having such a small and interconnected social circle may be detrimental if the perpetrator is part of the same community. Two respondents to FORGE's 2005 survey talked about this problem²⁸:

My partner's coerced/nonconsensual sex with another FTM has fractured the local community into parties who believe my partner, parties who believe the perpetrator, and parties who don't want to take sides (who are perceived to not believe my partner as a result). Moreover, there's no useful way to clear the air or hold the perpetrator publicly responsible without some degree of ostracizing him. It's a really evil situation.

My trans ex and I are part of a very small trans community, and as a result of our breakup, I have become largely alienated from our community. He is a respected leader in the trans community. He spreads rumors about me, and I don't defend myself because I don't want to engage him. But after leaving my abusive relationship, I pretty much lost my community. People don't take what happened seriously. It's difficult because it seems like every organization I want to be part of, he's there.

Because the transgender community is so interconnected, and most communities have limited resources and inclusive support services, it can be challenging for transgender individuals and their loved ones to access support if the perpetrator is transgender or part of the transgender community. In these cases, providers and neutral community members should be prepared to help survivors find safe supporters and activities outside of the transgender community.

If an assault involving members of the transgender community is known publicly within the community, there may be extensive ramifications. Rumors about providers "taking sides" may encourage leaders within the

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community to advise against seeking services from a particular provider. Due to the small nature of the community, individuals frequently know who works with which providers and may share providers, which may cause people to no longer feel safe accessing certain professionals for support. This can have a significant negative impact on the provider and the community. Physicians and therapists with large transgender client bases may quickly lose a large portion of their clientele due to community fissures caused by a within-group assault. The community also loses a potentially valuable source of support.

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Sexual Assault in the Transgender Community

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Notes

¹ FORGE, 2005, Sexual Violence in the Transgender Community Survey, unpublished data; G. Kenagy, 2005, "The Health and Social Service Needs of Transgender People in Philadelphia," *International Journal of Transgenderism* 8(2/3):49–56; G. Kenagy and W. Bostwick, 2005, "Health and Social Service Needs of Transgendered People in Chicago," *International Journal of Transgenderism* 8(2/3):57–66.

² J. Xavier, J.A. Honnold, and J. Bradford, 2007, [The Health, Health-Related Needs, and Lifecourse Experiences of Transgender Virginians](#), Richmond, VA: Community Health Research Initiative, Center for Public Policy, Virginia Commonwealth University, accessed Sept. 7, 2010; C. Reback, P. Simon, C. Bemis, and B. Gatson, 2001, *The Los Angeles Transgender Health Study: Community Report*, Los Angeles, CA: University of California at Los Angeles; J. Xavier, M. Bobbin, B. Singer, and E. Budd, 2005, "A Needs Assessment of Transgendered People of Color Living in Washington, DC," *International Journal of Transgenderism* 8(2/3):31–47; C.K. McGowan, 1999, *Transgender Needs Assessment*, New York, NY: New York City Department of Health, HIV Prevention Planning Unit; E. Lombardi, R. Wilchins, D. Priesing, and D. Malouf, 2001, "Gender Violence: Transgender Experiences With Violence and Discrimination," *Journal of Homosexuality* 42(1):89–101; K. Clements, M. Katz, and R. Marx, 1999, *The Transgender Community Health Project: Descriptive Results*, San Francisco, CA: San Francisco Department of Public Health.

³ J.M. Grant, L.A. Mottet, J. Tanis, J. Harrison, J.L. Herman, and M. Keisling, 2011, [Injustice at Every Turn: A Report of the National Transgender Discrimination Survey](#), Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force, accessed Feb. 4, 2011.

⁴ FORGE, Sexual Violence in the Transgender Community Survey; National Coalition of Anti-Violence Programs, 2009, [Hate Violence Against Lesbian, Gay, Bisexual, and Transgender People in the United States](#), New York, NY: National Coalition of Anti-Violence Programs, accessed Jan. 28, 2011.

⁵ J.M. Grant et al., [Injustice at Every Turn: A Report of the National Transgender Discrimination Survey](#).

⁶ National Coalition of Anti-Violence Programs, 2010, [Hate Violence Against the Lesbian, Gay, Bisexual, Transgender and Queer Communities in the United States in 2009](#), New York, NY: National Coalition of Anti-Violence Programs, accessed Jan. 28, 2011. NCAVP is a coalition of about 40 organizations that focus on serving lesbian, gay, bisexual, transgender, and queer victims of intimate partner violence, sexual assault, hate crimes, and police misconduct.

⁷ National Coalition of Anti-Violence Programs, [Hate Violence Against the Lesbian, Gay, Bisexual, Transgender and Queer Communities in the United States in 2009](#). Since the development of this online guide, new information on hate violence against these communities has been made available.

See NCAVP's [Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Hate Violence in 2012](#).

⁸ Ibid.

⁹ Ibid.

¹⁰ Ibid.

¹¹ Analysis based on narratives in the National Coalition of Anti-Violence Programs' [Hate Violence Against the Lesbian, Gay, Bisexual, Transgender and Queer Communities in the United States in 2009](#).

¹² Among FORGE survey respondents who self-reported details of the types of violence they experienced, at least 21 percent of those who experienced intimate partner violence were sexually assaulted as part of that violence. FORGE, 2011, Transgender Individuals' Knowledge of and Willingness to Use Sexual Assault Programs, unpublished survey data, Morehouse School of Medicine's Institutional Review Board.

¹³ M.L. Walters, J. Chen, and M.J. Breiding, 2013, [The National Intimate Partner and Sexual Violence Survey: 2010 Findings on Victimization by Sexual Orientation](#), Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 18–20, accessed Dec. 13, 2013.

¹⁴ More information is available at [Show Me Love Campaign's Web site](#), accessed Jan. 28, 2011.

¹⁵ J. Risser, A. Shelton, S. McCurdy, J. Atkinson, P. Padgett, B. Useche, B. Thomas, and M. Williams, 2005, "Sex, Drugs, Violence and HIV Status Among Male-to-Female Transgender Persons in Houston, Texas," in W. Bockting and A. Avery, eds., *Transgender Health and HIV Prevention: Needs Assessment Studies from Transgender Communities Across the United States*, Binghamton, NY: Haworth Press, 67–74.

¹⁶ Massachusetts Department of Education, 2004, *2003 Youth Risk Behavior Survey Results*, Malden, MA: Massachusetts Department of Education.

¹⁷ M. Ciarlante and K. Fountain, Ph.D., 2010, [Why It Matters: Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender, and Queer Victims of Hate Violence and Intimate Partner Violence](#), Washington, DC: National Center for Victims of Crime, and New York, NY: New York City Anti-Violence Project, accessed Jan. 28, 2011.

¹⁸ Anecdotal data from the National Coalition of Anti-Violence Programs. Also see the [Remembering Our Dead Web site](#), which highlights the stories of some transgender individuals who were murdered, and the [Transgender Day of Remembrance Web site](#), which documents some of the details of victims who were killed.

¹⁹ FORGE, Sexual Violence in the Transgender Community Survey.

²⁰ Ibid.

²¹ Ibid.

²² Ibid.

²³ American Psychiatric Association, 1994, *Diagnostic and Statistical Manual of Mental Disorders IV*, Arlington, VA: American Psychiatric Association; A.I. Lev, 2004, *Transgender Emergence: Therapeutic Guidelines for Working With Gender-Variant People and Their Families*, Binghamton, NY: The Haworth Press.

²⁴ FORGE, Sexual Violence in the Transgender Community Survey.

²⁵ N. Ray, 2006, [*Lesbian, Gay, Bisexual and Transgender Youth: An Epidemic of Homelessness*](#), New York, NY: National Gay and Lesbian Task Force Policy Institute and the National Coalition for the Homeless; Lambda Legal and Child Welfare League of America, 2012, [*LGBTQ Youth Risk Data*](#), New York, NY: Lambda Legal, Washington, DC: Child Welfare League of America.

²⁶ K.F. Balsam and A.R. D'Augelli, 2006, "The Victimization of Older LGBT Adults: Patterns, Impact, and Implications for Intervention," in D. Kimmel, T. Rose, and S. David, eds., *Lesbian, Gay, Bisexual, and Transgender Aging: Research and Clinical Perspectives*, New York, NY: Columbia University Press, 112.

²⁷ FORGE, Sexual Violence in the Transgender Community Survey.

²⁸ Ibid.

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Tips for Those Who Serve Victims

Having a gender identity that differs from the sex you are assigned at birth can be challenging, and any challenges may be more complicated if you are a victim of sexual violence. This section discusses some of the challenges that affect the work of professionals who serve transgender victims of sexual violence and offers tips to help improve services. Topics are grouped into three categories:

- [Victim Issues](#), which discusses transgender-specific issues as they relate to sexual assault.
- [Perpetrator Issues](#), which discusses issues involving the perpetrators of sexual assault against transgender people.
- [Standard Practices](#), which discusses procedural issues as they relate to sexual assault involving transgender victims.

This section also provides some quick reminders to help you serve transgender victims effectively (see [Five Keys](#)) and tips to help you reach out to the transgender community (see [Outreach](#)).

We strongly recommend that you review [Transgender 101](#) before reading this section. By doing so, you will gain an understanding of transgender identities and experiences or, if you already have significant knowledge, you will gain a greater understanding and will be better able to provide culturally competent services.



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Tips for Those Who Serve Victims

Victim Issues

[Preferred Language](#)[Body Image](#)[Internalized Transphobia and
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Victim Issues

Preferred Language

Victims are always experts in their own experience, identity, and language preferences. Listen carefully to the language that victims use to describe themselves and their bodies and reflect those words back to them.

Using a person's preferred name is validating and comforting, even more so when someone has recently experienced trauma and violence. Ask what the victim would like to be called, and if appropriate (or in doubt), which pronoun they prefer. Following their lead will encourage their continued interaction with you and ultimately will result in better professional care.

Transgender people are especially likely to pay increased attention to the language that you use as a way of assessing whether they are safe and will receive sensitive, culturally competent care. For example, if a transgender victim introduces himself as Gabriel, he will likely be paying attention to your comfort and willingness to call him Gabriel. Refer to transgender victims by their preferred names whenever possible. (In some cases, you may need to use a person's legal name. For example, the transgender person may not be out to loved ones who are present at the time.)

In addition to preferred names, pronouns are an especially important indicator of your cultural competence. It is critical to listen for, ask about, and accurately and consistently mirror a person's pronoun preference, even when the victim can't overhear you speaking with a colleague. If a victim's appearance and stated name are clearly feminine or clearly masculine, it is generally safe to use "she" or "he," respectively, when speaking about them. If name and gender presentation don't seem to match, the victim appears uncomfortable when a particular pronoun is used, or you are unsure which pronoun is preferred, ask. These questions acknowledge the victim's identity and establish your desire to serve the victim respectfully. Correctly identifying a person's gender and referring to that person with congruent pronouns increases rapport between victim and professional. That being said, don't let a mistake derail you; even long-time transgender activists occasionally mis-gender someone.

When at all possible, avoid gendered honorifics such as "Ms." or "Sir," unless a person has expressed a preference for them. Hearing the wrong gendered honorific can be especially distressing for transgender victims. In some cases, victims may discontinue care, unable or unwilling to hear incorrectly gendered references about them.

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Transgender people use various terms differently and to mean different things. If a person uses a specific identity word, echo that language. For example, if a victim states, "I identify as a transgender woman," use the phrase "transgender woman" moving forward. If you are not sure what a particular term means, it is okay to ask.

All professionals should focus only on the information they need to provide quality and respectful services.

Implications and Actions for ...

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Health Care Providers

Use patients' preferred names and pronouns consistently—directly with them and with others, whether or not they are within earshot. If you work in an office with other staff, make sure that they also mirror the patient's preferences. If you make a mistake and use the wrong pronoun or name, sincerely yet briefly apologize. A prolonged explanation may make the situation more awkward and uncomfortable.

Medical billing and charting issues may require that more than one name is on a patient's chart or records. Medical billing staff should work directly with patients to ensure their correct name and sex are assigned for insurance billing purposes. Even if billing records are in one name, make sure you still address patients by their preferred names and pronouns at all times. When providing information and making referrals to other providers, ask the patient which name and pronoun to use.

Allow patients to describe the assault using the words that are most comfortable to them. If you need more specific details, ask questions in ways that do not introduce gendered words or concepts. For example, ask if they were "penetrated" instead of "vaginally penetrated" or ask them to point to the anatomy on a body map.

If you have to directly refer to a person's anatomy, listen carefully for and echo the language that the person uses. Some transgender people use what some might consider slang or nontraditional language to describe specific parts of their bodies, particularly their genitals and chest/breast area. For example, a transgender person who identifies as male may have what most people consider to be breasts; if he refers to his "chest" during a medical exam, reflect his language rather than using medical or female-specific terms. Keep in mind that some transgender people have complicated relationships with their bodies, and that others have been subjected to providers who ask inappropriate questions or use offensive language. When unsure of patients' preferred language, use nongendered terms (e.g., genitals) or ask for their preference: "Are there any terms that you prefer I use when referring to parts of your body?"

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It might be challenging both to mirror the patient's preferred terminology **and** to use medically accurate language in charting and documentation. Focus on the interactions with the patient in the moment, take notes in a way that is congruent with the patient's preferences, and write official documentation at a later time. This helps ensure that the official records are correct, that the patient feels respected, and that you can focus on providing successful and comfortable medical care.

Emergency Medical Personnel

Use patients' preferred names and pronouns consistently—directly with them and with others, whether or not they are within earshot. If you make a mistake and use the wrong pronoun or name, sincerely yet briefly apologize. A prolonged explanation may make the situation more awkward.

As emergency medical personnel, you will generally ask conscious patients to describe how they are injured. Allow patients to describe their injuries using the words that are most comfortable to them. If you need more specific details, ask questions in ways that do not introduce gendered words or concepts. Using generic wording (e.g., "Can you show me or tell me where it hurts?") allows patients to choose how to convey what occurred in words that are in line with how they view their bodies.

Some transgender people use what some might consider slang or nontraditional language to describe specific parts of their bodies, particularly their genitals and chest/breast area. If a patient is describing where they are injured and you are unsure what they mean, ask more detailed questions. Once an individual has named a body part, ask if that is their preferred term and then use it.

Similarly, you may want to inform patients you are treating that you may use medical language but can use different words if they prefer. Telling people why something is being done (such as using clinical language) is a best practice that encourages cooperation. Being open to hearing and then using the patient's terms is an even better practice.

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Law Enforcement

Use victims' preferred names and pronouns consistently—directly with them and with others, whether or not they are within earshot. If you make a mistake and use the wrong pronoun or name, sincerely yet briefly apologize. A prolonged explanation may make the situation more awkward.

In some cases, using a victim's preferred language can be problematic. For example, a victim's family may be uncomfortable with the person's identity. If the family uses the victim's old name and pronoun, you may find yourself in a conversation with victim and family in which you're both referring to the same person by different names and pronouns. If the victim's family objects to this, you may want to switch to the old name and pronoun when you're talking with them; however, it's not your role to intervene in this kind of family matter. Another example would be if the victim disclosed to you but does not want to disclose to others; in this case, only use the victim's preferred language when you are alone with the victim.

Allow victims to describe the assault using the words that are most comfortable to them. If you need more specific details, ask questions in ways that do not introduce gendered words or concepts. For example, ask if they were "penetrated" instead of "vaginally penetrated" or ask them to point to the anatomy on a body map.

Some transgender people use what some might consider slang or nontraditional language to describe specific parts of their bodies, particularly their genitals and chest/breast area. If a victim is describing what happened during the crime or where they were injured and you are unsure what they mean, ask more detailed questions. Once an individual has named a body part, ask if that is their preferred term and then use it.

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Advocates

Use victims' preferred names and pronouns consistently—directly with them and with others,

whether or not they are within earshot. If you make a mistake and use the wrong pronoun or name, sincerely yet briefly apologize. A prolonged explanation may make the situation more awkward and uncomfortable.

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If accompanying a victim to services provided by another professional (e.g., health care provider), you may need to advocate for the use of the victim's preferred language. If necessary, explain how the professional can document the visit in a way that reflects the victim's preferred language, along with supporting narrative that describes and clarifies for other readers. For example, if a transgender victim refers to his torso as his "chest," support the victim by verbally using and repeating his language and support providers by encouraging them to document injuries using the victim's language and also using medical language, so that both are recorded and described.

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Therapists

Use clients' preferred names and pronouns consistently—directly with them and with others, whether or not they are within earshot. If you work in an office with other staff, make sure that they also mirror the clients' preferences. If you make a mistake and use the wrong pronoun or name, sincerely yet briefly apologize. A prolonged explanation may make the situation more awkward and uncomfortable.

Medical billing and charting issues may require that more than one name is on a client's chart or records. Medical billing staff should work directly with clients to ensure their correct name and sex are assigned for insurance billing purposes. Even if billing records are in one name, make sure you still address clients by their preferred names and pronouns at all times.

Allow clients to describe the assault using the words that are most comfortable to them. If you need more specific details, ask questions in ways that do not introduce gendered words or concepts. For example, ask if they were "penetrated" instead of "vaginally penetrated" or ask them to point to the anatomy on a body map.

It is also critical to determine and reflect the terms that clients use to refer to their bodies and identities. One respondent to FORGE's 2005 survey said about his therapist, "Had he and I needed to explore it, some discussion or emphasis on how vaginal penetration uniquely emasculates a male-identified biogirl would've possibly been useful."¹ When serving this client, the therapist would need to inquire as to whether "vaginal penetration," "male-identified," and "biogirl" are that client's preferred terms and then to respect and consistently use those terms.

Language goes far beyond body and identity. If the sexual assault occurred when the transgender

person was reflecting another (outward) gender, the client may want to talk about the assault while using a different name and/or pronoun. In contrast, some clients rewrite their life's history to align with their current gender identity. Being understanding about the "conflicting" language a transgender client uses, and reflecting the client's own language as often as possible, validates the client's experience and shows that you understand the complexity of how gender and trauma may interrelate.

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1. FORGE, 2005, "[Implications](#)," quotation from narrative response to the Sexual Violence in the Transgender Community Survey, accessed Feb. 13, 2013.

Support Group Facilitators

Use clients' preferred names and pronouns consistently—directly with them and with others, whether or not they are within earshot. Front desk staff, billing specialists, and everyone in your office who has contact with transgender clients should be trained on how to appropriately interact with them. A client who is repeatedly greeted by front desk staff with the wrong name or pronoun will feel immediately uncomfortable, which detracts from the healing environment. Many clients will not return for services at all if they are addressed incorrectly. If you or someone in your office makes a mistake and uses the wrong pronoun or name, sincerely yet briefly apologize. A prolonged explanation may make the situation more awkward and uncomfortable.

Medical billing and charting issues may require that more than one name is on a client's chart or records. Billing staff should work directly with clients to ensure their correct name and sex are assigned for insurance billing purposes. Even if billing records are in one name, make sure you still address clients by their preferred names and pronouns at all times.

In the support group setting, model the use of transgender clients' preferred names and pronouns in front of other group members. If you encounter resistance within the group, discuss why it is important to create a nonbiased, respectful environment, which includes addressing individuals as they would prefer to be addressed. Post ground rules that contain group agreements and refer to and remind participants of ground rules if they are violated.

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Body Image

Sexual assault, by its very nature, is an intimate crime of the body. Most frequently, this assault reveals the parts of the body that transgender people may feel the most vulnerable, anxious, or sensitive about—namely their chest and genitals and often their face. To decrease bodily discomfort, some transgender people keep these body parts covered, hide them (e.g., through binding, makeup, clothing), and seldom discuss them. Some transgender people may not like or may even abhor the genitals they were born with, viewing them as "birth defects." This can be in part because their gendered body parts are incongruent with their sense of self or may have been used against them by those who sought to oppose, deny, or destroy the person's gender identity or self-esteem. As a result, some transgender people try not to think or talk about their genitals at all, and discussing them with others after a sexual assault can be painful and humiliating.

WHAT'S THAT MEAN?

- [FTM](#)
- [MTF](#)

Sexual assault against transgender individuals is frequently accompanied by hateful epithets or slurs that denigrate the victim's body, gender expression, or existence. For example, FTMs (female-to-males) who bind their chests may have their binders destroyed or their chest specifically targeted for injury, and MTFs (male-to-females) who are sexually assaulted frequently have their faces or genitals cut.

Because of the nature of these types of sexual assaults and the harsh language that might accompany them, it is doubly important that professionals use respectful language that reflects how victims see and talk about their bodies, identities, and experiences.

There are few situations in which it would be appropriate for a professional to discuss a victim's body image or appearance. A solid indicator of appropriateness is to consider whether it would be equally appropriate to comment on or discuss a non-transgender person's body, body image, or appearance. If it is inappropriate to discuss with a non-transgender person, it is equally inappropriate to discuss with a transgender person.

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[Health Care Providers](#)

Some transgender people have a negative body image; they may be so uncomfortable with their chests, for example, that they do not allow health care providers to listen to their heart or lungs during routine exams. Being sexually assaulted may cause transgender patients to shut down and make them unable or unwilling to discuss their bodies during an exam or even be unable to accurately describe bodily sensations/symptoms. In these cases, maintain eye contact, engage the patient verbally, be patient, acknowledge that the topic may be uncomfortable, but ultimately be respectful of a patient's boundaries. As one survivor put it, "The [procedures] are more intrusive if you are uncomfortable with your body in the first place. [Health care professionals] need to understand that."¹

Other techniques for reassuring patients with poor body image include the following:

- Work with the patient to develop examination strategies that will work for them (e.g., listening to the heart and lungs through clothing).
- Before beginning the exam and then throughout, tell patients what will be done and why. This explanation is particularly critical for transgender people because their bodies may have been the object of curiosity (at best) and revulsion or violence (at worst). Telling patients why a procedure is medically necessary will give them greater confidence that it is appropriate to their medical care and not being done to satisfy your curiosity. (This practice also allows the patient to say no to any part of their medical care, letting them set and maintain boundaries.)
- If possible, allow patients to have a loved one or advocate present during the exam. Knowing that there is someone in the room who knows their transgender identity and will advocate on their behalf can be very reassuring. Of course, it is vital to screen the companion/loved one to make sure that this person is not the perpetrator (see [Companions as Abusers](#) in this e-pub).
- Many urgent care or forensic care facilities have dolls with detailed anatomy. Some transgender patients may find it easier to identify injuries, pain, or assault experiences through these assistive devices. (Offer multiple-gendered dolls, if available.)
- If needed, offer patients paper and pencils so that they can draw or write if they are unable to articulate or use other means to communicate.

1. FORGE, 2005, Sexual Violence in the Transgender Community Survey, quotation from narrative response, unpublished data.

Emergency Medical Personnel



Some transgender people have a negative body image, so being sexually assaulted may cause them to shut down and make them unable or unwilling to discuss their bodies or the assault. Be respectful of a patient's boundaries.

Law Enforcement



Some transgender people have a negative body image. Due to this discomfort with their bodies, they may be reluctant to discuss what happened during the sexual assault. Although many survivors have difficulty reporting details of their assault, transgender victims may have the added layer of not wanting to talk about specific parts of their bodies that they feel disconnected to or about which they feel embarrassed or ashamed. This may be especially true, for example, if law enforcement does not know that the victim is transgender and the assault violated a part of the body that is not typically associated with the gender the officer perceives the individual to be.

Advocates



Some transgender people are unable or unwilling to discuss their bodies because of poor body image. Being sexually assaulted may cause transgender victims to shut down even more. If this is the case, consider using dolls with detailed anatomy. Some transgender patients may find it easier to identify injuries, pain, or assault experiences through these assistive devices. (Offer multiple-

gendered dolls, if available.) If needed, offer patients paper and pencils so that they can draw or write if they are unable to articulate or use other means to communicate.

Therapists



Mental health providers who are helping survivors work through the aftermath of sexual assault need to take extra steps to be sensitive to transgender clients' needs. Be aware that transgender survivors may need your "permission" and extra support before they can talk about how the assault affects how they feel about their bodies and/or gender. Sexual assault may play a pivotal role in how people perceive their bodies and which course they pursue related to gender. It also is critical to determine and reflect the terms clients use to refer to their body and identity. See [Preferred Language](#): Implications and Actions for Therapists in this e-pub for more information.

Support Group Facilitators



Support group facilitators who are helping survivors work through the aftermath of sexual assault need to take extra steps to be sensitive to transgender clients' needs. Be aware that transgender survivors may need your "permission" and extra support before they can talk about how the assault affects how they feel about their bodies and/or gender, especially in a group setting. Sexual assault may play a pivotal role in how people perceive their bodies and which course they pursue related to gender.

Some support group participants may find the complicated stories of some transgender survivors challenging and confusing. Though it is important not to silence a transgender survivor's narrative about body image, you must not let the unique challenges of one survivor take the focus away from other group members or from discussion that benefits most or all in the group. One way to help this process is to draw comparisons between the experiences of transgender and non-transgender group members. Note, for example, how all people have different perceptions about their bodies. Drawing out similarities will help the transgender person feel less isolated and different and will help other group members see how human experiences are just that—human, not transgender or non-transgender.

RESPONDING TO TRANSGENDER VICTIMS of Sexual Assault

Message From the Director

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Transgender 101

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Tips for Those Who
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Internalized Transphobia and Shame

The cumulative effects of enduring ongoing prejudice may have an impact on transgender victims of sexual assault. It is not uncommon for transgender people to experience parental disapproval, bullying at school, harassment socially or at work, and intimate partners who engage in power-and-control tactics. Some transgender people have been conditioned to believe that abusive behavior is normal; therefore, they may not recognize that an interaction was abusive or sexually violent.

Many transgender people, particularly those who declared or displayed their gender non-conformity when young, have been subjected to years of messages that something is wrong with them, that they are unlovable, and that their gender identity will bring them lifelong pain and hatred. Not surprisingly, some of these individuals grow up believing that **any** relationship is better than no relationship at all, and therefore they stay in unhealthy relationships.

Both intimate partner violence and hate violence by strangers may include anti-transgender slurs, insults about the person's body, or commentary on the person's appearance. Some victims may well believe that they deserve and are at fault for violence or sexual assault. In FORGE's 2005 research, many respondents reported not recognizing assault as abuse when it was happening, feeling overwhelmed with shame related to being transgender and assaulted, or thinking they were responsible for the abuse because they were transgender. According to many respondents, shame played a large and varied role in the aftermath of sexual assault¹:

By me putting up with [the sexual violence], I thought it would help me to be "normal," not transgendered or lesbian.

Fear, not thinking anyone would understand (especially around trans issues), shame about having put up with [the abuse] for so long [reasons for not reporting sexual violence].

I was ashamed of myself, my identity, my desires, my inner person. They crucify people like me. It would have been nice to know that I wasn't a freak and that there were others like me. But when they asked me what was my problem in school they always assumed I was just a bad kid. Little did they realize I couldn't stand myself. And hated what I was. I felt I needed to be bad to be respected and left alone.

At age 12 my neighbor cornered me in the chicken coop behind my parents' house. He knocked out my tooth with a baseball bat. But [he] was too intoxicated to maintain an erection, so he used a screwdriver instead. Until he passed out. My mother felt that the incident was my fault and a normal response to my cross-dressing, and drove me to town to purchase feminine napkins for the anal bleeding. Mother didn't want the town to know I'd been raped for cross-dressing.

One author described the difference between shame and guilt this way: "[S]hame is a feeling of pervasive defectiveness, whereas guilt feelings stem from specific actions that are hurtful to others."² Four strategies people use to escape shame are—

1. withdrawal (isolation),
2. avoidance (drug/alcohol use or creating a false, arrogant self-image),
3. self-attack, and
4. attacking others.³

This author also discusses the shame-rage spiral: "Exploding in rage leads to a feeling of being out of control, which itself is humiliating, fueling further shame and rage, a volatile mix that often ignites physical abuse and battering."⁴

Implications and Actions for ...

[\[Collapse All\]](#)

Health Care Providers

Transgender individuals may believe that they are not entitled to respectful medical care or that only some parts of their body deserve to be treated. Because of past discrimination in health care settings, they may feel that discussing their body is risky and makes them vulnerable.

Embarrassment, shame, and apprehension may prevent transgender victims of sexual assault from revealing the extent of their injuries or lead them to refuse treatment. This may include being unwilling to have forensic evidence collected directly after an assault.

Internalized transphobia may also deter victims from seeking care because they fear disrobing for physical examinations. Remind these patients that they can undress to the level of their comfort and that they can wear gowns or be draped to feel less exposed and vulnerable, which will encourage them to return for additional care if needed. Also consider asking patients if they would like a nurse, certified nursing assistant, friend, partner, or another ally present during the exam (but see [Companions as Abusers](#) in this e-pub).

Treat transgender patients with the utmost respect and dignity, without commenting on or visibly reacting to the person's gender identity or body. As you would with any sexual assault victim, be gentle, respectful, patient, and dignified. No disgust or judgment should be shown, as patients are likely to internalize those responses as being about their gender identity, appearance, or behavior. Responsibility for the assault should be fully assigned to perpetrators, even if victims' behavior may have placed them in dangerous or risky situations.

If you treat transgender patients as part of their routine health care, be aware that transgender victims of sexual assault may forgo routine care or care of specific medical conditions after being assaulted. For example, it is common for people on the female-to-male spectrum to delay or avoid routine gynecologic care. If they have been sexually assaulted, they may avoid this form of medical care even more due to shame stemming from the assault. You may want to schedule longer appointment times for these patients to allow ample room for discussion, and proceed through the exam more slowly. Make sure not to "scold" patients or make them feel guilty if they are unwilling or unable to receive medically suggested treatment, testing, or care.

Patience and relationship building will increase trust and may gradually lead to patients who are more willing and able to receive more comprehensive care.

Emergency Medical Personnel

Treat transgender patients with the utmost respect and dignity, without commenting on or visibly reacting to the person's identity or body. Because certain aspects of a sexual assault may feel more shaming than others, patients may well try to avoid discussing these components and may also resist care. As you would with any sexual assault victim, be gentle, respectful, patient, and dignified. No disgust or judgment should be shown, as patients are likely to internalize those responses as

being about their gender identity, appearance, or behavior.

Internalized transphobia may result in transgender individuals resisting medical care, even if injuries are significant. They may also minimize the injuries they sustained. If this is the case, consider stressing that everyone deserves quality health care and the opportunity to pursue criminal justice options. Victims of sexual assault may be unaware of their options; you can help them understand the importance of receiving timely medical care.

Transgender individuals may believe that the sexual assault was their fault and may be hesitant or elusive or make statements that do not align with professional observations or experience. This reticence to share or the focus on other aspects of the assault are not necessarily signs of deception. For example, it may be clear that a victim has sustained an injury caused by another person, yet the transgender victim focuses on how they were at fault for wearing makeup or for walking down a specific street instead of describing the perpetrator or what happened. Although this line of thought is common in a wide range of sexual assault survivors, it may be more prevalent for transgender survivors.

Law Enforcement

Treat transgender victims with the utmost respect and dignity, without commenting on or visibly reacting to the person's identity or body. Because certain aspects of a sexual assault may feel more shaming than others, victims may well try to avoid discussing these components and may also be reluctant to file a police report or pursue evidence collection. As you would with any sexual assault victim, be gentle, respectful, patient, and dignified. No disgust or judgment should be shown, as victims are likely to internalize those responses as being about their gender identity, appearance, or behavior.

Internalized transphobia may result in transgender individuals resisting medical treatment, even if injuries are significant. They may also minimize the crime that occurred and be less willing to make a formal report to law enforcement. If a victim resists or hesitates to access medical care or a forensic examination, consider stressing that everyone deserves quality health care and the opportunity to pursue criminal justice options. Victims of sexual assault may be unaware of their options, so it is important for law enforcement officers to fully explain possible courses of action, including forensic examination, detailed reporting, access to sexual assault advocates, and other resources within the community. One of your overarching goals is to help victims regain control over what happens to them; respect and affirm their decisions of whether or not to seek care. You may encourage victims to pursue evidence collection and reporting, as long as you do so in a respectful way that does not pressure the victim.

Transgender individuals may believe that the sexual assault was their fault and may be hesitant or elusive or make statements that do not align with professional observations or experience. This reticence to share or the focus on other aspects of the assault are not necessarily signs of deception. For example, it may be clear that a victim has sustained an injury caused by another person, yet the transgender victim focuses on how they were at fault for wearing makeup or for walking down a specific street instead of describing the perpetrator or what happened. This line of thought is common in a wide range of survivors of sexual assault, but it may be more prevalent for transgender survivors.

Responsibility for the assault should be fully assigned to the perpetrator, regardless of the situation, location, or circumstances. Sexual assault is never the victim's fault; it was the perpetrator's choice to assault the victim. In the words of one transgender victim of sexual assault, initial responders could have helped the victim "to have realized that I was not to blame, and that I didn't 'ask for it' by being trans."¹

By modeling respect and compassion, you can help victims understand that they are not at fault and that they deserve respectful treatment.

Advocates

Because certain aspects of a sexual assault may feel more shaming than others, victims may well try to avoid discussing these components and may also resist medical care. As you would with any sexual assault victim, be gentle, respectful, patient, and dignified.

If a victim resists medical care or hesitates to receive that care or a forensic examination, consider stressing that everyone deserves good health care, and offer to accompany the victim to the medical exam. Concurrently, one of your overarching goals is to help victims regain control over what happens to them, so it is also important to affirm their decisions of whether or not to seek care. (Do consider reminding them, however, that evidence collection is time-sensitive.)

Therapists

As a result of internalized transphobia and shame, some transgender individuals are reticent to share information about their bodies, identities, or experiences, including sexual assault. You may need to address these layers of transgender-specific shame and self-blame before you can help clients begin healing from the assault; the healing process may be more prolonged as a result. Acknowledging clients' small steps toward self-understanding and self-acceptance is key. Overall—

- Be patient. Do not “scold” transgender clients or make them feel guilty about the pace or progress of their therapeutic process.
- Reassure them that they are normal.
- Help them realize that what happened to them is not their fault.
- Remind them that other survivors feel the same types of emotions and have the same types of responses.

Shame is common in most sexual assault clients, regardless of their gender history. With transgender individuals, it may be difficult to determine the exact root of their shame. Understanding the complex relationship between shame and transgender identity is essential, but it is more important to listen carefully and empathically, reflect language and concepts, and assist transgender clients in lessening their feelings of shame and guilt. According to one FORGE survey respondent who was sexually abused by their therapist:

Shame has kept me silent all these years. This survey is one of the few times that I have discussed these events. No one wants to hear about this, because therapists are supposed to be God and cannot do any wrong.¹

If clients begin to blame themselves, remind them that they did not cause the assault. This may be especially difficult for transgender clients to believe. Many perpetrators frequently claim the client's gender identity, expression, or noncongruence “caused” the assault. This can enhance clients' preexisting anxieties and contribute to a heightened belief that the assault was their fault.

If possible, encourage clients to join transgender support groups or participate in organized transgender events, which can help them create a more positive self-image. That said, it is important to keep in mind that the transgender community is small and tightly knit, which may make them feel too exposed (everyone knows everyone) or may put clients in contact with their perpetrators within the transgender community. Assess clients' comfort with their peers before steering them toward these options.

For more information on shame and its treatment, read *Treating Survivors of Childhood Abuse: Psychotherapy for the Interrupted Life*, by Marylene Cloitre, Lisa R. Cohen, and Karestan C. Koenen. One of their main recommendations is that therapists wait until late in treatment to tackle shame, after much relationship building and previous therapeutic work has already taken place.

1. FORGE, 2005, “[Transgender Sexual Violence Project: Summary of Wisconsin Data](#),” accessed Feb. 13, 2003.

Support Group Facilitators



Some transgender survivors may need individual therapy to work on internalized transphobia or shame before they are ready to enter a support group.

Because shame tends to be a common emotion for many survivors, it will likely emerge within support group settings. With transgender clients, it may be difficult to determine the exact root of their shame. Understanding the complex relationship between shame and transgender identity is essential, but it is more important to listen carefully and empathically, reflect language and concepts, and assist transgender individuals in lessening their feelings of shame and guilt. According to one FORGE survey respondent who was sexually abused by their therapist:

Shame has kept me silent all these years. This survey is one of the few times that I have discussed these events. No one wants to hear about this, because therapists are supposed to be God and cannot do any wrong.¹

If clients begin to blame themselves, remind them that they did not cause abuse. This may be especially difficult for transgender clients to believe because so many assaults of transgender survivors are reported as being related to transgender identity or expression. Many perpetrators target transgender people because of their transgender status, which can create a heightened belief that survivors are at fault.

Make sure not to "scold" clients or make them feel guilty if shame is overriding their ability to address other therapeutic issues. These clients may need additional time and tools to help them feel less shame, or they may need to work individually with a therapist to become ready to participate in a support group.

For more information on shame and its treatment, read *Treating Survivors of Childhood Abuse: Psychotherapy for the Interrupted Life*, by Marylene Cloitre, Lisa R. Cohen, and Karestan C. Koenen. One of their main recommendations is waiting until late in treatment to tackle shame, after much relationship building and previous therapeutic work has already taken place.

1. FORGE, 2005, "[Transgender Sexual Violence Project: Summary of Wisconsin Data](#)," accessed Feb. 13, 2003.

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Sexuality

Transgender people can be any sexual orientation: heterosexual, lesbian, gay, bisexual, pansexual, queer, and many others.⁵ Transgender people may be monogamous or polyamorous.⁶ They may be casually dating or in long-term relationships. Some may be celibate or asexual (i.e., have no sexual attraction to others)—by choice or by circumstance. Some avoid sexual relationships altogether because they are uncomfortable with their bodies, they feel physically vulnerable, or they fear not being seen as the gender they see themselves. Others have abstained for religious reasons or due to social reticence.

Some transgender and non-transgender individuals engage in alternative sexual practices such as bondage and discipline or sadism and masochism (BDSM). When practiced with respect for a person's boundaries, BDSM is safe, sane, and consensual. It should never be used to excuse actions taken against a person's will. Lack of consent is always sexual assault. As the following quote shows, a few victims may need help to understand this fact:

The abusiveness of my relationship was "masked" both to others and to myself by the fact that it was a same-sex relationship and a BDSM relationship. My partner took advantage of the fact that it was my first experience of the latter. I believed that I had to consent to anything or could not withhold consent, and the abuse was couched as "play."⁷

People engage in many different forms and types of sexual behavior, some of which may be outside a provider's comfort zone or knowledge base. Most professionals learn not to judge those who engage in sexual practices different from their own, or at least to refrain from sharing their opinions. Sadly, however, transgender victims of sexual violence frequently report negative interactions with all types of professionals.

Sexuality and sexual practices can be profoundly affected following a sexual assault, regardless of the person's gender or identity. Individuals who engaged in a vibrant sexual life prior to the assault may have a radically different relationship to sex and sexuality—with self or others—after being assaulted. Individuals may avoid any contact, decide to abstain, become "stone," or severely curb their sexual behavior. Enjoyment of sex and sexual expression may decrease substantially, and specific sexual behaviors that were previously enjoyed may now be triggers or unwelcome.

Transgender individuals, who may have had conflicting feelings about their bodies before being assaulted, may be even more uncomfortable with or dysphoric about their bodies afterward. Because the vast majority of

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In this e-pub*—

- Tips for Those Who Serve Victims: [Relationships](#), [Companions as Abusers](#), [Body Image](#)

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sexual assaults involve violation of a person's genitals, the level of trauma and dissociation (i.e., detachment from reality) concerning a transgender person's genitals and body may be significantly elevated as a result.

Implications and Actions for ...

[\[Collapse All\]](#)

Health Care Providers

Be careful of making assumptions about patients' sexuality, and make sure to listen to (and believe) their accounts. One transgender victim of sexual assault said that medical services would have been improved if providers—

[R]ealized that I was not to blame, and that I didn't "ask for it" by being trans. I felt that the residents in the ER felt that being transgender meant I had some "sexual fetish" and that I exposed myself to high-risk situations (which wasn't the case, it was partner-abuse). It pissed me off that they didn't listen or acknowledge the things I told them!¹

Unfortunately, some urgent care health care providers make unwarranted and damaging assumptions about patients' sexual orientation or gender identity and which sexual acts they participate in. In some cases, for example, health care professionals have minimized the trauma of anal assaults of MTFs (male-to-female individuals) by assuming that they regularly engaged in (consensual) anal sex.

WHAT'S THAT MEAN?

- [MTF](#)

Urgent care providers or specialists who may only see a transgender patient once will likely not need to know about the individual's consensual sexual behavior or sexual orientation. However, primary care physicians or providers with whom the transgender patient develops an ongoing relationship will want to have discussions about sexuality, sexual behavior, and sexual orientation. Some people may engage in higher risk behaviors because negotiating safer sex in addition to disclosing transgender status may feel overwhelming and defeating. If you are a routine health care provider, work with and educate your patients about the sexual risks involved with specific sexual behaviors (e.g., sexually transmitted infections, pregnancy) and help them develop effective strategies for reducing the risks of specific behaviors. Atypical prevention strategies may need to be implemented due to transgender bodies that may not lend themselves to traditional barrier methods of protection. Any testing or treatments should be accompanied by transgender-specific educational discussions and materials. Because many transgender people are of low income and because some are involved in the sex trade or engage in survival sex (i.e., the exchange of sex for food, shelter, safety, or other basic needs), consider offering free safer sex supplies.

READ MORE

- [TSISTA: Resource Guide for Adapting SISTA for Transwomen](#)
- [Safe Stick: Silicone](#)
- [Safe Stick: Testosterone](#)

Trusted providers are hopefully already having these discussions with both their transgender and non-transgender patients as well as with their straight and lesbian/gay/bisexual patients.

1. FORGE, 2005, Sexual Violence in the Transgender Community Survey, quotation from narrative response, unpublished data.

Emergency Medical Personnel

A patient's sexual orientation or consensual sexual practices are generally not relevant to your role as emergency medical personnel serving victims of sexual assault. If the assault appears to be motivated by bias, hate crime laws do not require the victim to actually be part of a protected class; it is the belief that a person is of a specific sexual orientation (or gender identity) that will result in the case being considered a hate crime. Concentrate on what the patient says, and do not inquire about sexual orientation. Recording what a patient says about an assault is important; having information in the record may be essential if the patient decides to press charges against the perpetrator.

As with all assaults, it is critical to remember that sexual behaviors that were part of a sexual assault do not represent an individual's consensual sexual behavioral choices.

Law Enforcement



A victim's sexual orientation or consensual sexual practices are generally not relevant to a law enforcement officer's role in serving victims of sexual assault. If the assault appears to be motivated by bias, hate crime laws do not require the victim to actually be part of a protected class; it is the belief that a person is of a specific sexual orientation (or gender identity) that will result in the case being considered a hate crime. Concentrate on the victim's statement, and do not inquire about sexual orientation.

As with all assaults, it is critical to remember that sexual behaviors that were part of a sexual assault do not represent an individual's consensual sexual behavioral choices.

Advocates



Most advocates also provide support for the victim's family and friends or connect victims to their support systems. In doing so, always use gender-neutral language when asking if there is someone they would like called. Be careful to avoid verbal and nonverbal reactions if a partner's gender differs from what was assumed. Generally speaking, a victim's sexual behavior will not be a topic of discussion between advocate and victim. If the victim brings up gender identity or orientation or sexual practices, however, having an open attitude and responding nonjudgmentally helps to encourage trust and maintain continued dialogue.

Therapists



Over the long term, sexual assault survivors may find that their sexual attractions and sexual practices are deeply affected by the assault. According to some respondents to the 2005 FORGE survey¹:

- "I have extreme difficulty with sex or [intimacy]."
- "I am sexually dead. My partner understands this."
- "My marriage was destroyed because of the [sexual violence] effects on me, including acting out."
- "I am sexually a mess."

Survivors in intimate relationships may benefit from couples therapy, which can help both partners understand how the assault affects their sexual relationship and help them develop or strengthen the skills they need to cope with any changes to that relationship.

Some people may engage in higher risk behaviors because negotiating safer sex may feel overwhelming and defeating. Explore negotiating skills with clients, specifically for navigating sexual interactions. Using role playing techniques can be especially empowering and can reinforce healthy behaviors.

1. FORGE, 2005, "[Implications](#)," quotation from narrative response to the Sexual Violence in the Transgender Community Survey, accessed Feb. 13, 2013. (Two of the four quotes are on FORGE's Implications Web page.)

Support Group Facilitators



Support groups may address issues of sexuality and intimacy with existing partners or new and potential partners. Transgender group members may have many of the same concerns as non-transgender members. All may benefit if they share how sexual assault affected their sexuality and if they discuss strategies for regaining the type of sexual (or asexual) life they want to have.

If the topic of sexuality emerges within a group discussion, you can ask questions without presuming people's sexual orientation or the types of relationships they desire. For example, ask "Do you have someone significant in your life?" or "Are you partnered?" rather than "Are you married?"

Similarly, if a client is sharing details about a partner ("my spouse and I...."), allow them the opportunity and control to share their partner's gender if they wish. Some clients may not disclose the gender of their partners, and others prefer to disclose gender on their own terms and in their own language. Never make an assumption about a partner's gender because that assumption may be incorrect.

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Relationships

Sexual assault affects every relationship in a victim's life—casual friendships, coworker relationships, interactions with family members, and dynamics with an intimate partner. According to one FORGE survey respondent:

The abuse that [occurred] now plays a part in physical aspects of my relationship with my current partner. There are many things that trigger panic attacks, and there is always caution to avoid these triggers.⁸

Being assaulted, particularly by someone you know or love (and who presumably loves you), has many unique short- and long-term ramifications. The ability to trust is often damaged and other relationships may suffer, as these FORGE survey respondents' answers suggest⁹:

My ability to trust people has been severely impacted by these traumas.

I broke up with an abusive partner; otherwise there has been tension in intimate relationships.

I can't hold a relationship.

[I] was too young [at the time of the assault to be partnered], but have serious problems with relationships/trust [now].

[T]he effects of sexual violence are woven into the fabric of my being, always have and still do affect every way I sit, walk, talk, stand, breathe, feel, think, all affects relationship[s].

If the abuse took place in childhood—particularly if it went on for many years or there were multiple abusers—the victim may not have mastered typical developmental tasks or have learned sufficient social skills. One respondent said that they would like to access services providing—

Social support and therapy to help me develop the missing social skills that are a consequence of my childhood abuse, and my years and years of cognitive dissociation.¹⁰

Although providers may inquire about partnership status, what they may actually need to know is very specific information about health insurance benefits, emotional support at home, economic stability or eligibility, or assessment of legal rights. For example, a common intake question is "are you married?" Given the variability of state and federal recognition of same-sex domestic partnerships, civil unions,

and marriages, this question is not particularly useful.

Instead, consider asking one of the following questions, depending on the information you seek:

- Do you live alone? If not, how many people live in your home?
- Are you sexually active?
- Who provides emotional support?
- Is there someone to care for you following medical treatment?
- What is your sexual orientation? (This question may be relevant, for example, if you need to place a transgender victim in a support group for LGBTQ victims.)
- Is there someone you want us to notify in an emergency?
- Are you pursuing a relationship? (This could be an appropriate question for mental health care providers, because sexuality and relationships can be affected by assault.)
- What pronoun should I use to refer to your partner?
- If you were hospitalized, might anyone challenge your partner's right to visit?
- For income eligibility purposes, do we count your partner's income?
- Are your legal affairs in order (e.g., durable power of attorney, will)?
- If you were widowed, would you be eligible for survivor's benefits?

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In this e-pub*—

- Transgender 101: [Relationships](#)
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Professionals who help victims of sexual assault should be aware of the information they are seeking, tell the victim why the question is being asked, and then ask the accurate question rather than relying on questions that may be both misleading and alienating.

Implications and Actions for ...

[\[Collapse All\]](#)

Health Care Providers

Because many transgender survivors of sexual assault have experienced previous traumas, they may already have trouble interacting with anyone new, including health care providers.¹ Patience and persistence are key to effectively serving sexual assault survivors of any gender identity or history.

Transgender patients who have been sexually assaulted often bring companions or family members to support and advocate for them when dealing with known and unknown professionals, especially if those professionals may expect them to disrobe. Some transgender people may not have family or partners to accompany them, but they may have developed strong social networks whose members have become family to them. Honoring these relationships as equally valid to legal family is another way to honor transgender peoples' lives and experiences. Treat transgender individuals' partners in the same manner as non-transgender patients' partners. Make sure, however, to screen companions first to ensure that they are not the perpetrators (see [Companions as Abusers](#) in this e-pub).

If the companion is not or may not be the perpetrator/abuser, encourage the patient to bring the companion, when medically feasible. If the companion is the abuser, speak with the patient privately to discuss the patient's immediate options and contact the local victim service provider or sexual assault victim advocate to help the patient with safety planning. (Safety planning is discussed in more detail in the [Companions as Abusers](#): Implications and Actions for Advocates section.)

1. According to unpublished survey data, for example, 72 percent of adult sexual assault victims who are transgender and 64 percent of those who were sexually abused as children have experienced at least one other form of victimization in their lives. FORGE, 2011, Transgender Individuals' Knowledge of and Willingness to Use Sexual Assault Programs, unpublished survey data, Morehouse School of Medicine's Institutional Review Board.

Emergency Medical Personnel



Because many transgender survivors of sexual assault have experienced previous traumas, they may already have trouble interacting with anyone new, including emergency medical personnel.¹ Patience and persistence are key to effectively serving sexual assault survivors of any gender identity or history.

Transgender patients may prefer to have a partner, family member, or friend present during medical exams or assessments. This may not be feasible in emergency care settings in which you have to quickly stabilize patients who are acutely injured or may need ample space to appropriately assess and treat patients.

When possible, allow patients to identify support people (e.g., family members, loved ones) who might be at the scene. If it is common practice to allow family members and loved ones of non-transgender patients to ride along in the ambulance, allow loved ones of transgender patients to do so as well (but see [Companions as Abusers](#), in this e-pub). Similarly, if it is common practice to hand paperwork or resource brochures or other information to a loved one, follow identical practices when serving a transgender patient who has a loved one present.

Some transgender people may not have family or partners, but they may have developed strong social networks whose members have become family to them. Honoring these relationships as equally valid to legal family is another way to honor transgender peoples' lives and experiences.

1. According to unpublished survey data, for example, 72 percent of adult sexual assault victims who are transgender and 64 percent of those who were sexually abused as children have experienced at least one other form of victimization in their lives. FORGE, 2011, Transgender Individuals' Knowledge of and Willingness to Use Sexual Assault Programs, unpublished survey data, Morehouse School of Medicine's Institutional Review Board.

Law Enforcement



Because many transgender survivors of sexual assault have experienced previous traumas, they may already have trouble interacting with anyone new, including law enforcement officers.¹ Patience and persistence are key to effectively serving sexual assault survivors of any gender identity or history.

Transgender survivors may prefer to have a partner, family member, or friend present during medical exams, discussions about the crime, or law enforcement interactions. Some transgender people may not have family or partners, but they may have developed strong social networks whose members have become family to them. Honoring these relationships as equally valid to legal family is another way to honor transgender peoples' lives and experiences.

It is critical to determine that the individual with the transgender person is not the perpetrator. Screening the victim and companion separately is essential to ensuring that appropriate boundaries are set and maintained. (See [Companions as Abusers](#) in this e-pub.)

Some jurisdictions do not allow friends or relatives to be present during questioning. In these cases, if the transgender person still would like accompaniment, arrange for questioning to occur after the transgender victim has been connected with an advocate, who can be present during questioning.

1. According to unpublished survey data, for example, 72 percent of adult sexual assault victims who are transgender and 64 percent of those who were sexually abused as children have experienced at least one other form of victimization in their lives. FORGE, 2011, Transgender Individuals' Knowledge of and Willingness to Use Sexual Assault Programs, unpublished survey data, Morehouse School of Medicine's Institutional Review Board.

Advocates



Because many transgender survivors of sexual assault have experienced previous traumas, they may already have trouble interacting with anyone new, including advocates.¹ Patience and persistence are key to effectively serving sexual assault survivors of any gender identity or history.

Transgender survivors may prefer to have a partner, family member, or friend present during meetings with you or with other professionals. Some transgender people may not have family or partners to accompany them, but they may have developed strong social networks whose members have become family to them. Honoring these relationships as equally valid to legal family is another way to honor transgender peoples' lives and experiences. Treat transgender individuals' partners in the same manner as non-transgender patients' partners. Make sure, however, to screen companions first to ensure that they are not the perpetrators (see [Companions as Abusers](#) in this e-pub).

1. According to unpublished survey data, for example, 72 percent of adult sexual assault victims who are transgender and 64 percent of those who were sexually abused as children have experienced at least one other form of victimization in their lives. FORGE, 2011, Transgender Individuals' Knowledge of and Willingness to Use Sexual Assault Programs, unpublished survey data, Morehouse School of Medicine's Institutional Review Board.

Therapists



Transgender people who are in an intimate relationship may be with a non-transgender or transgender partner. Given that one in two transgender people have been sexually assaulted at some point in their lives, 75 percent of relationships with two transgender partners will include at least one survivor; in 25 percent of these relationships, both will be survivors.¹ To best serve transgender survivors, you must be up to date on the literature about the impact of trauma histories on intimate relationships.

In general, therapy is frequently about relationships with parents, coworkers, children, spouses, friends, chosen family, neighbors, or strangers. Therapists are well-versed in helping people resolve conflicts within relationships, understand relationship dynamics, and strengthen relationships that may have been fractured or weakened. Many transgender people use therapy to process relationships that are already complicated by gender identity. Sexual assault may increase tension in these relationships, undermine effective communication, or have a negative impact on trust. Recognizing how previous relationship challenges are affected by sexual assault can help increase transgender clients' sense of being understood and their ability to successfully engage in therapy.

1. FORGE, 2005, Sexual Violence in the Transgender Community Survey, unpublished data; G. Kenagy, 2005, "The Health and Social Service Needs of Transgender People in Philadelphia," *International Journal of Transgenderism* 8(2/3):49–56; G. Kenagy and W. Bostwick, 2005, "Health and Social Service Needs of Transgendered People in Chicago," *International Journal of Transgenderism* 8(2/3):57–66.

Support Group Facilitators



Many books are available about working with couples in which one or both partners have a trauma history. Given that one in two transgender people have been sexually assaulted at some point in their lives, 75 percent of relationships with two transgender partners will include at least one survivor; in 25 percent of these relationships, both will be survivors.¹ To best serve transgender survivors, you must be up to date on the literature about the impact of trauma histories on intimate relationships, and you should invite clients to discuss trauma histories if they exist. In addition, encourage transgender survivors to engage their partners in therapy, support groups, or other forms of direct support.

1. FORGE, 2005, Sexual Violence in the Transgender Community Survey, unpublished data; G. Kenagy, 2005, "The Health and Social Service Needs of Transgender People in Philadelphia," *International Journal of Transgenderism* 8(2/3):49–56; G. Kenagy and W. Bostwick, 2005, "Health and Social Service Needs of Transgendered People in Chicago," *International Journal of Transgenderism* 8(2/3):57–66.

RESPONDING TO TRANSGENDER VICTIMS of Sexual Assault

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Victim Issues

Mistrust of Professionals

Providing culturally competent care is critical to successfully serving members of marginalized communities. In the joint report by the National Coalition of Anti-Violence Programs (NCAVP) and the National Center for Victims of Crime, *Why It Matters: Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender, and Queer Victims of Hate Violence and Intimate Partner Violence*, 93 percent of NCAVP member programs and 51 percent of mainstream victim assistance programs said that victim assistance programs need more population-specific training on transgender people.¹¹

Many transgender individuals avoid seeking help after an assault because they fear that the professionals who are supposed to serve them will be ignorant about transgender people at best or outright prejudiced or hostile at worst. These concerns are not unfounded.

- In FORGE's survey of transgender sexual assault survivors, one-third of the respondents did not access services because they were afraid to.¹² According to the survey, 5 percent reported being sexually assaulted by a law enforcement officer and 6 percent reported being assaulted by a health care professional or social service provider. One survivor told FORGE—

One assault was in an emergency room at a hospital, by a female doctor who I believe was angered by my appearance (I looked male and my hospital bracelet/chart said "female").

- NCAVP reports that of the anti-LGBTQ hate crimes that came to its attention in 2011, 9 percent were perpetrated by law enforcement officers and 4 percent by service providers.¹³
- According to the National Transgender Discrimination Survey, 28 percent of transgender individuals reported being harassed in medical settings, 19 percent reported being refused care outright, 2 percent reported being physically attacked in a doctor's office, 50 percent indicated they had to teach their medical providers about transgender care, and 1 in 10 reported that they had been sexually assaulted in at least one health care setting.¹⁴

In FORGE's survey, 9 percent of survivors had been forced into mental health care (including psychiatric inpatient admissions), and nearly 3 percent had been subjected to unwanted medical care. Abuse by therapists is also a problem:

I was inappropriately used sexually by my gender therapist in [city withheld]. He began sexually advancing to show me how to be a "real man," as a way of modeling masculine behavior. It became obvious that I needed to be sexual with him in order to receive the required letter to have chest surgery. We had sex a countless number of times—sometimes in his office, sometimes my house, sometimes he would make me take him out to dinner and pay the bill. When I realized that this was wrong, I asked him for my surgery letter so I could discontinue "therapy." He refused and I had to pay thousands of dollars to reestablish a relationship with another therapist in order to get a surgery letter.¹⁵

Even those who have not personally experienced problems may fear what might happen based on the experiences of friends or publicity about particularly egregious incidents of transphobia. One of the best

known examples is the gross negligence that resulted in the death of [Tyra Hunter](#) in Washington, D.C., in 1995. Tyra had been involved in a car accident. Once fire department personnel at the scene discovered that she had male genitals, they stopped treatment and began joking about her. The negligence continued at the local hospital's emergency department, where a doctor refused to provide treatment. She later died of her injuries. According to experts who testified at the trial, had she received proper medical care, she would have had an 86-percent chance of survival.

Due to past experience and fear based on other people's experiences, transgender victims of sexual assault may not trust law enforcement, health care providers, therapists, or other professionals. This is one of the primary reasons why reporting rates among this population are so low—only 9 percent of survey respondents reported their sexual assaults to law enforcement. As one respondent stated, "Now that I am out as trans, I'm less likely to report anything or seek medical attention, even if I need it."¹⁶

Trauma research clearly shows that the initial responses a victim of violence receives can make a huge difference in how traumatic the incident feels and how well the victim heals over time. Responding with compassion and care and listening closely to victims can make a huge difference in their lives.¹⁷

Training personnel is key. According to the Gay and Lesbian Medical Association, "all employees need to understand that discrimination against transgender clients, whether overt or subtle, is as unethical and unacceptable—and in many states as illegal—as any other kind of discrimination. Employers should make it clear to employees that discrimination 'will not be tolerated.'"¹⁸ In addition, any training that is effective will need ongoing monitoring: "It is important to monitor compliance [with nondiscrimination training] and provide a mechanism for patients to report any disrespectful behavior."¹⁹

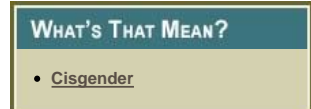
Training for staff members should include instruction on anti-transgender bias and unique transgender concerns. According to Public Health: Seattle and King County, "all staff dealing directly with clients should be able to talk comfortably about all forms of sexuality and all gender identities. Have staff practice with each other until they are comfortable."²⁰

Because transgender individuals' relationships with mental health care providers and law enforcement officers are particularly complicated, more information about each is found below.

Mental health care providers

Mental health care providers can often provide high levels of support, care, and survivor-specific skills and resources for sexual assault survivors, both directly following an assault and throughout years of followup. The uniquely complicated relationship that can exist between transgender people and mental health care providers is due to transgender health care protocols [e.g., World Professional Association for Transgender Health (WPATH) Standards of Care]²¹ and newer informed-consent models of care.²² The WPATH Standards of Care protocols position the therapist as a gatekeeper who can allow or deny a client the right to a letter to access hormones or surgery. Informed-consent models, while providing transgender clients with increased agency over their mental and physical health, may still include screening for mental health stability before prescribing hormones or writing surgery letters.

Transgender individuals are often uncomfortable being pathologized by therapists, mental health providers, and society. For many, being transgender is as natural for them as being cisgender is for non-transgender people. Being diagnosed with a mental health or medical condition is therefore highly upsetting.



Transgender people who do access therapists often do not reveal past traumas, current mental health issues, or drug or alcohol use because they fear the therapist will use that information as justification for not writing the letter they need to access hormones or surgery. Others will seek a therapist specifically for healing from sexual assault and will not disclose information about their transgender status or history.

Some therapists believe that transness causes abuse/assaults. Others believe that abuse/assault causes transgenderism. Many transgender people fear encountering a therapist who believes either of these. Many, fortunately, do not believe in causality in either direction.

GENDER IDENTITY DISORDER AND THE DSM

In December 2012, the American Psychiatric Association removed gender identity disorder from the latest version of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–V). Gender identity disorder had long been used to diagnose transgender individuals with a mental illness, which has frequently resulted in both stigma and denial of both mental health and physical health services due to insurance exclusions based on this diagnosis. The former diagnosis was in the DSM under "sexual disorders."

Due to the predominance of "gender dysphoria" language in the professional literature, gender identity disorder has been renamed "gender dysphoria" and has been moved out of the "sexual disorders" category. Separate diagnostic criteria have been developed for children and adults.

Law enforcement officers

Law enforcement officers may be the first people a transgender survivor encounters after an assault. The role of law enforcement to help victims of crime may be forgotten (or not believed) by transgender people who have had unhelpful interactions with law enforcement in the past. Officers can reinforce positive contact with survivors—either directly after an assault (e.g., when taking a report) or in the weeks or months following an assault—by actively reminding survivors that they are there to help.

In 2011, the National Coalition of Anti-Violence Programs reported that lesbian, gay, bisexual, and transgender crime victims who reported to law enforcement received "indifferent" responses 38 percent of the time, with 18 percent encountering a "hostile" response. Nearly one-third (32 percent) of those who contacted law enforcement reported misconduct, including misarrest (38 percent), excessive force (19 percent), and entrapment (12 percent).²³

Unprovoked street harassment, assaults, arrests, and officers' ignorance or insensitivity may make transgender individuals hesitant to interact with law enforcement under any circumstances. In addition, some transgender people, particularly those who transition from male to female, become involved in the sex trade or engage in survival sex (i.e., the exchange of sex for food, shelter, safety, or other essentials) to support their basic needs. Because of their involvement in the underground economy, these individuals may not want to involve law enforcement, even when they are victimized.

Reporting sexual assault is therefore relatively uncommon among the transgender population. In FORGE's survey, only 9 percent of survivors reported their assaults to law enforcement.²⁴

READ MORE

In this e-pub*—

- Sexual Assault in the Transgender Community: [Gender Identity and Sexual Assault](#)

*Clicking these links will take you to other sections in this e-pub. To return, hit your browser's "back" button.

Implications and Actions for ...

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Health Care Providers

When transgender patients first come to the hospital or your office seeking care, they should receive a patient's bill of rights and information about HIPAA to help them understand their privacy rights and what their recourse is if they feel that a provider is not acting in a culturally competent manner or has violated their rights. Frontline staff should review the bill of rights with patients. When possible, remind transgender patients that you are committed to respectful and competent care and that they will be treated with respect and professionalism. Consider the benefits of specifically stating that the relationship is professional and will not be abusive or exploitive in any way.

You may want to model your bill of rights after others that have created inclusive, welcoming, and victim-empowered statements of rights. One trans-aware example is from Johns Hopkins Hospital, which states, in part¹—

- You have the right to receive considerate, respectful, and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity, or disabilities.
- You have the right to be called by your proper name and to be in an environment that

- maintains dignity and adds to a positive self-image.
- You have the right to have a family member or person of your choice and your own doctor notified promptly of your admission to the hospital.
- You have the right to have someone remain with you for emotional support during your hospital stay, unless your visitor's presence compromises your or others' rights, safety, or health. You have the right to deny visitation at any time.
- You can expect full consideration of your privacy and confidentiality in care discussions, exams, and treatments. You may ask for an escort during any type of exam.

Transgender people may arrive at emergency rooms reluctantly, sometimes due to well-intentioned pressure from partners, family, or friends. If the patient comes in with someone, allow the support person to be present in examinations and interviews if the patient requests this (but see [Companions as Abusers](#) in this e-pub). If the patient comes in alone, ask if there is someone who can be called in to serve as support. All victims can benefit from the support and services victim advocates provide. (If your facility does not have victim advocates, patient advocates can work with victims to contact local victim advocates or victim service providers.) Proactively connect victims with an advocate, regardless of whether the victim arrives alone or with a companion. Some larger facilities have sexual assault response teams that have well-trained, LGBT-knowledgeable advocates.

Staying highly focused on the patient's injuries and overtly stated medical concerns, without becoming distracted by asking questions about transgender history, will help patients develop greater trust in you. Overtly stating that the role of the medical team is to assess and address the patient's medical conditions may help reduce their concerns related to revictimization or exploitation.

In urgent care settings, patients often see multiple providers. Due to the sensitive nature of sexual assault coupled with the patient's transgender identity, it may be beneficial to reduce the number of providers the patient sees. The need to repeatedly disclose the details of the assault or the patient's transgender identity or history may cause the patient additional emotional stress. The presence of an advocate can reduce many of the stresses of disclosure for patients.

You may need to make referrals to mental health care providers or work with law enforcement to best serve transgender patients who have been sexually assaulted. Information on how to navigate the often complicated interactions that transgender people have with these professionals follows.

Mental health care providers

If you believe a transgender patient may benefit from mental health services, be aware that some transgender people have had previously negative or discriminatory experiences with therapists or other mental health care providers, particularly related to their gender. Expressing concern for patients' overall well-being and overtly stating that untreated mental health issues can have negative health implications may help them understand that you are not pathologizing their gender but are truly concerned about their health. If a patient talks about suicide or hopelessness, a prompt referral to a mental health care provider or crisis team is necessary, if not mandated.

When possible, prescreen mental health care providers before making a referral to ensure that they are knowledgeable about and welcoming of transgender clients. Most urban communities have therapists who specialize in working with transgender clients, and every state has at least one transgender support group that may have a referral list of transgender-friendly therapists (see [Outreach](#) in this e-pub). You can also contact FORGE, which maintains a database of mental health care providers across the country who work with transgender clients. Contacting your local LGBT anti-violence program is also an excellent source for transgender-informed referrals; see the member list on the [National Coalition of Anti-Violence Programs' Web site](#). Patients may be more open to a referral (and actually keeping an appointment) if given a prescreened referral list, and even more so if you have actively partnered with mental health care providers who work with transgender clients.

If a patient refuses a therapy referral, consider support groups and/or online support services, such as FORGE's online course [Writing to Heal](#), its [Survivors Listserv](#), and The Network/La Red's all-gender LGBT [phone-based support group](#) (the latter of which is not regularly offered).

When permissible, it may be preferable not to document a mental health care referral, which could be included in a forensic file that is released to the police, prosecutors, and defense counsel in the event of prosecution. Documented mental health care referrals may also have an impact on an insurance

company's willingness to pay for medical services, particularly if there is any notation about the patient's transgender status. Health care providers should be familiar with local rules and requirements regarding record-keeping and record submission and should be clear about these rules when meeting with patients. Speak with patients ahead of time about which information can be shared and which information they would prefer not be revealed.

Law enforcement

Remind patients of confidentiality policies and any limitations on maintaining their confidentiality, and reassure them that police or other authorities will not be called unless the patient agrees to have them called, except in cases of mandatory reporting (e.g., the patient is under age or has developmental disabilities). Sexual assault victims may not know their options regarding whether or how to report the assault as a crime and whether or when they need to talk with law enforcement. Ensure that the patient is connected with an advocate who can explain the choices; outline potential risks/consequences and benefits; and soothe the client's fears.

If a patient has reported the assault to the police and the case goes to court, a health care provider may be asked to give a statement or testify. Speak with patients ahead of time about which information can be shared and which information they would prefer not be revealed. **Do not make promises that cannot be kept.** Having one or more transparent conversations ahead of time will build trust and reduce fears. (See [Disclosure and Confidentiality](#) for more information.)

If a jurisdiction has the option, inform the patient that forensic evidence can be collected within the first 72 hours after an assault, and the patient therefore has some time to decide if police will be involved. Some states and jurisdictions allow for up to 120 hours. Regardless of evidence collection, some victims may have months to decide to involve the police; however, waiting this long may affect the success of a case if prosecuted.

Note: Some jurisdictions will collect evidence without calling the police. It may also be useful for the patient to understand that police need to be involved if the client wants to file for crime victim compensation. An advocate can explain the process and rules to the patient.

IMPROVE YOUR REPUTATION BY IMPROVING YOUR KNOWLEDGE

In general, providers receive very little formal training about best practices in working with transgender people. Become better informed of transgender issues by—

- **Attending conferences.** Transgender-specific or -inclusive workshops are increasingly offered at professional conferences primarily intended to enhance general therapeutic knowledge and skills (e.g., conferences of the American Medical Association, American Academy of Physician Assistants, and American Society on Aging) and at trauma-specific conferences (e.g., National Center for Victims of Crime's national conference, National Sexual Assault Conference, Sexual Assault Response Team Training Conference). There are also quite a few transgender-specific conferences with tracks or workshops focused on providers, including the following:
 - [Philadelphia Trans Health Conference](#)
 - [World Professional Association for Transgender Health Biennial Symposium](#)
 - [First Event](#)
 - [Gender Odyssey](#)
 - [TransOhio Conference](#)
 - [Empire Conference](#)
 - [Southern Comfort Conference](#)
 - [Fantasia Fair](#)
 - [Creating Change](#) (although not transgender specific, this is the largest LGBT conference in the Nation)
- **Participating in webinars.**
 - [FORGE webinars \(upcoming, recorded\)](#)
 - [Just Detention International webinars](#)

- **Reading books** specifically on working with transgender people.
 - *Transgender Emergence: Therapeutic Guidelines for Working With Gender-Variant People and Their Families*, Arlene Istar Lev, 2004
 - *Guidelines for Transgender Care*, edited by Walter O. Bockting and Joshua Goldberg, 2007
- **Joining special interest groups**, which often offer listservs that allow you to network with other providers.
 - [LGBT Physician Assistant Caucus](#)
 - [Gay and Lesbian Medical Association](#) (trans-specific links available)
 - [LGBT Aging Issues Network](#), American Society on Aging
- **Viewing documentary films.**
 - [TRANSforming Healthcare: Transgender Cultural Competency for Medical Providers](#)
 - [Diagnosing Difference](#)
- **Participating in listservs.** Many health care providers are benefitting from one-on-one, direct responses to their questions by participating in the [trans-medicine listserv](#). The listserv, which is limited to health care providers, addresses a wide range of medical questions with peer-to-peer, evidence-based responses and dialogue.
- **Developing or strengthening relationships with local LGBT and transgender organizations** and other professionals working with transgender individuals (see [Outreach](#) in this e-pub).
- **Building relationships and partnerships with local service providers.** No single discipline can provide the victim-centered services and support that every transgender victim of sexual violence deserves. You are not alone. Research and join local multidisciplinary or coordinated response teams (e.g., sexual assault response teams, sexual assault councils or committees) to play a role in first response and to build awareness of transgender issues in your community.

1. See Johns Hopkins Hospital's ["Participating in Your Care"](#) for its patient bill of rights.

Emergency Medical Personnel

Because so many transgender people have had negative experiences with professionals who are supposed to help them—therapists, physicians, emergency medical personnel, and many other people in positions of authority—transgender victims of crime may be hesitant to call 911 or to interact with emergency medical personnel (EMPs) ([see more information about these negative experiences](#)). Rather than viewing emergency medical personnel and other first responders as people who are there to help them, transgender individuals may be concerned that first responders will blame, harass, abuse, assault, or arrest them, even when they have done nothing wrong.

Some EMPs may perceive a patient's reticence as an indication of defensiveness or deception, which may lead them, or law enforcement officers on the scene, to question the legitimacy of the person's story. With a transgender patient, this reticence is more likely related to self-protection and fears of being wrongly arrested, falsely accused, or treated with disrespect.

Providing patients with sensitive and respectful care and using phrases such as "I'm here to help you," and "Can you tell me more about what happened, so I can better serve you?" may help reduce their fears and resistance. Remaining professional at all times will also help lessen transgender patients' anxieties about interacting with helping professionals in uniform.

Remind patients that what is most important for them in the minutes or hours post-assault is to receive care for their medical injuries, and consider informing them that they have more than one opportunity to have forensic evidence collected. Although forensic evidence is most effective when collected directly after an assault, it can often be collected up to 72 hours post-assault. Some states and jurisdictions allow for up to 120 hours. Reminding patients of their options and providing them with information on how to contact law enforcement at a later date gives them options and control. It is also useful to remind patients that they are entitled to have a sexual assault victim advocate present during all interactions with medical staff at the hospital, if their injuries warrant hospital care. They should also be informed that the advocate can be present in discussions with law enforcement or if they consider pursuing victim compensation or for other emotional support.

It is rare for EMPs to receive any form of diversity training on transgender issues unless there is a specific incident or need. Some transgender communities have mobilized efforts to raise awareness of transgender issues and have pushed for training of people who serve transgender victims of violence, including EMPs. Unfortunately, a lack of staff time, limited resources, and other training priorities mean most fire departments and other first responders have no or minimal formal training in these issues.

IMPROVE YOUR REPUTATION BY IMPROVING YOUR KNOWLEDGE

Most first responders treat all patients with professionalism and respect and are not intentionally ignorant or prejudiced toward transgender people. A lack of formal training in transgender issues, however, may result in accidentally engaging in behavior that is inappropriate or prejudicial. Become better informed of transgender issues by—

- Attending trainings and conferences, a growing number of which are including LGBT (and even trans-specific) workshops and educational materials.
- Encouraging the appointment of an LGBT liaison who can represent lesbian, gay, bisexual, **and** transgender community members.
- Being part of a diversity group and raising issues related to serving transgender individuals more sensitively.
- Accessing and suggesting resources that can be shared at staff meetings. Even a 10-minute awareness video or quick fact sheet can help people respond more appropriately when encountering a transgender individual. Consider some of the following resources¹:
 - [Transgender Basics: Gender Identity Project](#)
 - [Transgender Training Video](#) (10-minute roll call video, Chicago Police Department)
 - [Transgender Community of Police and Sheriffs](#)
 - [Transgender 101 for Victim Service Providers](#)
- Building relationships and partnerships with local service providers. No single discipline can provide the victim-centered services and support that every transgender victim of sexual violence deserves. You are not alone. Research and join local multidisciplinary or coordinated response teams (e.g., sexual assault response teams, sexual assault councils or committees) to play a role in first response and to build awareness of transgender issues in your community.

1. FORGE is not aware of any EMP-specific transgender resource. The resources listed may be useful, even if they are not profession specific.

Law Enforcement

Because so many transgender people have had negative experiences with professionals who are supposed to help them—therapists, physicians, law enforcement officers, and many other people in positions of authority—transgender victims of crime may be hesitant to call 911 or to interact with law enforcement ([see more information about these negative experiences](#)). Rather than viewing law enforcement officers as people who are there to help, transgender individuals may be concerned that they will be blamed, harassed, abused, assaulted, or arrested, even when they have done nothing wrong. Within the transgender community, there are many true stories of transgender people being targeted for using the "wrong" public bathroom, for example, or being accused of solicitation while walking down the street.¹

Some law enforcement officers may perceive a victim's reticence as an indication of defensiveness or deception, which may lead them to question the legitimacy of a victim's story. With the transgender victim, this reticence is more likely related to self-protection and fears of being wrongly arrested, falsely accused, or treated with disrespect.

Providing victims with sensitive and respectful care and using phrases such as "I'm here to help you" and "Can you tell me more about what happened so I can better serve you?" may help reduce victims' fears and resistance. Remaining professional at all times will also help lessen victims' anxieties about interacting with law enforcement officers. Consider informing victims that they have more than one opportunity to talk to law enforcement or to make a report. The additional time allows victims to access medical care (if needed or appropriate) and to determine if they want to file a police report or have

evidence collected. Although forensic evidence is most effective when collected directly after an assault, it can often be collected up to 72 hours post-assault. Some states and jurisdictions allow for up to 120 hours. Reminding victims of their options and providing them with information on how to contact you at a later date gives them control. It is also useful to remind victims that they are entitled to have a sexual assault victim advocate present during all interactions with law enforcement, which may encourage reporting or cooperation.

It is rare for law enforcement to receive diversity training on transgender issues unless there is a specific incident or need. Some transgender communities have mobilized efforts to raise awareness of transgender issues and have pushed for training of people who serve transgender victims of violence, including law enforcement officers. Unfortunately, a lack of staff time, limited resources, and other training priorities mean most police departments and other first responders have no or minimal formal training in these issues.

IMPROVE YOUR REPUTATION BY IMPROVING YOUR KNOWLEDGE

Most law enforcement officers treat all victims with professionalism and respect and are not intentionally ignorant or prejudiced toward transgender people. A lack of formal training in transgender issues, however, may result in accidentally engaging in behavior that is inappropriate or prejudicial. Become better informed of transgender issues by—

- Attending trainings, conferences, and roll call meetings, a growing number of which are including LGBT (and even trans-specific) workshops and educational materials.
- Encouraging the appointment of an LGBT liaison who can represent lesbian, gay, bisexual, **and** transgender community members.
- Being part of a diversity group and raising issues related to serving transgender individuals more sensitively.
- Accessing and suggesting resources that can be shared at roll call and staff meetings. Even a 10-minute awareness video or quick fact sheet can help people respond more appropriately when encountering a transgender individual. Consider some of the following resources:
 - [Transgender Basics: Gender Identity Project](#)
 - [Transgender Training Video](#) (10-minute roll call video, Chicago Police Department)
 - [Transgender Community of Police and Sheriffs](#)
 - [Transgender 101 for Victim Service Providers](#)
- Building relationships and partnerships with local service providers. No single discipline can provide the victim-centered services and support that every transgender victim of sexual violence deserves. You are not alone. Research and join local multidisciplinary or coordinated response teams (e.g., sexual assault response teams, sexual assault councils or committees) to play a role in first response and to build awareness of transgender issues in your community.

1. Make the Road New York, 2012, [Transgressive Policing: Police Abuse of LGBTQ Communities of Color in Jackson Heights](#), New York, NY: Make the Road New York, accessed June 18, 2013.

Advocates

Your role is to support the victim, no matter what the victim's gender identity is or the circumstances of the assault. Due to previous experiences of abused trust, transgender people may be wary of anyone serving in a supportive role and it may be difficult to earn their trust. To increase trust, be consistently respectful, avoid asking inappropriate and insensitive questions, and support the victim's need for control. Other steps, such as reminding victims that your role is to support them in what they want and need, providing them with options, and encouraging them to determine the course of action, will help them feel safer with you.

Simple actions can have a big impact. For example, accompanying victims to visits with other professionals may help them feel less vulnerable. When victims give you explicit and advance permission, help educate these other professionals about transgender issues so that victims do not have to and can instead focus on their sexual assault-related needs. This helps maintain a victim's dignity and privacy and ensures that the other professionals (e.g., health care providers) act

professionally and ethically. When you combine these actions with those used to support all victims, such as keeping track of questions and making sure they are answered in a way that makes sense to the victim, you can have a significant impact on the success of a victim's care.

Some advocates are able to participate in community events and educational opportunities. Advocating for systematic change can have a significant impact on client services. When possible, training other members of sexual assault response teams and engaging in public education with transgender audiences may help build trust within the transgender community. See [Outreach](#) in this e-pub for more information.

You may need to make referrals to mental health care providers or work with law enforcement to best serve transgender victims who have been sexually assaulted. Information on how to navigate the often complicated interactions that transgender people have with these professionals follows.

Mental health care providers

With good cause, transgender victims may refuse referrals to mental health care providers. Victims may be more open to a referral (and actually keeping an appointment) if given a prescreened referral list, and even more so if you have actively partnered with mental health care providers who work with transgender clients. If a victim refuses a therapy referral, consider support groups and/or online support services such as FORGE's online course [Writing to Heal](#), its [Survivors Listserv](#), and The Network/La Red's all-gender LGBT [phone-based support group](#) (the latter of which is not regularly offered).

Law enforcement

Becoming familiar with the local officers who respond to sexual assault allegations and exploring whether you can request a particular officer can be useful in minimizing police misconduct and increasing the victim's willingness to engage with law enforcement. If you do request particular officers because of their sensitivity, let the victim know. Remind victims that they are entitled to have you present for all interactions with law enforcement, which may encourage reporting and cooperation with police investigations.

If a jurisdiction has the option, inform the victim that forensic evidence can be collected within the first 72 hours after an assault and the victim therefore has some time to decide if law enforcement will be involved. Some states and jurisdictions allow for up to 120 hours. Regardless of evidence collection, some victims may have months to decide to involve law enforcement; however, waiting this long may affect the success of a case if prosecuted.

Note: Some jurisdictions will collect evidence without calling law enforcement. It may also be useful to explain that law enforcement needs to be involved if the victim wants to file for crime victim compensation.

IMPROVE YOUR REPUTATION BY IMPROVING YOUR KNOWLEDGE

For the long-term improvement of care of transgender victims, advocates can ease the way by educating themselves about transgender issues and advocating for widespread professional education as well. Become better informed of transgender issues by—

- **Watching videos and webinars.**

- [Transgender Basics: Gender Identity Project](#)
- [TRANSforming Healthcare: Transgender Cultural Competency for Medical Providers](#)
- [Transgender 101 for Victim Service Providers](#)
- [Creating a Trans-Welcoming Environment](#)

- **Joining or following organizations.**

- [National Coalition of Anti-Violence Programs](#)
- [National Center for Transgender Equality](#)
- [FORGE](#)

- **Participating in listservs.**
 - [FORGE's listserv](#)
- **Reading publications.**
 - [FORGE Anti-Violence FAQ Sheets](#)
- **Developing or strengthening relationships with local LGBT and transgender organizations** and other professionals working with transgender individuals (see [Outreach](#) in this e-pub).
- **Building relationships and partnerships with local service providers.** No single discipline can provide the victim-centered services and support that every transgender victim of sexual violence deserves. You are not alone. Research and join local multidisciplinary or coordinated response teams (e.g., sexual assault response teams, sexual assault councils or committees) to play a role in first response and to build awareness of transgender issues in your community.

Therapists

When transgender clients first come to your office seeking care, they should receive a client's bill of rights and information about HIPAA to help them understand their privacy rights and what their recourse is if they feel that a provider is not acting in a culturally competent manner or has violated their rights. Frontline staff should review the bill of rights with clients. When possible, remind transgender clients that you are committed to respectful and competent care and that they will be treated with respect and professionalism. Consider the benefits of specifically stating that the relationship is professional and will not be abusive or exploitive in any way.

You may want to model your bill of rights after others that have created inclusive, welcoming, and client-empowered statements of rights. One trans-aware example is from Johns Hopkins Hospital, which states, in part¹—

- You have the right to receive considerate, respectful, and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity, or disabilities.
- You have the right to be called by your proper name and to be in an environment that maintains dignity and adds to a positive self-image.
- You have the right to have a family member or person of your choice and your own doctor notified promptly of your admission to the hospital.
- You have the right to have someone remain with you for emotional support during your hospital stay, unless your visitor's presence compromises your or others' rights, safety, or health. You have the right to deny visitation at any time.
- You can expect full consideration of your privacy and confidentiality in care discussions, exams, and treatments. You may ask for an escort during any type of exam.

As you begin treatment, be mindful of the fact that some transgender people have had previously negative experiences with therapists, particularly related to their gender. Some transgender people were forced into therapy as children to “cure” them of their gender non-conformity, and others have had to endure mental health providers who are ignorant or prejudiced in order to obtain documentation necessary for medical transition. Keep these factors in mind, and make sure to be patient and consistent during the trust-building stages of the therapeutic relationship.

REPORTING TO LAW ENFORCEMENT

Some clients you are treating may need support when interacting with law enforcement officers, and others may need additional support after this interaction. If a client decides to report a sexual assault to law enforcement, consider stepping out of your office role to accompany that client to the police department or to be present as an advocate and witness during interviews. Before making this offer, however, be mindful of your confidentiality requirements and consider consulting with colleagues or your clinical supervisor or licensing board.

If a client you are treating has reported to law enforcement and is pursuing legal action or there is a prosecution in a case, disclosure of therapeutic records and client notes may be requested or compelled. Familiarize yourself with the local rules and requirements regarding record-keeping and record submission, and be clear about these rules when meeting with clients. Keep in mind that written notes, even if not in the primary file, may be subject to disclosure (e.g., through a subpoena) in legal proceedings. Discuss confidentiality and the possible subpoena of records in advance with the client. **Do not make promises that cannot be kept.** Having one or more transparent conversations ahead of time may help to build trust and reduce fears. (See [Disclosure and Confidentiality](#) for more information.)

Do not assume that just because a client is transgender, they are seeking mental health services to explore their gender identity. Knowing one or two facts about a person—transgender status, sexual assault history, or any other trait—is only a small piece of who that person is. Asking questions, paying attention to a person's explanation of what is important to them, and not presuming causality will better ensure that transgender clients receive the care they need.

Because transgender people often experience improper behavior from professionals, they may need multiple sessions before they can begin to trust you. Allowing them to bring a companion with them to sessions may encourage them to make and keep their appointments (but see [Companions as Abusers](#) in this e-pub).

IMPROVE YOUR REPUTATION BY IMPROVING YOUR KNOWLEDGE

In general, therapists receive very little formal training about best practices in working with transgender people. Become better informed of transgender issues by—

- **Attending conferences.** Transgender-specific or inclusive workshops are increasingly offered at professional conferences primarily intended to enhance general therapeutic knowledge and skills (e.g., conferences of the American Medical Association, American Academy of Physician Assistants, and American Society on Aging) and at trauma-specific conferences (e.g., National Center for Victims of Crime's national conference, National Sexual Assault Conference, Sexual Assault Response Team Training Conference). There are also quite a few transgender-specific conferences with tracks or workshops focused on providers, including the following:
 - [Southern Comfort Conference](#)
 - [Philadelphia Trans Health Conference](#)
 - [TransOhio Conference](#)
 - [Gender Odyssey](#)
 - [First Event](#)
 - [Empire Conference](#)
 - [Fantasia Fair](#)
 - [World Professional Association for Transgender Health Biennial Symposium](#)
 - [Creating Change](#) (although not transgender specific, this is the largest LGBT conference in the Nation)
- **Participating in webinars.**
 - FORGE webinars ([upcoming](#), [recorded](#))
 - [Just Detention International webinars](#)
- **Reading books** specifically on working with transgender people.
 - *Transgender Emergence: Therapeutic Guidelines for Working With Gender-Variant People and Their Families*, Arlene Istar Lev, 2004
 - *Transition and Beyond: Observations On Gender Identity*, Reid Vanderburgh (also see [Reid Vanderburgh's Web site](#))
- **Joining special interest groups**, which often offer listservs that allow you to network with other therapists.
 - [American Psychological Association's Division 44](#)
 - [National Association of Social Workers LGBTQI special interest group](#)
 - [American Association of Sexuality Educators, Counselors, and Therapists](#)
- **Viewing documentary films.**
 - [Diagnosing Difference](#)
 - [TRANSforming Healthcare: Transgender Cultural Competency for Medical Providers](#)
- **Developing or strengthening relationships with local LGBT and transgender organizations** and other professionals working with transgender individuals (see [Outreach](#) in this e-pub).
- **Building relationships and partnerships with local service providers.** No single discipline can provide the victim-centered services and support that every transgender victim of sexual violence deserves. You are not alone. Research and join local multidisciplinary or coordinated response teams (e.g., sexual assault response teams, sexual assault councils or committees) to play a role in first

response and to build awareness of transgender issues in your community.

1. See Johns Hopkins Hospital's "[Participating in Your Care](#)" for its patient bill of rights.

Support Group Facilitators

Some transgender victims may hesitate to join support groups for fear that they will encounter anti-transgender bias, not just from support group professionals but also from other clients within the group. Confronting bias can be challenging and is often not a well-developed skill; ignoring it, however, creates an unsafe and unhealthy environment for everyone involved. Tackling bias is discussed in the [Treating the Victim](#) section of this e-pub (see Implications and Actions for Support Group Facilitators in that section).

When transgender people do decide to join a support group, make sure that they and everyone else in the group receives a client's bill of rights to help them understand what their recourse is if they feel that a provider is not acting in a culturally competent manner or has violated their rights.¹ Review the bill of rights together. When possible, remind transgender clients that you are committed to respectful and competent care and that they will be treated with respect and professionalism. Consider the benefits of specifically stating that the relationship is professional and will not be abusive or exploitive in any way.

DISCUSSIONS RELATED TO POLICE OFFICERS

Some support group members may have reported their sexual assault to law enforcement and may want to talk about it during the group. Others may have strong emotions about law enforcement because they may have experienced previous police misconduct. Sensitivity to and awareness of this issue are helpful in creating a space that will ideally not revictimize individuals.

It is important to focus on the reason that a transgender client entered the group—for support following a sexual assault. Transgender issues may not need to be discussed at all or may only need tangential comments. Knowing one or two facts about a person—transgender status, sexual assault history, or any other trait—is only a small piece of who that person is. Asking questions, paying attention to a person's explanation of what is important to them, and not presuming causality will better ensure that transgender clients receive the support they need.

IMPROVE YOUR REPUTATION BY IMPROVING YOUR KNOWLEDGE

Most support group facilitators are not intentionally ignorant or prejudiced. They simply have limited or no experience in working with transgender people. Of course, transgender victims are more likely to seek out services from well-informed support group facilitators, and to trust those facilitators as well. The following resources may be useful in improving your knowledge about core transgender issues:

- [Transgender Basics: Gender Identity Project](#)
- [TRANSforming Healthcare: Transgender Cultural Competency for Medical Providers](#)
- [American Psychological Association's Division 44](#)
- *Transgender Emergence: Therapeutic Guidelines for Working With Gender-Variant People and Their Families*, Arlene Istar Lev, 2004
- Reid Vanderburgh, retired therapist ([transgender consulting and resources](#))
- [Transgender 101 for Victim Service Providers](#)
- [Creating a Trans-Welcoming Environment](#)
- [FORGE's listserv](#)

Also consider developing or strengthening relationships with local LGBT and transgender organizations and other professionals working with transgender individuals (see [Outreach](#) in this e-pub) and building relationships and partnerships with local service providers. No single discipline can provide the victim-centered services and support that every transgender victim of sexual violence deserves. You are not alone. Research and join local multidisciplinary or coordinated response teams (e.g., sexual assault response teams, sexual assault councils or committees) to play a role in first response and to build awareness of transgender issues in your community.

1. Clients should also receive information about HIPAA, if applicable, e.g., the support group is facilitated by a psychotherapist or a professional with specific licensure, such as an MSW.

RESPONDING TO TRANSGENDER VICTIMS of Sexual Assault

Message From the Director

About This Guide

Transgender 101

Sexual Assault in the
Transgender Community

Tips for Those Who
Serve Victims

JUNE 2014

Printer-Friendly Option

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Tips for Those Who Serve Victims

+ Victim Issues

− Perpetrator Issues

Gender of Perpetrator

Companions as Abusers

+ Standard Practices

− Notes

Five Keys

Outreach

Perpetrator Issues

Gender of Perpetrator

When FORGE first analyzed its sexual violence study findings, it appeared there was a transgender-specific anomaly: 29 percent of respondents said at least one of their perpetrators was female.²⁵ In researching this "anomaly," FORGE found that multiple studies have shown that about one-quarter of all sexual violence victims report a female assailant.²⁶ These data are not well-known; in part because the public's image of sexual assault is usually that of a male perpetrator and a female victim, and in part because there is ample evidence that accusations against female perpetrators are routinely dismissed or rationalized.²⁷

Several respondents in the FORGE survey noted that they did not bother reporting sexual assaults by female perpetrators because they did not expect anyone to believe them²⁸:

I was afraid to go to the police for the last one [assault] because my attacker was a woman, and I had enough trouble trying to convince them it was a real attack when my attacker was male.

I was considered a male at [the] time, so no one would have believed I was raped by a female.

The popular conception of what constitutes a sexual assault can affect a victim's ability to understand and label the behavior as abuse or assault²⁹:

I've had trouble naming what happened as abuse. Although I know that things happened against my will, I get angry at myself and blame myself for letting it happen—particularly because I was forced to do things to my partner rather than her forcing herself on me. I don't have a name for what that is, but it has deeply affected my relationship to my body and my sexuality.

I didn't recognize it as "sexual assault" because it didn't fit the portrayed image ("man" assaulting "woman").

Twelve percent of the FORGE survey respondents' perpetrators were transgender. This, too, can be ideologically difficult for some people to believe. This is particularly true if someone believes that transgender people are relatively powerless and that sexual violence is an act of a more powerful person against a less powerful person.³⁰ According to one FORGE survey respondent, "I never expected it from a fellow FTM [female-to-male]."³¹

WHAT'S THAT MEAN?

• FTM

Regardless of the gender of the victim, automatically assuming the perpetrator is male has at least

three potential consequences:

1. It perpetuates the incorrect cultural myth that (almost) all perpetrators are male,
2. It invalidates and revictimizes the victim, and
3. It almost always effectively shuts down communication between professional and victim.

Implications and Actions for ...

[Collapse All]

Health Care Providers

You may need specific information about the sexual assault to provide accurate, quality care. If, for example, a patient has a vagina, uterus, and ovaries, you would need to determine the possibility of pregnancy. Asking if there was penetration is a good place to begin, but it is critical not to presume that penetration was by a penis or that the patient's vagina was penetrated. Allowing him to tell what happened, through gentle, nongender-specific prompts, will generally result in the patient revealing essential information.

Knowing the gender of the perpetrator allows you to recommend specific tests, prescribe certain prophylactic care, or pursue specific diagnostic tests or treatments. For example, if an MTF (male-to-female) patient has had vaginoplasty (the creation of a vagina) and has been vaginally penetrated by a penis, she may be at increased risk for HIV or other sexually transmitted infections because the tissue of surgically constructed vaginas is generally more fragile and vulnerable than a non-transgender woman's vagina.

WHAT'S THAT MEAN?

- **FTM**
- **MTF**

Emergency Medical Personnel

There are perpetrators of all genders. When inquiring about the details of the assault, keep in mind the cultural misconceptions that perpetrators are always male and victims are always female. Use genderless language and don't ask leading questions. For example, "is there anything else you remember about the perpetrator?" or "did you notice any scars, tattoos, or unique clothing?" Keep your questions open ended to allow the patient to reveal information without needing to correct your assumption about the perpetrator.

Law Enforcement

When inquiring about the details of the assault, keep in mind the cultural misconceptions that perpetrators are always male and victims are always female. Use genderless language and don't ask leading questions. For example, "is there anything else you remember about the perpetrator?" or "did you notice any scars, tattoos, or unique clothing?" Keep your questions open ended to allow the victim to reveal information without needing to correct your assumptions about the perpetrator.

Advocates

There are perpetrators of all genders. Believe the victim's account of what happened and help them to understand that they are not the only one to experience that type of assault or that type of perpetrator. If necessary, help the victim acquire a more up-to-date and comprehensive understanding of what constitutes sexual assault.

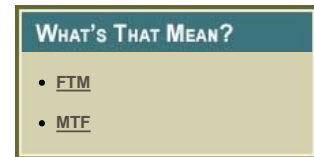
When inquiring about the details of the assault, keep in mind the cultural misconceptions that perpetrators are always male and victims are always female. Use genderless language and don't ask leading questions. For example, "is there anything else you remember about the perpetrator?" or "did you notice any scars, tattoos, or unique clothing?" Keep your questions open ended to allow the victim to reveal information without needing to correct your assumptions about the perpetrator.

Encourage the agencies with which you work to get training regarding female perpetrators and discuss the service implications for a victim assaulted by a woman. For example, support groups may be focused on male perpetrators and may isolate or not allow in victims with female perpetrators, and law enforcement may not believe victims who state they have a female perpetrator. Revise any materials the agencies have that imply that only men can perpetrate sexual assaults.

Therapists

Many therapists who specialize in sexual assault and trauma recovery have a strong background in an oppression model that envisions sexual assault as male violence against women. Although this outdated model does a great disservice to all victims, it can be especially painful for transgender victims, particularly for those who do not identify as either male or female and may have had a perpetrator who was not male.

The pervasive cultural belief that men are violent or dangerous also contributes to exaggerated fears some transgender people have about their safety on the streets, in public facilities, and in health care settings. For example, some MTFs (male-to-females) (whether they have a history of being assaulted or not) fear being assaulted or harassed in public. These fears stem directly from a systemic “all-men-are-violent” culture. (Similar fears abound for FTMs (female-to-males), such as fears about being assaulted in men’s bathrooms.) You can best serve your clients by not reinforcing these cultural stereotypes, which increase fear and insecurity and lead to deepened isolation and depression.

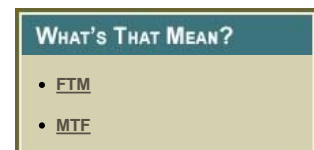


There are perpetrators of all genders. Believe the client's account of what happened and help them to understand that they are not the only one to experience that type of assault or that type of perpetrator. If necessary, help the client acquire a more up-to-date and comprehensive understanding of what constitutes sexual assault.

Support Group Facilitators

Many support group facilitators who specialize in sexual assault and trauma recovery have a strong background in an oppression model that envisions sexual assault as male violence against women. Although this outdated model does a great disservice to all survivors, it can be especially painful for transgender clients, particularly for those who do not identify as either male or female and may have had a perpetrator who was not male.

The pervasive cultural belief that men are violent or dangerous also contributes to the exaggerated fears some transgender people have about their safety on the streets, in public facilities, and in health care settings. For example, male-to-female (MTF) individuals (whether they have a history of being assaulted or not) may fear being assaulted or harassed in public. These fears stem directly from a systemic all-men-are-violent culture. (Similar fears abound for female-to-male (FTM) individuals, such as fears about being assaulted in men’s bathrooms.) You can best serve your clients by not reinforcing these cultural stereotypes, which increase fear and insecurity and lead to deepened isolation and depression.



There are perpetrators of all genders. Believe the client's account of what happened and help them understand that they are not the only one to experience that type of assault or that type of perpetrator. If necessary, give the client a more up-to-date and comprehensive understanding of what constitutes sexual assault.

Often, support groups for survivors of sexual assault are segregated by gender, and most are for

female survivors only. The underlying presumption is that female-only space is necessary for clients to feel safe because of the assumption that all perpetrators are male. If your support group is segregated by gender, it is still important to keep in mind that perpetrators may be male, female, or transgender.

READ MORE

In this e-pub*—

- Tips for Those Who Serve Victims: [Segregated Services](#)

*Clicking these links will take you to other sections in this e-pub. To return, hit your browser's "back" button.

RESPONDING TO TRANSGENDER VICTIMS of Sexual Assault

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Transgender 101

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Tips for Those Who Serve Victims

+ Victim Issues

- Perpetrator Issues

Gender of Perpetrator

Companions as Abusers

+ Standard Practices

- Notes

Five Keys

Outreach

Perpetrator Issues

Companions as Abusers

Many transgender people feel safer if they are accompanied by a loved one in health care or other settings. These companions can be helpful not only to the victim but to the professionals involved as well, and they often provide valuable information. At the same time, it is critical to remember that abusers sometimes escort their victims when they seek care to intimidate them and control what is revealed. As with other sexual assault survivors, the vast majority of perpetrators are known to their victims. According to FORGE's survey of survivors of sexual violence, perpetrators were usually a family member (40 percent), "someone else you knew," (35 percent), an intimate partner (29 percent), or "a date" (20 percent). Only 25 percent were assaulted by a stranger.³²

As stated above, many people are sexually assaulted by their partners, including by partners who are female and/or transgender. Transgender people may be less likely than non-transgender people to leave sexually abusive partners due to a fear—often perpetuated by others, including other transgender people—that it is extremely difficult for transgender people to find loving, respectful partners. Those who are assaulted by a transgender individual may hesitate to report for fear of the treatment the offender may receive from law enforcement, health care providers, mutual acquaintances, and/or family members.

If a victim is accompanied by someone to the emergency room or another facility after an assault, screen the victim privately to ensure that the companion is not the abuser.

READ MORE

In this e-pub*—

- Tips for Those Who Serve Victims: [Relationships](#)
- Sexual Assault in the Transgender Community: [Community Ramifications](#)

*Clicking these links will take you to other sections in this e-pub. To return, hit your browser's "back" button.

Implications and Actions for ...

[\[Collapse All\]](#)

Health Care Providers

Abusive companions often try to control how much the victim says by accompanying their victims when they seek medical care. Ask patients privately about the perpetrator of their abuse to ensure that the people who have accompanied them to exams are not the ones who assaulted them. To screen patients privately, consider asking companions to complete administrative forms in a separate room.¹

READ MORE

- [Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings](#)
- [Trans/SOFFA-Specific Power and Control Tactics](#)

Many agencies and organizations already have screening policies in place regarding partner and family abuse. Some hospitals and other facilities have implemented screening of all patients, asking several brief questions about past or current abuse (family, partner, stranger, others). The types of questions you ask will depend on the patient's age, current physical and psychological state, ability to communicate effectively, and need for acute medical care that supersedes screening. The circumstances of the patient's arrival at the facility and the nature of the crime that occurred should also guide your questions. For example, it may be less necessary to screen a friend accompanying a patient to the emergency room if the patient and friend were both victims and there are other witnesses as noted by law enforcement officers, who also arrive at the emergency room.

During the screening, ask direct, nonjudgmental questions. To normalize the process, inform the patient that everyone is asked these screening questions. Because many transgender people have encountered providers who correlate transgender identity with abuse history, make sure that your questions do not imply that being transgender and having a history of sexual assault or abuse are related.

Screening questions could be as simple and direct as "Do you feel safe at home?" or "Does anyone in your life hurt, hit, or threaten you?" or "Is there any reason you may feel uncomfortable or unable to openly answer questions while your companion is present?"

Keep in mind that some transgender relationships involve power and control tactics that do not apply in non-transgender relationships (e.g., claiming that rough sex is normal, threatening to out the person, controlling access to the person's hormones). Ask even more specific questions if you see signs of some of these tactics in the screening interview.

The screening process should be thorough, yet brief. Transgender victims of sexual assault often rely heavily on their companions for emotional support and safety and should be quickly reunited with them if no danger is present.

If you determine that the companion, partner, loved one, or family member is the perpetrator, privately talk with the patient about what options are available to ensure that the patient is and will remain safe. If the perpetrator is not currently with the patient but will be after treatment, safety planning is highly recommended. Partner with a victim advocate or a victim service provider to ensure that the patient is aware of available safety planning options. (More information on safety planning is in Implications and Actions for Advocates.)

States have varying mandatory reporting requirements about domestic violence and sexual abuse; it is vital that you remain up to date regarding the requirements of your profession and local laws.

1. Mayor's Office to Combat Domestic Violence, 2004, [*Medical Providers' Guide to Managing the Care of Domestic Violence Patients within a Cultural Context*](#), 2d ed., New York, NY: New York City Mayor's Office, accessed April 22, 2013.

Emergency Medical Personnel

You may be called to a scene or hospital directly following a sexual assault. In some cases, the patient's intimate partner, spouse, or date may be the perpetrator and may

ABUSER'S USE OF HORMONES

When a transgender person is the abuser, hormones may be used as an excuse for the abuse. For example, one survivor said of her perpetrator, "He was FTM [female-to-male]. He used him being on testosterone as one of the excuses for his 'needs'" (FORGE, 2005, Sexual Violence in the Transgender Community Survey, quotation from narrative response).

READ MORE

- [Safety Planning: A Guide for Transgender and Gender Non-Conforming Individuals Who Are Experiencing Intimate Partner Violence](#)
- [Safety Planning With Transgender Clients](#) (webinar)
- [Trans-Specific Power and Control Tactics](#)

READ MORE

- [Safety Planning: A Guide for](#)

be with the patient. In these cases, the perpetrator might be acting supportive and loving and it may be difficult to recognize that the intimate partner is actually the abuser. Learning screening methods to help identify perpetrators is essential for victim safety in both the short and long term. Each individual should be questioned (briefly) in isolation, to help determine if the perpetrator is present.

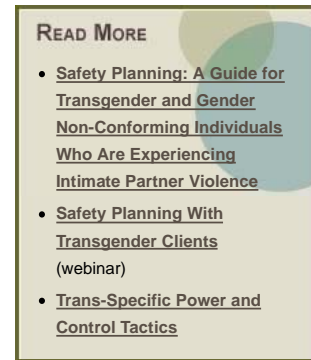
If the companion is the perpetrator (or if the perpetrator is still in an active role in the patient's life), it is important that safety planning discussions take place. Partner with a victim advocate or a victim service provider to ensure that the patient is aware of available safety planning options. (More information on safety planning is in Implications and Actions for Advocates.)



Law Enforcement

You may be called to a scene or hospital directly following a sexual assault. In some cases, the victim's intimate partner, spouse, or date may be the perpetrator and may be with the victim. In these cases, the perpetrator might be acting supportive and loving and it may be difficult to recognize that the intimate partner is actually the abuser. Learning screening methods to help identify perpetrators is essential for victim safety in both the short and long term. Each individual should be questioned (briefly) in isolation, to help determine if the perpetrator is present.

If the companion is the perpetrator (or if the perpetrator is still in an active role in the victim's life), it is important that safety planning discussions take place. Partner with a victim advocate or a victim service provider to ensure that the patient is aware of available safety planning options. (More information on safety planning is in Implications and Actions for Advocates.)



Advocates

If the person accompanying a victim for medical or other services is determined to be the perpetrator, safety planning is a must. Safety planning typically includes a predetermined course of action that victims can take if they need to escape from an unsafe environment or situation. Safety planning is always necessary in emergency situations but is also important to review with clients who have a history of abuse or assault. Augment the typical safety planning questions with reminders that they may also need to pack or secure alternate supplies of hormones and prostheses and copies of supporting documents or "carry letters" (documentation from a mental health therapist or a physician saying the patient is in the process of transitioning).

READ MORE

- [Safety Planning: A Guide for Transgender and Gender Non-Conforming Individuals Who Are Experiencing Intimate Partner Violence](#)
- [Safety Planning With Transgender Clients](#) (webinar)
- [Trans-Specific Power and Control Tactics](#)

If you are uncomfortable or unaccustomed to assisting patients with safety planning, many agencies are available to help. Knowing local referrals to transgender-inclusive, anti-violence agencies is essential to better serve patients who have been or are being abused. If local referrals are unavailable, contact [FORGE](#) for direct technical support and referrals or contact the LGBT anti-violence program nearest you for a referral (see the [National Coalition of Anti-Violence Program's Web site](#) for a list of local programs).

Therapists

Abusive companions often try to control how much the victim says by accompanying their victims when they seek care. Ask clients privately about the perpetrator of their abuse to ensure that the people who have accompanied them are not the ones who assaulted them.

Many agencies and organizations already have screening policies in place regarding partner and family abuse. Some facilities have implemented screening of all clients, asking several brief questions about past or current abuse (family, partner, stranger, others). The types of questions you ask will depend on the client's age, current physical and psychological state, ability to communicate effectively, and need for acute care that supersedes screening.

During the screening, ask direct, nonjudgmental questions. To normalize the process, inform the client that everyone is asked these screening questions. Because many transgender people have encountered providers who correlate transgender identity with abuse history, make sure that your questions do not imply that being transgender and having a history of sexual assault or abuse are related.

Screening questions could be as simple and direct as "Do you feel safe at home?" or "Does anyone in your life hurt, hit, or threaten you?" or "Is there any reason you may feel uncomfortable or unable to openly answer questions while your companion is present?"

READ MORE

- [Trans/SOFFA-Specific Power and Control Tactics](#)

Keep in mind that some transgender relationships involve power and control tactics that do not apply in non-transgender relationships (e.g., claiming that rough sex is normal, threatening to out the person, controlling access to the person's hormones). Ask even more specific questions if you see signs of some of these tactics in the screening interview.

The screening process should be thorough, yet brief. Transgender victims of sexual assault often rely heavily on their companions for emotional support and safety and should be quickly reunited with them if no danger is present.

If you determine that the companion, partner, loved one, or family member is the perpetrator,

privately talk with the client about what options are available to ensure that the client is and will remain safe. If the perpetrator is not currently with the client but will be after treatment, safety planning is highly recommended. Partner with a victim advocate or a victim service provider to ensure that the client is aware of available safety planning options. (More information on safety planning is in Implications and Actions for Advocates.)

States have varying mandatory reporting requirements about domestic violence and sexual abuse; it is vital that you remain up to date regarding the requirements of your profession and local laws.

READ MORE

- [Safety Planning: A Guide for Transgender and Gender Non-Conforming Individuals Who Are Experiencing Intimate Partner Violence](#)
- [Safety Planning With Transgender Clients](#) (webinar)
- [Trans-Specific Power and Control Tactics](#)

Support Group Facilitators

Although rare, it is possible in any support group setting for an abusive partner to try to access the same support services as the victim. For this reason, consider screening all potential participants carefully. If a transgender survivor in your group was sexually assaulted by an intimate partner, it is critical that one-on-one safety planning discussions take place whether they are still in a relationship with the abusive partner or not.

Privately talk with the client about what options are available to ensure that the client is and will remain safe. In addition, partner with a victim advocate or a victim service provider to ensure that the client is aware of available safety planning options. (More information on safety planning is in Implications and Actions for Advocates.)

READ MORE

- [Safety Planning: A Guide for Transgender and Gender Non-Conforming Individuals Who Are Experiencing Intimate Partner Violence](#)
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RESPONDING TO TRANSGENDER VICTIMS of Sexual Assault

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Standard Practices

Disclosure and Confidentiality

Being transgender may not be a primary facet of a person's everyday concerns.

Victims in particular, who have more pressing concerns, may forget to tell providers and other professionals about their transgender identity or history. Others don't know whether such disclosure would be safe. Some victims of sexual violence are so traumatized that they are unable to focus on anything other than the pain and trauma of the assault or may be so severely injured they are unable to speak or communicate. Finally, exercising control over whom to tell and when and how to disclose can be a strategy for increasing safety and regaining control after an assault.

Due to fears of rejection, denial of services, or violence, some transgender victims segregate their care, with certain professionals knowing about their transgender status and others not. For example, when the National Center for Transgender Equality asked survey respondents if they were out to their medical providers, 28 percent of respondents reported being out to all of their providers, 18 percent said they were out to most, 33 percent of respondents were out only to a few, and 21 percent were out to none.³³ Although it may slow the healing process and create additional challenges, if a victim chooses not to be out, that choice should be respected as being in the victim's best interest.

In some cases, a person's trans status or history is disclosed—but not voluntarily. This happens most commonly through—

- "Noncongruent" body parts being exposed during emergency or routine medical care.³⁴ The majority of transgender people have not had any surgery at all related to their primary or secondary sex characteristics.³⁵
- Noncongruent identity documents that have different names or gender markers. Insurance cards and driver's licenses are commonly required prior to providing services. A perceived mismatch between a client's appearance and the information on the documents may out the person as transgender.
- Guesses or assumptions that a person is transgender because that person does not fully meet society's high standards of femininity for girls and women or masculinity for boys and men.
- Someone else's disclosure, intentionally or accidentally, without the transgender person's

KEEP IN MIND ...

- The process of coming out may change over time.
- Nondisclosure doesn't equal dishonesty or deception.
- People may honestly forget to disclose their transgender history or identity.
- Partners and family members may or may not know of a loved one's transgender history or identity.
- The victim's insurance company may or may not know of the victim's transgender history or identity.
- Not all documents may have the same name or gender.
- People may disclose some components of their lives but not

consent. Involuntary disclosure may be doubly distressing to a victim whose sense of control and safety have been damaged by this sexual assault and/or previous sexual assaults.

Many professionals are already required to adhere to strict confidentiality procedures, but extra care should be taken with transgender clients to ensure that their gender history or status are not shared with others. It is also a good idea to review confidentiality procedures with victims to help them feel more confident that their privacy will be protected.

others.

- Other people may out someone intentionally or unintentionally.
- All individuals deserve to be treated equally and with confidentiality.

Written permission to release information will most likely be needed before service providers can talk to or share records with other professionals. Victims should be allowed to select which information can be disclosed and to request that transgender information not be shared with other service providers. Honor these requests. Let victims know that they can request and review their records so that if they are asked for copies, they can make an informed decision as to which parts, if any, they feel comfortable releasing.³⁶

Key elements of confidentiality policies include the information that is covered by the policy; who has access to the victim's records; the policy on sharing information with other agencies (particularly law enforcement); and times when maintaining confidentiality is not possible.³⁷ You may want to explicitly offer victims the right to refuse to answer a question in writing until it can be discussed in the privacy of an office with the provider. Even without such an instruction, "if a patient has left blanks on the intake form, this may be an indication that they felt uncomfortable being open in writing. You have another, better chance to create trust ... during the initial interview."³⁸

A confidentiality statement may not be sufficient for some transgender victims, particularly if you are creating medical records. Lawyers familiar with LGBT legal issues advise that it is of utmost importance that clinicians protect confidential information and train office staff to do the same. Discuss with your clients why it is sometimes important to include sexual orientation or gender identity information in their medical records (e.g., certain routine screenings are recommended for sexually active gay and bisexual men) and how that information will be used and protected. Be aware, however, that some LGBT individuals may still request that their sexual orientation or gender identity be kept out of their medical records.

READ MORE

In this e-pub*—

- Transgender 101: [Degree of "Outness"](#)

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Implications and Actions for ...

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Health Care Providers

Some providers believe that patients are being deceptive or are intentionally withholding information if they do not disclose their transgender identity or history. Some patients may disclose only after they have developed adequate trust in the provider. This could take one visit or many months. Choosing when and how to disclose information is often self-empowering for victims and should be validated, not scorned.

If you inadvertently learn that a patient is transgender during an examination, do not show surprise, shock, dismay, or concern. Instead, your reaction should be much the same as when encountering an unexpected scar. Do not allow the disclosure, whether intended or not, to distract you from the reason you are treating the patient. Ask more questions only if they are necessary for effective treatment.

One reason that transgender victims of sexual assault may hesitate to disclose is that they are concerned that their transgender identity will be shared with others (e.g., other staff in your office, companions who do not yet know of their transgender status). Carefully explain, follow, and reiterate

your confidentiality policies and procedures. Make sure that all patients receive HIPAA privacy documents when beginning treatment, and review these documents together. Be willing to create additional statements regarding privacy rights, confidentiality, and codes of conduct if needed.

Ensure that patients understand the circumstances under which their medical records might be released to health insurance providers or others. Although a transgender patient's medical charts may indicate preferred or former names, it is gratuitous to overtly chart that a patient is transgender.

To maintain patient confidentiality, consider the following:

- Note preferred names and pronouns in sections of medical charts that are not released to other professionals.
- Use codes or nondescript colored stickers "so that only the health care provider or other key people in the office can identify this information."¹
- If you use paper charts, make a simple notation in the inside of the patient's folder noting the preferred name and pronoun.
- Regarding electronic records, many medical software systems have customizable fields that securely store information and only allow access to staff treating a patient.

When in doubt, refer to the requirements of your profession and local laws and ask patients how they would like you to handle their personal information. Reassure patients who are concerned about confidentiality by informing them that they can place limits on the information released to third parties and that they can request copies of their records at any time.² Patience, reassurance, and overt reminders of your professional boundaries may be helpful as well.

It is critical to note that transgender patients may be accompanied by someone who does not know they are transgender (e.g., partners, parents, children). Be very careful to treat the patient's transgender identity or history with the utmost confidentiality, and do not discuss it with companions unless given explicit permission.

If someone in the office breaks confidentiality, advise the patient of their rights and let them know how to make a formal complaint. Administrative staff should follow up with both the patient and the staff in question and work to resolve the issue.

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1. S. Brotman and B. Ryan, 2001, *Critical Issues in Practice With Gay, Lesbian, Bisexual and Two-Spirit People: Educational Module for Professionals in the Fields of Health and Allied Health*, Montreal, Canada: McGill School of Social Work, 35.

2. D. McWilliams, D. Fournier, B.A. Booth, P. Burke, and J. Kauffman, 2008, "Legal Issues of Importance to Clinicians," in H.J. Makadon, K.H. Mayer, J. Potter, and H. Goldhammer, eds., *Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health*, Philadelphia, PA: American College of Physicians, 446–447.

Emergency Medical Personnel

Emergency medical personnel may never know that a patient is transgender. In many cases, the location and type of injuries (e.g., head trauma, abrasions) would not physically disclose the patient's transgender identity or history.

In critical care situations, the patient may not be able to verbally disclose (even if they wanted to). Through the course of medical treatment, however, you may inadvertently discover that a patient is transgender. Emergency medical personnel see a wide variety of bodies and bodily configurations. Most can and do stay focused on the presenting medical situation—concussion, lacerations, broken bones, or other injuries. If you find out that the patient is transgender, continue to focus your attention on the patient's urgent care needs.

Transgender people are acutely aware when their documentation does not match their appearance and will often disclose prior to treatment. If the patient's documentation and presentation do not align, you can nonjudgmentally ask if the person uses another name to allow for more respectful interaction. If patients ask you to call them by a specific name or pronoun, respect their preferences regardless of documentation, and insist that others do the same. However, if others who do not know that the patient is transgender are present, be careful how you refer to the patient; you do not want to out the patient accidentally.

If you are unable to gain a patient's consent to disclose (e.g., if the patient is unconscious), use language that is respectful, accurate, and detailed if there is a disparity between legal name/gender and preferred name/gender. For example, "Susan Smith (given name, Travis Smith) was sexually assaulted at <location>. Susan is white, 33 years old. She will be transported to <hospital name> via ambulance." Although this outs Susan as a transgender individual, it does so in a respectful way by using her preferred name and pronoun.

Information gathered about the patient's injuries should center on those injuries; a person's transgender identity or expression should not be the focus of your questioning or interactions. A patient's transgender history is just one piece of information among many that may or may not have relevance.

Law Enforcement

A victim may elect to disclose a transgender identity or history to you, or you may learn that a victim is transgender from an external source (e.g., another professional on the scene, conflicting documents, physical "incongruity"). In other cases, you will not and do not need to know that a victim is transgender. If you do know, treat this information with the utmost care and confidentiality. After disclosure, if the victim is conscious, it may be appropriate to ask them what name and pronoun they would prefer to allow more respectful interaction. Whenever possible, call victims by their preferred names and pronouns regardless of documentation, and insist that others do the same. However, if others who do not know that the victim is transgender are present, be careful in how you refer to the victim; you do not want to out the victim accidentally.

Because law enforcement officers are trained to look for documentation discrepancies and to confirm that a person is who they report to be, there might be additional scrutiny or questioning. Identity documents generally have information that helps confirm a person's identity, even if name or gender markers are different from a person's appearance. For example, height, weight, and eye color on the identity document should match the person's appearance. The person's address should also be consistent. If the victim's documentation and presentation do not align, you can nonjudgmentally ask if the person uses another name and determine what the victim's legal name and gender are for reporting purposes.

Transgender people are acutely aware when their documentation does not match their appearance and will often disclose prior to any additional questioning by law enforcement. Some carry a notarized statement or "carry letter" from their therapist or physician which indicates that they are in the process of transition and are living as one gender yet have documentation in another. Asking victims if they have a carry letter or where they are in the legal process of changing their name or gender marker may help them recognize your awareness of transgender issues. This can increase their sense of trust and their willingness to engage.

You may encounter transgender victims who are unconscious or seriously injured. In these situations, the victim may not be able to verbally disclose (even if they want to). When calling in the crime and there is a disparity between legal name/gender and preferred name/gender, use language such as the following: "A 24-year-old woman, Jane Smith, with driver's license identification as John Smith, gender male, was found unconscious at

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- Transgender 101: [Documentation](#)
- Tips for Those Who Serve Victims: [Preferred Language](#)

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<address>." Avoid language such as "A 24-year-old male, John Smith, was found unconscious at <address>," or "A 24-year-old cross-dresser was discovered at <address>." Although this outs Jane as a transgender individual, it does so in a respectful way.

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Information gathered about the crime should center on injuries sustained and the potential criminal actions against the victim. A victim's transgender identity or expression should not be the focus of your questioning or interactions. A victim's transgender history is just one piece of information among many that may or may not have relevance in the case.

Advocates

A victim may elect to disclose a transgender identity or history to you, or you may learn that a victim is transgender from an external source (e.g., another professional, conflicting documents, physical "incongruity"). In other cases, you will not and do not need to know that a victim you are helping is transgender. If you do know, treat this information with the utmost care and confidentiality. When sexual assault victims trust advocates enough to reveal their transgender identity, they are taking a significant risk in doing so. Disclosing to one person does not imply permission for that person to disclose to others, even other professionals.

Get explicit permission from victims about if, when, and with whom you may share the information. Never discuss or mention transgender-related topics with other professionals, partners, family members, or other companions of the victim without the victim's consent. This includes careful use of a victim's preferred name or pronoun. For example, if the victim's family is present and does not know that the victim is transgender, be careful in how you refer to the victim.

If you are unable to gain a victim's consent to disclose (e.g., in an emergency in which the victim is unconscious and you have to call for help), use language that is respectful, accurate, and detailed if there is a disparity between legal name/gender and preferred name/gender. For example, "Susan Smith (given name, Travis Smith) was sexually assaulted at <location>. Susan is white, 33 years old. She will be transported to <hospital name> via ambulance." Although this outs Susan as a transgender individual, it does so in a respectful way by using her preferred name and pronoun.

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You may need to advocate on behalf of the victim if other professionals do not treat disclosed information with the appropriate level of sensitivity and discretion. In addition, consider that disclosure can lead to additional complications for the victim (e.g., disclosing to a young person's family may result in unwanted questions or possibly even violence at home). In most cases, victims will be able to identify areas of particular concern so that you can help prevent, mitigate, or address these complications.

Therapists

Transgender people may decide not to disclose their gender identity to therapists because they do not want them to think that being sexually assaulted caused them to be transgender or that being transgender caused the sexual assault. Some transgender people have two therapists: one with whom they discuss sexual assault issues and one with whom they discuss gender issues. This prevents the gender therapist—whom the client may be relying on to "write a letter" giving them access to hormones or surgery—from using the sexual assault as a reason to slow down or stop the person's gender transition.¹ As one respondent put it—

I'm afraid to go to a mainstream provider because I don't want to have to justify my

existence to receive help, but I am afraid to go to a trans-knowledgeable provider because I know the SOC [typical Standards of Care for transgender people] are more harsh if you are an assault survivor. I feel like I'm falling through the cracks and no one cares.²

Some mental health providers believe that clients are being deceptive or are intentionally withholding information if they do not disclose their transgender identity or history. Some clients may disclose only after they have developed adequate trust in the therapist. This could take one session or many months. Choosing when and how to disclose information is often self-empowering for clients and should be validated, not scorned.

If and when a client discloses, keep in mind that this is only one piece of data. If a client determines that navigating gender identity is not a therapeutic goal, extensive discussion of gender identity is likely irrelevant and often offensive or insensitive. Only ask questions that are relevant to their care (e.g., about personal history, experiences, trauma, desires). Be nonjudgmental and sensitive, and satisfy your curiosity about transgender issues elsewhere rather than using your client to acquire more knowledge about general transgender issues. One way to know whether a question is appropriate is to consider if you would ask the same question of a non-transgender client or if the information you are seeking is general information you could research on your own time versus your client's time.

Asking about a client's surgical status, prior name (if not relevant to billing paperwork), hormone use, or other information about a person's gender transition or gender journey is generally not appropriate, unless the client initiates the discussion as part of the healing process. Asking about medical interventions is inappropriate and often impolite and frequently indicates that a provider is not culturally competent. These questions presume that an individual has medically transitioned and that mental health professionals are entitled to this very intimate information. They also create an impression that a person's gender identity is less valid if they have not pursued medical steps toward transitioning.

One reason that transgender victims of sexual assault may hesitate to disclose is that they are concerned that their transgender identity will be shared with others (e.g., other staff in your office, companions who do not yet know of their transgender status). Carefully explain, follow, and reiterate your confidentiality policies and procedures. Make sure that all clients receive HIPAA privacy documents when beginning treatment, and review these documents together. Be willing to create additional statements regarding privacy rights, confidentiality, and codes of conduct if needed.

When in doubt, refer to the requirements of your profession and local laws and ask clients how they would like you to handle their personal information. Reassure clients who are concerned about confidentiality by informing them that they can place limits on the information released to third parties and that they can request copies of their records at any time.³ Patience, reassurance, and overt reminders of your professional boundaries may be helpful as well.

If someone in the office breaks confidentiality, advise the client of their rights and let them know how to make a formal complaint. Administrative staff should follow up with both the client and the staff in question and work to resolve the issue.

1. See World Professional Association for Transgender Health's [Standards of Care](#).

2. FORGE, 2005, "[Implications](#)," quotation from narrative response to the Sexual Violence in the Transgender Community Survey, accessed Feb. 13, 2013.

3. D. McWilliams, D. Fournier, B.A. Booth, P. Burke, and J. Kauffman, 2008, "Legal Issues of Importance to Clinicians," in H.J. Makadon, K.H. Mayer, J. Potter, and H. Goldhammer, eds., *Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health*, Philadelphia, PA: American College of Physicians, 446–447.

Support Group Facilitators

Some providers believe that clients are being deceptive or are intentionally withholding information if they do not disclose their transgender identity or history. Some clients may disclose only after they have developed adequate trust in the provider. This could take one visit or many months. Choosing when and how to disclose information is often self-empowering for clients and should be validated,

not scorned.

If and when a client discloses, it is important to keep in mind that this is only one piece of data. If a client determines that navigating gender identity is not a therapeutic goal within the support group setting, extensive discussion of gender identity will likely be irrelevant. Only ask questions that can be answered by clients and are relevant to their care. Be nonjudgmental and sensitive and satisfy your curiosity about transgender issues elsewhere rather than using your client to acquire more knowledge about transgender individuals.

Asking if or when a client had surgery or physically transitioned is generally inappropriate, unless the client initiates the discussion as part of the healing process. Not only is asking impolite, but it also assumes that an individual has had surgery and that you are entitled to this very intimate information. Such questions could also create an impression that a person's gender identity is less valid if they have not pursued medical steps toward transitioning.

Disclosure may play an essential role in a support group. If a transgender survivor discloses during a group discussion, other group members may start asking questions, expressing interest that diverts discussion, or voicing concerns. Although some level of discussion about transgender issues may be appropriate and necessary, it may also sidetrack the group's primary purpose. As facilitator, be mindful of the needs of the group but also of specific individuals and keep the group focused on its goals. You may want to meet with individual group members if they express discomfort or have questions about transgender issues. (In most cases, discussing specifics about the transgender person in the group is inappropriate, but having a general conversation about transgender lives and experiences often helps other group members begin to understand and accept transgender individuals.)

Ideally, support groups are safe places where participants can feel comfortable and safe when discussing intimate details about their assault and how their lives have been affected. Confidentiality is often a critical component of support groups, and most members will want to feel some level of certainty that the information they share in the group will stay within the group. Establishing ground rules about confidentiality at the first meeting—with reminders at subsequent meetings—may help all individuals feel more confident that the other members will remember to keep the information shared at meetings confidential.

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Insurance and Financial Matters

Compared to the general population, transgender individuals are more likely to be uninsured or underinsured and unemployed or underemployed. Insurance disparities are often the result of joblessness and poverty related to discrimination.³⁹ The number of transgender individuals who are uninsured ranges from 19 to 64 percent.⁴⁰

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- [Health Care Rights and Transgender People](#)
- [Transline: Transgender Medical Consultation Service](#)

Transgender individuals who are insured may be concerned about the transgender exclusions of many health insurance policies. These exclusions systematically deny care related to being transgender and are sometimes used to justify not covering any care, even when the condition needing treatment is not related to a transgender-specific medical or mental health concern. In 2011, the University of California's Department of Family and Community Medicine released a protocol on primary care for transgender patient care that concisely reviews some key concerns related to insurance billing and medical records.⁴¹

When a transgender person's insurance does cover medical care, the coverage may be so minimal that the person fears exhausting their insurance benefits before their health needs are met, or the care may involve copayments and high out-of-pocket costs that they cannot afford.

In some cases, transgender people choose to self-pay rather than processing claims through insurance companies. Paying out of pocket allows for privacy and allays concerns or fears that transgender histories will be disclosed to employers or others. However, many transgender individuals—just as many non-transgender people—cannot afford the high cost of health care, which may discourage or prohibit transgender victims from seeking care after a sexual assault.

Depending on the service you are providing, you may or may not need to know about a transgender victim's insurance or financial status.

Implications and Actions for ...

[Collapse All]

Health Care Providers

It is not uncommon to see transgender patients who are overdue for medical care or who have been living with a condition or infection for a long time because they were unable to seek care sooner. In many cases, this is due to insurance and related financial issues.

Having a nonjudgmental attitude toward all patients, and overtly expressing an understanding that many factors play a role in when and how someone initiates medical care, may put transgender patients at ease and help them feel less shame and self-blame about delaying medical care. Phrases such as "I'm glad you came to see me today" let transgender patients know that you are willing and able to accept them where they are, when they are able to walk through the door.

If the patient has insurance and decides to use it, it is vitally important to select an accurate and carefully chosen International Classification of Diseases (ICD) code. Accurate diagnoses are important for all patients but may be especially so for transgender patients.

When unsure of how to proceed with billing, engage the transgender patient in the process and work together to decide the best course of action. Additionally, be conscientious when preparing clinical notes that include transgender-related content, and be mindful about using either preferred or former names in official medical records. If a transgender patient's insurance policies are in another name, ask the patient for clarification and confirmation when needed.

For patients who are uninsured or underinsured and have limited incomes, consider offering sliding scale rates, payment plans, pro bono services, or assistance in enrolling in public insurance options. You may have to discuss these options first with your billing specialist, who may direct patients to social or case workers for help with payment arrangements. If these alternatives are unavailable, be prepared to offer referrals to local providers and services that offer transgender-inclusive care at reduced or no cost. Connecting with a local transgender group may yield referrals to these providers and services (see [Outreach](#) in this e-pub); if you cannot identify any local groups, contact the nearest LGBT community center. Looking online may also be a useful source for referrals; screen the providers you find, however, to ensure that their information is accurate and try to find out if they actively work with transgender individuals.

The cost of medication may also be an issue for uninsured, underinsured, or low-income clients. Even if a transgender patient has health insurance, it may not cover medications. Frequently, low-income patients leave a health care providers' office with a prescription in hand but will never fill it due to lack of funds. Whenever possible, offer patients medically appropriate, free drug samples or starter kits for medication or prescribe medications that are available in generic brands.

Emergency Medical Personnel



As a first responder, you may need to know a patient's insurance or financial status. For example, they may be concerned about how they will pay for an ambulance ride to the hospital or may strongly oppose being taken to a hospital or other care facility.

A calm, informing presence can help them understand how necessary it is for them to go to the hospital or to see a physician. Consider sharing information about programs that will help patients pay health care costs, or refer them to agencies or advocates that can provide that information, to help ease their immediate financial concerns.

As always, be careful, accurate, and detailed when reporting on the patient's medical condition. An accurate and detailed report increases the likelihood that the patient will qualify for victim compensation, if other requirements are met.

Law Enforcement



As a law enforcement officer, you may need to know a victim's insurance or financial status. For example, victims may be concerned about how they will pay for an ambulance ride to the hospital or may strongly oppose being taken to a hospital or other care facility.

A calm, informing presence can help them understand how necessary it is for them to go to the hospital or to see a physician. Consider sharing information about programs that will help victims

pay health care costs, or refer victims to agencies or advocates that can provide that information, to help ease their immediate financial concerns.

As always, be careful, accurate, and detailed in your report about the crime. An accurate and detailed crime report increases the likelihood that the victim will qualify for victim compensation, if other requirements are met.

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Advocates

When transgender individuals seek health care, they may be unfairly expected to educate their health care professionals about being transgender before being able to receive care. In a time of crisis, this can be especially challenging. A provider's lack of knowledge about transgender health care and insurance exclusions further complicates the situation.

If the victim decides to release health care insurance information to a provider, sensitively and privately ask the victim to consider what gender is on file with the insurance company, how the victim would like to have any gender-linked procedures handled (e.g., pregnancy tests, cervical pap smears), and whether these procedures should be billed to the insurance company or paid for privately or through another public source. Ideally, you would want to have this conversation with the victim before information is released to the insurance provider. Having specific information readily available about alternate sources of payment helps to increase the likelihood that victims will seek care, that the services they receive will meet their needs, and that the care will be delivered appropriately.

Therapists

When mental health care is covered as a part of an insurance plan, the coverage may be minimal or for short-term treatment only. Clients are often concerned about running out of coverage before they reach their mental health goals. Transgender clients who are medically transitioning may feel additional financial pressure because they may be required to see a therapist before the transition. Many of these survivors segment their mental health care—one therapist for trauma, one therapist for gender-related issues—which increases the financial burden.

If the client has insurance and decides to use it, it is vitally important to select an accurate and carefully chosen Diagnostic and Statistical Manual of Mental Disorders (DSM) or International Classification of Disease (ICD) code. Accurate diagnoses are important for all clients but may be especially so for transgender clients.

In general, survivors who are in therapy are usually not in treatment for their gender identity, but rather are working on the trauma, grief, anger, depression, sleep disruption, or loss associated with the sexual violence they experienced. Use the code that best applies to the disorder you are treating (e.g., adjustment disorder, anxiety). When unsure of how to proceed with billing, engage the transgender client in the process and work together to decide the best course of action. Additionally, be conscientious when preparing clinical notes that include transgender-related content, and be mindful about using either preferred or former names in official records. If a transgender client's insurance policies are in another name, ask the client for clarification and confirmation when needed.

For clients who are uninsured or underinsured and have limited incomes, consider offering sliding

scale rates, payment plans, pro bono services, or assistance in enrolling in public insurance options. You may have to discuss these options first with your billing specialist, who may direct clients to social or case workers for help with payment arrangements. If these alternatives are unavailable, be prepared to offer referrals to local providers and services that offer transgender-inclusive care at reduced or no cost. Connecting with a local transgender group may yield referrals to transgender-inclusive therapists who may offer lower cost care or culturally competent free clinics (see [Outreach](#) in this e-pub); if you cannot identify any local groups, contact the nearest LGBT community center. Looking online may also be a useful source for referrals; screen the therapists you find, however, to ensure that their information is accurate and try to find out if they actively work with transgender individuals.

Support Group Facilitators

Transgender individuals who are insured have many of the same concerns about insurance benefits as non-transgender people. Insurance companies often have limited mental health benefits, and clients are often concerned about running out of coverage before they reach their mental health goals. If a transgender individual in your group has insurance and decides to use it, it is vitally important to select an accurate and carefully chosen diagnostic code. Accurate diagnoses are important for all clients, but may be especially so for transgender clients.

Many insurance companies are noticing perceived discrepancies in what the insured individual is eligible for and which services they are receiving. If your support group is segregated by gender, for example, and a client's insurance coverage is under a gender not included in that group, the insurance company may deny payment and may even drop other types of medical coverage.

Many transgender people experience employment discrimination or they work in low-paying jobs, and a substantial number do not have health insurance and also do not have enough income to pay for services out of pocket.¹ For clients who are uninsured or underinsured and have limited incomes, consider offering sliding scale rates, payment plans, pro bono services, or assistance in enrolling in public insurance options. You may have to discuss these options first with your billing specialist, who may direct clients to social or case workers for help with payment arrangements. If these alternatives are unavailable, be prepared to offer referrals to local providers and services that offer transgender-inclusive care at reduced or no cost. Connecting with a local transgender group may yield referrals to these providers and services (see [Outreach](#) in this e-pub); if you cannot identify any local groups, contact the nearest LGBT community center. Looking online may also be a useful source for referrals; screen the providers you find, however, to ensure that their information is accurate and try to find out if they actively work with transgender individuals.

In some circumstances, transgender survivors may benefit from simply connecting with other transgender individuals and their loved ones at support groups that do not focus on sexual assault. All states have transgender support groups of some kind; see [FORGE's Web site](#) for a support group directory.

1. J.M. Grant, L.A. Mottet, J. Tanis, J. Harrison, J.L. Herman, and M. Keisling, 2011, [Injustice at Every Turn: A Report of the National Transgender Discrimination Survey](#), Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force, accessed June 18, 2013.

RESPONDING TO TRANSGENDER VICTIMS of Sexual Assault

Message From the Director

About This Guide

Transgender 101

Sexual Assault in the
Transgender Community

Tips for Those Who
Serve Victims

JUNE 2014

Printer-Friendly Option

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Tips for Those Who Serve Victims

+ Victim Issues

+ Perpetrator Issues

— Standard Practices

Disclosure and Confidentiality
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Treating the Victim

Documenting the Assault
Segregated Services
Crime Victim Compensation

— Notes

Five Keys

Outreach

Standard Practices

Treating the Victim

To ensure successful care of transgender victims of sexual assault, first responders and frontline staff must be trained in how to appropriately and respectfully interact with and treat people who are visibly gender non-conforming, identify as transgender, or have identity documents with names or gender markers that do not match their presentation. First responders and frontline staff set the tone for all subsequent interactions. Inappropriate reactions, questions, or remarks may cause victims to become distrustful or self-protective and they may abandon their efforts to seek help after an assault.

When helping victims of sexual assault, professionals tend to expect someone who appears male while dressed, for example, to have a flat male chest and penis while undressed. When a transgender victim has a body configuration that the professional was not expecting, it can be unsettling and may lead to confusion, delay, or abandonment of appropriate service; inappropriate questions (sometimes voiced in an aggressive tone); or abuse. Some professionals feel deceived if victims being served are not proactively explicit about the configuration of their bodies prior to disrobing. This is one of the many reasons transgender people avoid accessing care, even when they are seriously ill or injured.

Strive to deliver professional, respectful, and equal service to everyone, regardless of gender identity or expression. Your response—even when subtle—can greatly influence whether victims feel they are being judged. Even slight changes in body language (e.g., pulling back), facial expressions (e.g., eyes slightly widening, lips pursing), or sounds (e.g., gasps, sharp intakes of breath, sighing) cue transgender individuals that they may not be treated with respect, be fully heard, or even be treated at all. Be aware of your nonverbal reactions and avoid conveying surprise or judgment.

Two core principles will promote respectful care:

- **Maintain professionalism.** Because they are both a sexual assault victim and transgender, they will need as much explanation, privacy, control, and reassurance as circumstances permit. Both sexual assault victims and transgender individuals may be uncomfortable with physical contact. Transgender individuals may also be anxious about whether you will be respectful or prejudiced. Upholding a professional demeanor and having some knowledge of transgender people will help reduce the transgender victim's fears.

READ MORE

[Why It Matters: Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender, and Queer Victims of Hate Violence and Intimate Partner Violence](#)

In this e-pub*—

- Transgender 101: [Physical Appearance](#)
- Tips for Those Who Serve Victims: [Mistrust of Professionals, Disclosure and Confidentiality](#)

*Clicking these links will take you to other sections in this e-pub. To return, hit your browser's "back" button.

- **Respect identity.** Transgender victims of sexual assault need to have their identity and autonomy respected.

Implications and Actions for ...

[\[Collapse All\]](#)

Health Care Providers

Effective treatment begins at reception and intake. It is essential that these frontline staff, and all staff for that matter—

- Respectfully ask patients what they would like to be called in person and what they would like on file in their records and fully respect their request. Use a person's preferred name and pronoun at all times.
- Ask only questions that are medically necessary.
- Keep all patient information confidential and do not share details with others unless it is medically relevant and you have the patient's permission.
- Do not comment on the quality of someone's gender-related appearance, even if intended as a compliment.

If a patient experiences inappropriate behavior or mistreatment by frontline staff, promptly follow up with an apology and a corrective course of action and then move on.

Before beginning any examination—

- State why you recommend specific exams, tests, or procedures.
- Explain what is involved in each component of an exam, test, or procedure.
- Ask for overt permission or consent prior to every portion of an exam or procedure.
- Inquire about and, if possible, accommodate preferences regarding the gender of providers.
- Remind patients that they have a right to say no to any portion of an exam, test, or procedure.

Although this may seem time-consuming, it could help alleviate the concerns of transgender patients who may have a long history of being subjected to invasive questions and procedures that were performed solely for curiosity's sake. It also helps patients gain back a sense of control, which was taken from them during the assault.

SCREENING FOR ASSAULT DURING ROUTINE CARE

Sexual assault victims—both non-transgender and transgender—frequently do not inform their health care providers of any previous sexual assault history for numerous reasons, including shame, stigma, or a belief that past assaults are not relevant to current medical care.

Sexual assault can leave long-lasting scars with long-term health implications, such as posttraumatic stress disorder; substance abuse; self-harm or self-injury; depression; sexually transmitted infections; sleep, eating, and dissociative identity disorders; suicidal ideation and attempts; and other health problems.¹ Transgender people also experience higher rates of depression, anxiety, suicidality, and other mental health or emotional conditions (and disabilities) than non-transgender people.²

Unfortunately, research in these areas is limited and has not yet examined the extent to which these higher prevalence rates might be related to transgender people's higher sexual victimization rate. Despite this, it is clear that the combination of a person's transgender identity/history with a sexual assault history makes it more likely that the person is living with long-term physical and mental health needs.

For these reasons alone, when you are providing routine health care for transgender patients, you should know of their abuse/assault history whenever possible. Given the hesitance of patients to volunteer information about sexual assault, consider routinely and sensitively asking them about possible past and current sexual assaults or abuse.

Sexual assault survivors are likely uncomfortable in situations in which they feel physically vulnerable, such as in any type of medical procedure that involves disrobing. This may be even truer for transgender patients. Extreme discomfort with genitals and reproductive organs is common among transgender people and even more so among those who have been sexually assaulted.

As you begin examining and treating transgender patients who have been sexually assaulted, you may

encounter the following:

- Patients who use prosthetics or other devices.
- Patients who use medications.
- Patients who use hormones.
- Patients who have had surgery.
- Patients who have non-suicidal self-injuries.
- Patients who have injected silicone.
- Patients who dissociate.

Prosthetics or other devices

If your transgender patients use prosthetics or similar devices, they may not want to part with them, even for a short time. For example, some FTMs (female-to-male individuals) bind nearly 24 hours a day and only remove their binders for showering. These patients may be unwilling to remove or uncomfortable removing their binders for an examination. Patience is essential. Work together to find solutions that are tolerable for the patient and that allow you to proceed with the exam. For example, it might be possible for the FTM to remove his binder in the privacy of the exam room before you are present and to wear a t-shirt during the exam.

Similarly, many transgender individuals wish to remain clothed because they do not want others—even health care providers—to know they use items to enhance their gender presentation or function.

In some cases, these devices may not only create barriers to care—they may actually cause health problems. For example, FTMs or gender non-conforming, trans-masculine individuals may have difficulty breathing, rashes, or chronic back pain from binding or heat-related conditions from wearing multiple layers of clothing to create a more masculine appearance.

Similarly, MTFs (male-to-female individuals) who frequently gaff with tape may experience rashes or other skin irritations on their genitals, may have difficulties urinating, or may develop infections or scarring under the taped areas. If a device is causing health problems, be sensitive to the patient's emotional and safety needs when discussing options of care or when suggesting that use of the device be discontinued or that an alternative be identified. Many transgender individuals risk increased violence on the street, in the workplace, and even at home without these devices.

WHAT'S THAT MEAN?

- **FTM**
- **MTF**

If medical issues do arise from the use of these devices, note that it is often possible to chart and describe the patient's symptoms and diagnosis without a detailed report of the assistive devices used.

Medications

When asking patients for a full list of medications that they take, normalize this request by informing them that all patients are asked to provide a list of their medications and supplements. Many transgender individuals do not consider hormones a medication, so ask specific, direct questions to find out the type and dosage to provide more informed medical care.

Transgender victims of sexual assault might be seeing therapists for emotional support and may be on medications for anxiety, depression, posttraumatic stress disorder, or issues related to sleep. Talking about all medication prescribed by other providers in nonjudgmental ways will allow patients to fully disclose their medications (and the reasons they are taking them). It may be appropriate to coordinate care with the patient's other prescribing physicians (but see [Disclosure and Confidentiality](#) in this e-pub).

Hormones

FTMs. Because hormones may decrease the plasticity in the vagina, penetration in this area may result in increased physical trauma and/or potentially put an FTM at higher risk for sexually transmitted infections (STIs). If you are conducting a vaginal exam on a

PROTOCOLS

The following protocols outline assessment strategies, health screenings and prevention, hormone

transgender patient who uses hormones, consider using a pediatric speculum. Although unlikely, pregnancy is still possible in FTMs who use testosterone, particularly those who are on a "low dose."³ Discuss appropriate pregnancy testing approaches with these patients.

MTFs. MTF victims of sexual assault may not have many medical complications related to hormone use, but this depends on the extent of the injuries sustained. Because sexual assault against transgender individuals—particularly transwomen of color—can include hate-motivated, physical violence, MTF patients may be bleeding from cuts, abrasions, gunshot wounds, or vaginal/anal penetration. MTFs who are taking estrogen are at substantially increased risk for blood clot complications. Prophylactic anticoagulant care may be appropriate.

therapy approaches, and medical management of transgender individuals:

- [Transgender Primary Medical Care: Suggested Guidelines for Clinicians in British Columbia](#)
- [Protocol for Hormone Therapy](#) (Fenway)
- [Protocols for Hormonal Reassignment of Gender](#) (Waddell)
- [Medical Therapy and Health Maintenance for Transgender Men: A Guide for Health Care Providers](#) (Gorton et al.)

Surgery

The majority of transgender people have not had (or do not want) surgery to alter their body.⁴ When treating FTM transgender patients who have had surgery as part of their transition, keep the following in mind:

- FTMs who have had chest surgery may have bilateral scars that run from mid-chest to armpit. Nipples or other parts of the chest may be numb due to tissue grafts or disruption of nerves during surgery.
- If an FTM patient has not had a hysterectomy with oophorectomy and is within childbearing age, discuss the risk of pregnancy (even if the patient has taken testosterone and believes that pregnancy is impossible).
- Even if the patient has had a vaginectomy (closure of the vagina), some of the techniques used in the surgery may make it possible to penetrate or forcefully reopen the vagina.
- FTMs who have had phalloplasty may have graft sites on their forearm, abdomen, or thigh. Some graft sites are very pronounced and some individuals are self-conscious about the scars.

When treating MTF transgender patients who have had surgery as part of their transition, keep the following in mind:

- Surgically constructed vaginas are typically more shallow than others, do not self-lubricate, and may be more fragile and easily damaged, increasing the risk of STIs/HIV transmission.
- Increased blood loss may result if a surgically constructed vagina has been injured during a sexual assault.
- If a transgender woman's vagina is damaged in an assault, she may be even more upset than non-transgender women might be because of the cost of the surgery and because it may symbolize her womanhood. She may be concerned that surgical repair would be required, which is unlikely to be covered by insurance and may not be financially accessible.
- If an MTF has had breast augmentation surgery and her implants were damaged during the assault, surgery may be required to remove the damaged implants. This would likely add another layer of emotional distress.
- If a transgender woman's face is damaged during an assault, she may be highly distressed because her face may be a key marker of her femininity and may have allowed her to pass safely in the world as female.

Non-suicidal self-injury

Self-harming behaviors are extremely common in survivors of sexual assault and other trauma. One study estimates that self-injuring behavior may be as high as 60 percent.⁵ Such behaviors are also extremely common within the transgender community, many of whom are survivors of sexual assault.⁶

Self-injuring behaviors are likely the result of self-preservation instincts, desperation leading to survival, and emotional, cathartic release.⁷

Although self-injury is common among transgender individuals (41.8%) and very common among victims of sexual assault, do not assume that any cuts you see on a patient are self-inflicted.⁸ Hate crime perpetrators often deliberately cut or mark their victims during an assault. If some cuts are self-inflicted, be careful not to assume that other bodily damage is also self-induced. Determining the origin (self-imposed or not) or intention (hate-motivated, non-suicidal, or suicidal) of cuts may be difficult. If you suspect that cuts are self-inflicted, consider referring the patient to a therapist, victim advocate, or victim service provider, who can play a key role in helping patients learn healthier strategies for dealing with stress and trauma.

Silicone

Silicone use may result in damages not typically seen in most assault survivors. For example, if an MTF has a blunt force injury to her silicone-injected face, it may appear more disfigured than other patients with similar facial injuries due to the migration of the silicone. If an MTF has injected silicone in her chest/breast area and the area was targeted during the assault, that silicone may have migrated as well. Be prepared for these types of injuries and do not show alarm when you see them.

HATE CRIME

Perpetrators who commit hate crimes against transgender people often deliberately damage or mutilate their victims' genitals, breasts, and face. As a result, it is not uncommon for transgender victims of sexual assault to present with these types of injuries or to have long-term medical issues resulting from them.

Dissociation

Survivors of trauma sometimes experience flashbacks or dissociate, particularly when they have been triggered by something that reminds them of the trauma. Medical exams or any interaction involving touch can increase the likelihood of dissociative responses such as being confused, distracted, or unresponsive. If the patient you are treating exhibits dissociation, discontinue an exam, test, or procedure until the patient is fully present. Maintain direct eye contact, remind the patient of the date and time, and help the patient reorient. You may also want to suggest that they look at the clock on the wall, remind them of who you are, or even overtly state that you are not the perpetrator to help keep them from continuing to dissociate. Try to ensure that the patient has an immediate support structure in place, which may include staying in the exam room (alone or with a loved one or advocate) until the patient has stopped dissociating and is able to leave the office safely.

If the patient is having forensic evidence collected or is being treated for an injury that requires immediate care, be aware of their dissociation, explain what you are going to do, and ask permission before proceeding. The presence of an advocate or loved one can minimize distress.

1. Rape, Abuse & Incest National Network, "[Effects of Sexual Assault](#)," accessed Jan. 28, 2011.

2. J. Xavier, J. Honnold, and J. Bradford, 2007, [The Health, Health-Related Needs, and Lifecourse Experiences of Transgender Virginians](#), Richmond, VA: Virginia HIV Community Planning Committee and Virginia Department of Health, accessed Sept. 7, 2010.

3. FTMs are usually informed that consistent testosterone use, which typically results in ovarian atrophy and the cessation of ovulation, will make them sterile; however, there have been cases of FTMs unexpectedly becoming pregnant even if they have ceased menstruating.

4. J.M. Grant, L.A. Mottet, J. Tanis, J. Harrison, J.L. Herman, and M. Keisling, 2011, [Injustice at Every Turn: A Report of the National Transgender Discrimination Survey](#), Washington, DC: National Center for Transgender Equality and National Gay and Lesbian Task Force, accessed Feb. 4, 2011.

5. C. Zlotnick, J.I. Mattia, and M. Zimmerman, 1999, "Clinical Correlates of Self-Mutilation in a Sample of General Psychiatric Patients," *The Journal of Nervous and Mental Disease* 187:296–301.

6. I.m. dickey, 2010, Non-suicidal self-injury in the transgender community. Unpublished dissertation, University of North Dakota, Grand Forks.

7. Ibid.

8. Ibid.

Emergency Medical Personnel



You can take several steps to respectfully serve transgender victims of sexual assault:

- Be mindful about your language choices (e.g., avoid slurs, epithets, slang).
- Keep a neutral facial expression (e.g., avoid frowns, pursed lips, scornful looks).
- Avoid judgmental sounds (e.g., suppress gasps and sighs).
- Avoid discussing the patient's transgender status with coworkers or others on the scene.
- Stay focused on the patient's critical care.

In other words, be professional.

While you are treating transgender patients who have been sexually assaulted, please keep the following in mind:

- **You may see injuries not commonly seen in non-transgender patients.** For example—
 - If a transgender woman has a blunt force injury to her silicone-injected face, it may appear more disfigured than other patients with similar facial injuries due to the migration of the silicone. If she has injected silicone in her chest/breast area and the area was targeted during the assault, that silicone may have migrated as well.
 - Transgender individuals with vaginas (e.g., transgender women, transgender men who have not had the vaginal opening closed) who experience vaginal penetration as a part of the assault may have a higher rate of injury than non-transgender patients, including increased blood loss, tears, damage, and increased pain.
 - In those individuals who have not had a vaginectomy (surgical closure of the vaginal opening), testosterone use may decrease the plasticity in the vagina. Penetration in this area may result in increased physical trauma and may potentially put transgender men at higher risk for sexually transmitted infections.
 - Surgically constructed vaginas are typically more shallow than others, do not self-lubricate, and may be more fragile and easily damaged, increasing the risk of STI/HIV transmission, increased blood loss, and tears.
 - Transgender women or people who use estrogen are at greater risk for blood clots, especially if they smoke. Asking about hormone use and smoking history may be critical to providing more effective medical care.
- **Some transgender individuals may have different medical priorities than you might expect.** For example, a transgender woman may have a broken arm but be more concerned about a bruised face. She may have a substantial emotional and financial investment in her facial appearance because of facial feminizing surgeries, electrolysis, or silicone injections. In some cases, she may view her face as the primary component that keeps her safe on the streets by allowing her to “pass” and reducing her chances of discrimination, harassment, and violence.

Law Enforcement



You can take several steps to respectfully serve transgender victims of sexual assault:

- Be mindful about your language choices (e.g., avoid slurs, epithets, slang).
- Keep a neutral facial expression (e.g., avoid frowns, pursed lips, scornful looks).
- Avoid judgmental sounds (e.g., suppress gasps and sighs).
- Avoid discussing the victim's transgender status with fellow officers.
- Stay focused on the victim's critical care.
- Perform duties in a manner that respects the victim's time and energy.

In other words, be professional.

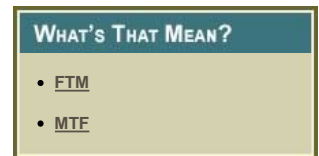
Although the medical transition of a transgender victim of sexual assault is generally not relevant for law enforcement officers, please keep the following issues in mind:

- **You may see injuries not commonly seen in non-transgender victims.** For example, if a transgender woman has a blunt force injury to her silicone-injected face, it may appear more disfigured than other victims with similar facial injuries due to the migration of the silicone. If she has injected silicone in her chest/breast area and the area was targeted during the assault, that silicone may have migrated as well. Be prepared for these types of injuries, do not show alarm when you see them, and because these injuries can be fatal if not treated promptly, strongly advocate for the victim to receive medical care.
- **Some transgender individuals may have different medical priorities than you might expect.** For example, a transgender woman may have a broken arm but be more concerned about a bruised face. She may have a substantial emotional and financial investment in her facial appearance because of facial feminizing surgeries, electrolysis, or silicone injections. In some cases, she may view her face as the primary component that keeps her safe on the streets by allowing her to "pass" and reducing her chances of discrimination, harassment, and violence.
- **If you are arresting the transgender victim for a crime, you may need to know about their medical transition so that the person can be housed safely while incarcerated.** In addition, if a transgender person is incarcerated for more than a few days, access to hormones may become a human rights or medical issue that will need to be addressed.

Advocates

As an advocate, you provide critical assistance to transgender victims of sexual assault during medical treatments (e.g., physical examinations, collection of forensic evidence). In advance of these visits, discuss with the victim how the advocacy process works. Smooth the way for victims by ensuring that medical providers act professionally, stay focused on the victim's crime-related medical needs, make no unnecessary remarks, and refrain from questioning the victim to fulfill their own curiosity about hormone or surgical status.

If needed, help victims set medical priorities with providers. For example, a male-to-female (MTF) transitioning victim may have deep emotional and financial investment in her facial appearance. This victim may have had one or more facial feminizing surgeries, expensive electrolysis, or silicone injections and may care much more about injuries to her face than to other parts of her body. In some cases, an MTF may view her face as the primary component that keeps her safe from anti-transgender discrimination, harassment, and violence. In these cases, encourage physicians to attend to the victim's facial injuries, cuts, scars, or abrasions first, before evaluating other injured areas.



You may also play a critical role in some forms of medical exams. For example, female-to-male (FTM) victims who use testosterone may experience vaginal atrophy. If the victim has been vaginally assaulted and wishes to have evidence collected or needs medical care of any kind on this area of his body, encourage the use of a pediatric speculum or remind the medical provider that the victim's vaginal tissue may not respond like a non-transgender woman's tissue. Also reinforce the use of male pronouns (if that is the victim's preference), as most providers conducting vaginal exams frequently and automatically use female pronouns.

Two of the biggest challenges transgender people contend with are other people's curiosity and the belief that others have a right to determine if someone's gender is "true" based on their hormone status, genitals, or other bodily configuration. If accompanying a transperson who is asked about these matters, it may be appropriate to intervene. Ask the professional to explain why they need to know and ensure that the question is medically necessary. If it isn't, set boundaries with the provider. A clear exception to the usual boundaries is when a health care professional needs to know which medications a patient takes to ensure there are no side effects or contraindications; victims should disclose hormone use for those reasons. Some transgender individuals do not consider hormones a medication, however, so you may need to ask specific, direct questions about hormone use.

Therapists

Effective treatment begins at reception and intake. It is essential that these frontline staff, and all staff for that matter—

- Respectfully ask clients what they would like to be called in person and what they would like on file in their records and fully respect their request. Use a person's preferred name and pronoun at all times.
- Ask only questions that are necessary for a client's mental health care.
- Keep all client information confidential and do not share details with others unless it is relevant and you have the client's permission.
- Do not comment on the quality of someone's gender-related appearance, even if intended as a compliment.

If a client experiences inappropriate behavior or mistreatment by frontline staff, promptly follow up with an apology and a corrective course of action and then move on.

As you work with transgender clients who have been sexually assaulted, keep in mind that many sexual assaults of transgender people include some form of "message" injury that results in greater damage to the genitals, chest, or face. Transgender people may be especially devastated by these injuries because their identity and sense of self-worth are often strongly linked to these areas of the body. Many have saved for a decade or more to pay for surgical intervention. If a perpetrator causes permanent damage, the victim may feel even more despair, frustration, and hopelessness. Transgender victims face additional challenges if they have to explain to coworkers, friends, or family what happened and why their physical appearance may be radically different after an assault.

If the physical harm was severe enough to warrant corrective/reparative surgery, the client's insurance company may not cover the expenses. If this is the case with your client, consider reaching out to transgender-sensitive, creative victim service providers to help the client find local resources and options.

If surgery of any type is needed post-assault—such as placing a pin in a broken bone—individuals taking estrogen are often asked to discontinue it due to an increased risk for blood clots. This can be emotionally devastating as well as mood altering. If your client needs to stop taking estrogen, reassure them that it is a temporary precaution and help them develop coping strategies to deal with discrimination, prejudice, and stress.

Do not ask questions about bodily injuries or configuration for curiosity's sake. If clients need to discuss the implications of damage to their bodies, or have any other reasons to talk about their bodies or surgical status, they will likely initiate the discussion, as long as you have created a safe and welcoming environment.

SELF-HARMING BEHAVIORS

Self-harming behaviors are extremely common in survivors of sexual assault and other trauma. One study estimates that self-injuring behavior may be as high as 60 percent.¹ Such behaviors are also extremely common within the transgender community, many of whom are survivors of sexual assault.² Self-injuring behaviors are likely the result of self-preservation instincts, desperation leading to survival, and emotional, cathartic release.³

If a client's cuts or other injuries are self-inflicted, you can play a key role in helping that client learn healthier strategies for dealing with stress and enhancing their ability to cope with their emotions.

1. C. Zlotnick, J.I. Mattia, and M. Zimmerman, 1999, "Clinical Correlates of Self-Mutilation in a Sample of General Psychiatric Patients," *The Journal of Nervous and Mental Disease* 187:296–301.

2. I.m. dickey, 2010, Non-suicidal self-injury in the transgender community. Unpublished dissertation, University of North Dakota, Grand Forks.

3. Ibid.

Support Group Facilitators

One of the most useful purposes of support groups—for both transgender and non-transgender individuals—is as an environment where participants feel free to share their experiences without being judged or discriminated against, and it is the facilitators who must set the stage and moderate the group discussion to achieve this safe environment. The diversity of experiences shared within the group can help all members see the range of emotions, reactions, processes, and solutions that are possible. Transgender people may discover that their experiences as survivors are not transgender specific, but are instead survivor specific or simply human experiences.

Unfortunately, some support groups are not the safest, most sharing environments. Transgender people often feel **censored** by facilitators or **excluded** by other group members. If a transgender client discloses to the group and is neither censored nor excluded outright, that client still may encounter **anti-transgender bias** among the group or staff in your office. Beyond confronting this bias, you must also be aware of some of the **specific concerns** that transgender clients may have, so that you can address them appropriately when they are raised in a group setting.

Censorship

Some facilitators ask transgender people not to discuss any aspect of their transgender status, experience, body, or reality with the group. For example, female-to-male survivors who were vaginally penetrated during an assault have been asked not to share this information in a group for men. This prohibition may also mean that a person cannot talk about an assault that occurred in childhood or at any time in their lives when they were perceived as or living as another gender. If the assault occurred within the context of a hate crime, it forces them to conceal this as well.

Exclusion

Some groups have inclusion/exclusion rules that are enforced through discussion and/or voting within the group, and some have used this process to expel transgender individuals simply because they feel uncomfortable around them. An existing policy that defines who is or is not allowed into groups is a good place to start if the group initiates this discussion (see [Segregated Services: Implications and Actions for Support Group Facilitators](#) for information about such policies). If there is no policy, consider what this dynamic would feel like if most group members were white and they did not feel "comfortable" with a person of color in the group. Would you, as a facilitator, allow the group to vote out participants because of the color of their skin?

Anti-transgender bias

As the support group facilitator, you should address cultural bias, transphobia, and incorrect assumptions and statements when they happen, regardless of who states them. Confronting bias and ensuring a safe space for all participants is one of your primary roles.¹

You can help by getting group members to stay focused on the purpose of the group and steering discussion away from intrusive or inappropriate questions. As noted in FORGE's *Confronting Client Bias* handout,² you can reduce bias among group members and staff in these four ways:

1. **Set the stage.** Create a bias-free zone. Include bias-free language in employee manuals and forms and hang "bias-free zone" signs to remind staff of expected behavior and attitudes. Set ground rules at the beginning of group meetings to remind all clients of the non-bias environment. Add clauses to the client's bill of rights to reinforce the expectation that everyone deserves to be treated without bias.
2. **Train and empower.** Confronting bias can be difficult for anyone, including staff. Practice appropriate and sensitive ways to confront bias by using role plays in staff training, creating handouts with tips on addressing bias, modeling appropriate behavior in day-to-day meetings and other activities, or drawing connections between biases/experiences people understand and biases/experiences they may not understand.
3. **Address and follow up with the speaker.** Address bias the moment it occurs, but do not abandon the existing agenda or person speaking to devote the rest of a group session to discussing the biased statement. Instead, develop responses to potential issues in advance (e.g., "What you said may feel painful to some other group members, would you be willing to rephrase it

in a less global way?") and follow up with the speaker later.

4. **Address and follow up with the target.** Some biased statements are clearly aimed at a person in the group. Pausing the discussion when it happens is key so the person who made the comment can be asked to rephrase and, ideally, apologize. The pause will also allow the person to whom the comment was made to express their emotional response and determine if they are comfortable staying for the rest of that group session or if something else needs to happen (e.g., calling a break). Follow up with any targets of the biased comment to discuss their feelings, provide support, and to get feedback on how the intervention felt.

Biased statements are not always aimed at any given person, although those who are present may identify with the targeted group. A simple intervention as discussed above may be enough to reassure people that bias won't go unaddressed. Some people in the group may be more distressed and may need more time to process the biased comment and resulting feelings.

The Men's Project in Eastern Ontario, Canada, has very successfully screened potential group members for homophobia before they are admitted into mixed sexual orientation groups. Potential members with biases are offered individual therapy until they are able to safely be in groups with members of different sexual orientations. A similar process could be used to screen group members about anti-transgender bias or other possible biases that could affect the safety and effectiveness of the group. Potential group members should also be screened for abusive behavior by loved ones, to prevent survivors from being in the same group as perpetrators (see [Companions as Abusers](#) in this e-pub for more information).

As facilitator, you should help the group construct ground rules and enforce those rules as necessary. Failure to do so may result in transgender (and other) clients deciding to leave the group. According to one transgender sexual violence survivor: "I've never been in an emotional support environment where I felt safe discussing transgender issues."³

If a client doesn't feel supported within the group, and you cannot find other local options for group support, several online and phone options are available, regardless of a client's location:

- [FORGE's survivors listserv](#) for transgender sexual violence survivors (including secondary survivors). To subscribe, e-mail majordomo@lists.forge-forward.org and type "subscribe sv-support" in the body of the e-mail.
- [FORGE's Writing to Heal](#) groups, offering trauma-informed Internet- and phone-based support for transgender survivors.
- [The Network La Red's phone-based support group](#) for intimate partner violence survivors. Call 614-742-4911 for more information. (Note: This group is not being regularly offered.)
- [1in6 Online SupportLine](#). Although oriented toward male survivors of sexual assault, other survivors are invited to chat.

Transgender-specific concerns

As you work with transgender clients who have been sexually assaulted, keep in mind that many sexual assaults of transgender people include some form of "message" injury that results in greater damage to the genitals, chest, or face. Transgender people may be especially devastated by these injuries because their identity and sense of self-worth as male or female are often strongly linked to these areas of the body. Many have saved for a decade or more to pay for surgical intervention. If a perpetrator causes permanent damage, the victim may feel even more despair, frustration, and hopelessness. Transgender victims face additional challenges if they have to explain to coworkers, friends, or family what happened and why their physical appearance may be radically different after an assault.

It is not uncommon for both providers and the general public (including members of support groups) to be curious about and to ask inappropriate questions regarding a transgender person's surgical status. One of the most common questions transgender people field is "Have you had genital surgery?" These questions are almost always inappropriate, insensitive, and damaging. Non-transgender people are rarely asked questions about their genitals or other personal details, and the same should hold true for transgender individuals. If a member of a support group asks about someone else's genitals, intervene

immediately. A simple, firm statement of "that question is not appropriate" will remind everyone of the appropriate boundaries of discussion as well as reassure the transgender person that you will not allow intrusive questions.

Self-harming behaviors are extremely common in survivors of sexual assault and other trauma. One study estimates that self-injuring behavior may be as high as 60 percent.⁴ Such behaviors are also extremely common within the transgender community, many of whom are survivors of sexual assault.⁵ You can play a key role in helping clients learn healthier strategies for dealing with stress and trauma and enhancing their ability to cope with their emotions.

1. L. Cook-Daniels, 2001, *Making Space Safe*, Milwaukee, WI: FORGE, accessed Jan. 28, 2011. [A Transgender Support Group Facilitator's Guide is expected to be published in 2013 and will be available on [FORGE's Web site](#).]

2. FORGE, 2009, *Confronting Client Bias*, Milwaukee, WI: FORGE.

3. FORGE, 2005, Sexual Violence in the Transgender Community Survey, quotation from narrative response, unpublished data.

4. C. Zlotnick, J.I. Mattia, and M. Zimmerman, 1999, "Clinical Correlates of Self-Mutilation in a Sample of General Psychiatric Patients," *The Journal of Nervous and Mental Disease* 187:296–301.

5. I.m. dickey, 2010, Non-suicidal self-injury in the transgender community. Unpublished dissertation, University of North Dakota, Grand Forks.

RESPONDING TO TRANSGENDER VICTIMS of Sexual Assault

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Transgender 101

Sexual Assault in the
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Tips for Those Who
Serve Victims

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Documenting the Assault

Accurate, nonbiased, descriptive reporting of the assault and physical injuries is crucial. If providers insert colloquial language or personal opinions in official reports, it may damage or invalidate a victim's ability to proceed with a criminal case. It is also important to document specific medical injuries or observations objectively, which is critical for both accurate medical care in the emergency room (when applicable) and for criminal justice purposes.

To help health care providers and other professionals objectively report injuries, FORGE developed a [sample gender-neutral body map](#).

Implications and Actions for ...

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Health Care Providers

Ideal documentation includes charting through body maps and narrative. Gender neutral body maps are recommended but may not be within your control if you work for a large hospital or health care facility. If you are using gendered body maps, consider developing a protocol for charting transgender patients' injuries. If it is necessary to use a gendered body map that does not match the patient's gender identity, reassure the patient by saying something like, "I know you are [patient's stated gender], but this body chart will allow me to more accurately document your injuries."

The complexity of transgender bodies, coupled with the need for accurate forensic recording, may require writing a more lengthy narrative to explain how information was charted. If illnesses and injuries are not related to transgender-specific anatomy, medication, or surgery, do not reference that the patient is transgender. If illnesses or injuries are related to transgender-specific anatomy, medication, or surgery, constructing an objective narration is critical to the patient's privacy, continued medical care, and forensic evidence collection/recording.

Emergency Medical Personnel

When documenting medical injuries, accurately and consistently reflect the person's chosen name, gender identity, and pronoun choice. When there are conflicting identity documents, or there is a difference between a person's identity documents and their presentation, it is most respectful to state the person's legal name and gender marker and note that the rest of the report will be under the preferred name or gender.

Individual fire departments or first responder agencies may require staff to file reports using a patient's legal name or require the use of gendered body maps. In these cases, accurately

describing an individual's appearance and stated name and pronoun choice can help validate the reality of the patient's daily life.

Law Enforcement

When documenting the assault in records, accurately and consistently reflect the person's chosen name, gender identity, and pronoun choice. When there are conflicting identity documents, or there is a difference between a person's identity documents and presentation, it is most respectful to state the person's legal name and gender marker and note that the rest of the report will be under the preferred name or gender. Individual jurisdictions may require officers to file reports using a victim's legal name. In these cases, accurately describing an individual's appearance and stated name and pronoun choice can help validate the reality of the victim's daily life.

Advocates

Due to a general lack of knowledge among health care providers and the public about how to support transgender victims, you may need to offer other professionals recommendations on how to respectfully and accurately document case details.

READ MORE

- [A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/Adolescents, Second Edition](#)

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Segregated Services

Services for sexual assault victims may be segregated by gender (male/female), sexual orientation (LGB/straight), or any number of other demographic variables. Many services are for women only or, at best, are offered separately for men and women. In addition, many services and institutions that a victim may need or want to access are segregated

by sex: social support groups; shelters; hospital rooms; substance abuse or drug treatment; OB/GYN and urologists' offices; gyms and health/wellness programs; religious facilities; community service groups; some hair salons and barber shops; mentoring programs; YMCAs; clothing banks; and sweat lodges and other spiritual healing retreats.

READ MORE

- [Services Outside of the Box:
Helping Your Transgender
Clients Navigate
Sex-Segregated Services](#)

FACILITY RESTROOMS

Gender-specific bathrooms are a source of stress for transgender people. More than 65 percent of over 1,000 transgender respondents to a 2011 FORGE study said that they viewed the availability of gender-neutral bathrooms as "important," "very important," or "extremely important" in deciding whether to access professional services.⁴²

Many facilities have converted single-stall bathrooms to unisex bathrooms. This quick and low-cost change benefits a wide range of people, including non-transgender individuals who feel they must wait in a hallway for "their" bathroom to become available—even if the one next door is unoccupied.

Your policies should clearly state who is or is not eligible for services based on gender, and your staff should understand the policies and be able to clearly state them to victims seeking services. For example, if services are only available to women who have a female gender designator on their driver's license or identification card, outline that in the eligibility requirements for that service. If a particular service requires a prescreening interview to determine if it is an appropriate match for a victim's healing needs, make this requirement clear.

Implications and Actions for ...

[Collapse All]

Health Care Providers

Some medical offices have public areas (e.g., waiting areas in x-ray departments) that are divided by gender. If a transgender patient needs a service that usually involves waiting in a gender-segregated

space, consider the patient's safety and comfort. Offering to place a patient directly in an exam room without any other patients is a short-term solution. Facilities should address their policies and procedures of sex-segregated spaces and determine if there might be a more effective and comfortable practice for all patients.

If a transgender person requires inpatient medical care, you may play an important role in helping to minimize the additional layers of distress that person may feel. Four primary issues might be particularly distressing:

1. **Roommates.** Most facilities house patients in shared rooms based on legal gender or sex. If legal gender does not align with gender expression (or gender identity), such room placement may be inappropriate and uncomfortable. Even if legal gender and gender expression align, transgender patients may require additional privacy to avoid potential roommate issues.
2. **Gender-specific tests.** Some medical tests are highly sex-specific and professionals working in these areas (e.g., people who specialize in transvaginal ultrasounds) may be unaccustomed to working with transgender patients. Many hospitals have gender-segregated changing areas for these sex-specific services.
3. **Personal care/bathing.** Hospitalized patients may need assistance with personal care, bathing, dressing changes, and other care. Most facilities have a large number of staff providing care to multiple patients. Many transgender individuals rarely undress in front of others, so this level of care may be particularly distressing. If care is typically provided by matching the patient's gender with the provider's gender, consider asking transgender patients if they prefer a male or female nurse or nursing assistant.
4. **Gender-related prosthetics and materials.** Some transgender individuals use devices to align more closely with their gender identity, which may be difficult to use in a hospital setting. For many transgender people, these items are essential. If not allowed to use them, they may feel increasingly anxious and depressed and may be concerned that others will not see them as the gender with which they identify.

Each patient's needs are unique. Direct, sensitive communication, using inclusive and respectful language, can be a successful first step to collectively determining solutions that meet the facility's needs as well as the patient's.

Patients may need to enter transitional care facilities following hospitalization. Many of the same concerns will apply in other types of residential facilities.

Whenever possible, consider alternatives to hospitalization or segregated housing, such as outpatient day surgery centers and hospitals with private rooms.

If referring the patient to a sex-segregated service and the patient's gender expression and gender identity align with the sex being served, that may be an appropriate referral. The patient may choose never to disclose gender history to the service provider or other people being served by that provider. If referring the patient to a sex-segregated residential service and the patient's gender identity, appearance, documentation, or genital status does not fit the service's eligibility policies, discuss options with the patient to determine the best course of action. Never disclose a patient's gender when referring that patient to another service provider or agency without overt permission.

READ MORE

In this e-pub*—

- Tips for Those Who Serve Victims: [Disclosure and Confidentiality](#)

*Clicking these links will take you to other sections in this e-pub. To return, hit your browser's "back" button.

Law Enforcement

In most situations, segregated services will not likely pose any issues for law enforcement officers. The exception would be if the victim is being arrested for a crime while reporting a crime committed against them (e.g., a person damages property during a bar fight but is also sexually assaulted).

When transgender individuals are incarcerated, they are typically housed according to their genital status, gender assigned at birth, or legal gender—even if this is a dangerous situation for the person. For example, a transgender woman who is housed with men may experience extensive harassment and possibly violence or sexual assault from other inmates. According to numerous agencies that work extensively on issues involving transgender individuals and incarceration,¹ some incarcerated transgendered individuals are being placed in solitary confinement as a protective custody measure.

The Sylvia Rivera Law Project works extensively with low-income transgender people, who have higher rates of involvement in the criminal justice system as a result of engaging in the underground economy (e.g., involvement in the sex trade, drug dealing). It recommends that—

[A] new policy regarding placement of transgender and intersex prisoners [should be] researched and developed. Criteria for placement should include gender identity (focused on placing inmates in facilities that comport with their current gender identity rather than birth gender) and safety (assessing where an inmate will be least vulnerable to sexual assault).²

[Just Detention International](#), which seeks to end sexual violence in jails and prisons (including sexual violence against transgender inmates), provides national technical assistance and may be a useful resource for local police departments.

1. For example, National Center on Lesbian Rights, Transgender Law Center, Sylvia Rivera Law Project, Just Detention International, and National PREA Resource Center.

2. [Letter](#) from Dean Spade of the Sylvia Rivera Law Project to the National Prison Rape Elimination Commission on August 15, 2005.

Advocates

Some sexual assault service providers—including therapists—only serve women. Before you refer victims to therapists or other service providers, you must know the attitudes, beliefs, and approaches they have about working with individuals who are male identified or transgender identified (or who have previously identified this way). Referring a victim to providers who are ignorant of transgender people, or who are prejudiced against them, could result in the victim being revictimized by the very people who are supposed to help them.

If referring the victim to a sex-segregated service and the victim's gender expression and gender identity align with the sex being served, that may be an appropriate referral. The victim may choose never to disclose gender history to the service provider or other people being served by that provider. If referring the victim to a sex-segregated residential service and the victim's gender identity, appearance, documentation, or genital status does not fit the service's eligibility policies, discuss options with the victim to determine the best course of action. Never disclose a victim's gender when referring that victim to another service provider or agency without overt permission.

READ MORE

- [Services Outside of the Box: Helping Transgender Clients Navigate Sex-Segregated Services](#)
- [Sex-Segregated Services: Finding Resources for Transgender Clients](#) (webinar)

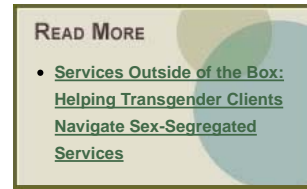
Therapists

Your advertising must accurately represent the populations you actually serve. For example, if you specialize in working with lesbian and bisexual women, be clear that you only serve women. Only use the acronym “LGBT” when serving all members of the lesbian, gay, bisexual, and transgender community.

If referring your client to a sex-segregated service (e.g., support group, single-gender retreat, spiritual gathering) and the client's gender expression and gender identity align with the sex being served, that may be an appropriate referral. A client's choice not to disclose gender history to the service provider or other clients must be respected and held confidential. If referring your client to a

sex-segregated residential service and the client's gender identity, appearance, documentation, or genital status does not fit the service's eligibility policies, discuss options with the client to determine the best course of action. Never disclose a client's gender when referring that client to another service provider or agency without overt permission.

If your client requires inpatient psychiatric care, you can play an important role in helping to minimize the additional layers of distress that client may feel. Four primary issues might be particularly distressing:



1. **Roommates.** Most facilities house clients in shared rooms based on legal gender or sex. If legal gender does not align with gender expression (or gender identity), such room placement may be inappropriate and uncomfortable. Even if legal gender and gender expression align, transgender clients may require additional privacy to avoid potential roommate issues.
2. **Gender-segregated group activities.** Many inpatient facilities continue to create group activities based on gender. Although some transgender individuals are easily able to determine which gender group feels most comfortable and appropriate, not all facilities allow individuals to self-select their group placement. Additionally, many transgender individuals do not identify with a binary gender, so neither group would be an ideal placement. Consider allowing these individuals to use the group time to meet privately with the psychiatrist or to engage in other formal or unstructured activities.
3. **Supervised showering.** Many inpatient units have a staff member supervise each client's showering and other typically private activities. Supervised showering is invasive for all individuals but may be especially troubling for transgender clients, particularly those who have not disclosed their transgender history and may have anatomy that does not align with the staff's expectations of their gender. Even clients who have disclosed their gender identity or history may not have disclosed possible surgical interventions or hormone use. Work with clients and facility staff to mutually determine the best solution for supervised showering (e.g., allowing the client to select the gender of the supervising staff member).
4. **Gender-related prosthetics and materials.** Some transgender individuals use devices to align more closely with their gender identity, which may be difficult to use in inpatient facilities that restrict the use of certain items as a way of reducing the risk of suicide. Restricting access to these items (e.g., tape to secure wigs, binders to flatten chests) may severely increase the person's anxiety, depression, and even suicidality. Lack of access may also influence the client's ability to be actively engaged in their inpatient treatment. Work with staff to secure exceptions and/or to help your client develop specific strategies to compensate for the loss of these supports.

Each client's needs are unique. Direct, sensitive communication, using inclusive and respectful language, can be a successful first step to collectively determining solutions that meet the facility's needs as well as the client's.

Clients who have been hospitalized for mental health reasons may move to transitional housing at some point during their treatment. The majority of transitional housing is segregated by sex. Similar types of advocacy may be necessary if transitional housing is recommended.

Whenever possible, consider alternatives to hospitalization or segregated housing. All-day mental health programs, housing with friends or family, or combining multiple types of services may yield the same results as being hospitalized or living in shelter or transitional housing.

Support Group Facilitators

Support groups for survivors are often segregated by gender, sexual orientation, or another demographic variable. Most are for women only and very few are for men or for people of all genders. These groups may not accept a male-to-female (MTF) survivor, particularly if they are told

she is transgender or if she is visibly gender non-conforming. Female-to-male (FTM) survivors would not be welcome either, unless they presented as female and did not discuss their masculine identity. According to one FORGE survey respondent:¹

There was a "survivor of male childhood sexual abuse" group in my community, but until I transitioned completely physically, I could not attend it. Once I transitioned, I didn't need the group.

Having clear, well-thought-out written policies and procedures in place for eligibility requirements is an excellent place to begin. If your support group has gender-based restrictions, be clear about the entrance requirements. The clearer the policy, the better clients—both transgender and non-transgender—will be served. Some support groups that are segregated by gender determine entrance eligibility by factors such as legal gender (e.g., M or F on a driver's license), surgical/genital status (which would not be asked of non-transgender clients or clients not perceived to be transgender), or even hormone status. These screening protocols are discriminatory. Policies related to eligibility requirements should be carefully constructed, clear, and as unbiased as possible and uniformly applied to all potential group participants.

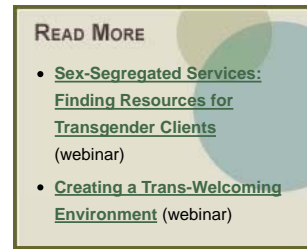
If no policy exists, consider developing a work group to outline the implications of various policy choices. After the policy is finalized, make sure that all staff are fluent in its meaning and application and make the policy available to any potential group member who wishes to see it.

If transgender individuals are eligible for your group, can they openly discuss their whole lives, including their gender histories and gendered bodies, in ways that are similar to what non-transgender individuals can share? Or are they restricted from broaching certain topics, as was the case with one FTM survivor, who was told by a facilitator that he could attend the male sexual assault survivors group "if I did not talk about my vaginal rape"?²

If unsure whether group members will be receptive to a transgender member, create a plan with the transgender client about their preferences regarding your response, while assuring them that they are not the problem. Some transgender participants may want to be "out" in the group while others may not want to disclose. Do not assume that a particular transgender person prefers a group of a specific gender. If possible, allow participants to select which group they would like to attend. In working with an all-LGBTQ survivor's group, it is considered best practice to integrate all genders.

If a prospective client is ineligible for your services, make sure you have appropriate referrals on hand so that the survivor can receive services elsewhere. Develop strong connections with local transgender groups, LGBT community centers, or providers who extensively work with transgender clients so that you can better refer clients who do not meet your eligibility requirements.

For the long term, consider revising your policies so that all survivors, including transgender survivors, are eligible to participate.



1. FORGE, 2005, Sexual Violence in the Transgender Community Survey, quotation from narrative response, unpublished data.

2. Ibid.



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Standard Practices

Crime Victim Compensation

Transgender victims of sexual assault who report the crime to law enforcement may encounter barriers to receiving crime victim compensation that others do not encounter:

- Name and gender disparities could pose problems.
- Expenses that are not typically reported (e.g., replacement costs of prosthetic devices) may not be covered.
- The victim may not be eligible if the sexual assault took place while negotiating sex for money.
- Low-income transgender victims may not have bank accounts or any other means for accepting payment by check.

Creativity is key to helping clients find ways to apply for and accept compensation and to replace damaged items.

Implications and Actions for ...

[\[Collapse All\]](#)

Health Care Providers

Generally, victim advocates help victims file for crime victim compensation. Smaller or rural communities, however, may not have a victim advocate. If patients pursue compensation in these communities, they may ask for assistance regardless of whether there is an advocate or not. See OVC's [U.S. Resource Map of Crime Victim Services and Information](#) to find local assistance for victims who want to file compensation claims.

Emergency Medical Personnel

Accurate reporting is essential for victims to receive crime victim compensation. Collecting information and documenting the patient's medical condition will increase the likelihood that the patient will be able to access victim compensation.

Law Enforcement

Accurate reporting of the crime is essential for victims to receive crime victim compensation. Collecting information, documenting the crime, and asking appropriate investigative questions will increase the likelihood that victims will be able to access victim compensation.

Advocates



Support transgender victims by first helping them understand that compensation may be available to help with medical services, lost wages from work, damage to personal property, and other allowable crime-related expenses.

You can be most helpful by clearly detailing what the process involves, thereby allowing the victim to make informed choices. For example, if you tell victims that compensation may be available, they might be more interested in filing police reports and/or having evidence collected.

Some transgender victims may be unclear about whether they can claim specific transgender-related expenses, such as damaged prosthetics or wigs or even gendered clothing. Help assure victims about what is and is not covered by crime victim compensation.

As you would with any victim of crime, walk transgender victims through the crime victim compensation form one question at a time, and remind them of their rights.

Therapists



Generally, victim advocates help victims file for crime victim compensation. If the client is pursuing compensation, they may ask for assistance regardless of whether there is an advocate or not. Smaller or rural communities may not have a victim advocate. See OVC's [U.S. Resource Map of Crime Victim Services and Information](#) to find local assistance for clients who want to file victim compensation claims.

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¹ FORGE, 2005, Sexual Violence in the Transgender Community Survey, quotations from narrative response, unpublished data.

² J.G. Allen, 2005, *Coping With Trauma: Hope Through Understanding*, 2d ed., Arlington, VA: American Psychiatric Publishing, Inc., 70.

³ Ibid.

⁴ Ibid.

⁵ Pansexual differs from bisexual in that it does not imply there are only two genders.

⁶ Polyamorous individuals are capable of loving more than one person at the same time. Polyamory is consensual non-monogamy, which may result in different types of relationships.

⁷ FORGE, 2005, "[Implications](#)," quotation from narrative response to the Sexual Violence in the Transgender Community Survey, accessed Feb. 13, 2013.

⁸ FORGE, Sexual Violence in the Transgender Community Survey.

⁹ Ibid.

¹⁰ Ibid.

¹¹ M. Ciarlante and K. Fountain, Ph.D., 2010, [Why It Matters: Rethinking Victim Assistance for Lesbian, Gay, Bisexual, Transgender, and Queer Victims of Hate Violence and Intimate Partner Violence](#), Washington, DC: National Center for Victims of Crime, and New York, NY: New York City Anti-Violence Project, accessed Jan. 28, 2011.

¹² FORGE, Sexual Violence in the Transgender Community Survey.

¹³ National Coalition of Anti-Violence Programs, 2012, *Hate Violence Against Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Communities in the United States in 2011*, New York, NY: National Coalition of Anti-Violence Programs, 43. Since the development of this online guide, new information has been made available. See NCAVP's [Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Hate Violence in 2012](#).

¹⁴ J.M. Grant, L.A. Mottet, J. Tanis, J. Harrison, J.L. Herman, and M. Keisling, 2011, [Injustice at Every Turn: A Report of the National Transgender Discrimination Survey](#), Washington, DC: National

¹⁵ FORGE, "[Implications](#)."

¹⁶ FORGE, Sexual Violence in the Transgender Community Survey.

¹⁷ A.C. McFarlane and B.A. van der Kolk, 1996, "Conclusions and Future Directions," in A.C. van der Kolk, A.C. McFarlane, and L. Weisaeth, eds., *Traumatic Stress: The Effects of Overwhelming Experience on Mind, Body, and Society*, New York, NY: The Guilford Press, 559–575.

¹⁸ Gay and Lesbian Medical Association, 2006, [Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients](#), Washington, DC: Gay and Lesbian Medical Association, 14, accessed July 18, 2013.

¹⁹ Ibid.

²⁰ Public Health: Seattle and King County, 2005, [Culturally Competent Care for GLBT People: Recommendations for Health Care Providers](#), Seattle, WA: Public Health: Seattle and King County, accessed July 18, 2013.

²¹ See WPATH's ["Standards of Care"](#).

²² The three largest LGBT health centers follow informed-consent protocols. See Fenway Community Health Center's ["Protocol for Hormone Therapy"](#), Tom Waddell Health Center's ["Protocols for Hormonal Reassignment of Gender"](#), and Howard Brown Health Center's [THInC](#) program.

²³ National Coalition of Anti-Violence Programs, *Hate Violence Against Lesbian, Gay, Bisexual, Transgender, Queer, and HIV-Affected Communities in the United States in 2011*, 36–37.

²⁴ FORGE, Sexual Violence in the Transgender Community Survey.

²⁵ Ibid.

²⁶ L. Cook-Daniels, 2009, "'Atypical' Sexual Abuse Survivors and Perpetrators: Where Are the Male Victims and Female Perpetrators? (Part Two of Two)," *Victimization of the Elderly and Disabled* 11(5).

²⁷ Ibid.

²⁸ FORGE, Sexual Violence in the Transgender Community Survey.

²⁹ Ibid.

³⁰ Ibid.

³¹ Ibid.

³² Ibid.

³³ Grant et al., [Injustice at Every Turn: A Report of the National Transgender Discrimination Survey](#).

³⁴ "Noncongruent" in this context means that an individual has primary and/or secondary sex characteristics that an observer would not expect based on that person's gender identity or clothed appearance.

³⁵ Grant et al., [Injustice at Every Turn: A Report of the National Transgender Discrimination Survey](#).

- ³⁶ D. McWilliams, D. Fournier, B.A. Booth, P. Burke, and J. Kauffman, 2008, "Legal Issues of Importance to Clinicians," in H.J. Makadon, K.H. Mayer, J. Potter, and H. Goldhammer, eds., *Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health*, Philadelphia, PA: American College of Physicians, 446–447.
- ³⁷ J. Xavier, J.A. Honnold, and J. Bradford, 2007, [*The Health, Health-Related Needs, and Lifecourse Experiences of Transgender Virginians*](#). Richmond, VA: Virginia HIV Community Planning Committee and Virginia Department of Health.
- ³⁸ Public Health: Seattle and King County, 2005, [*Culturally Competent Care for GLBT People: Recommendations for Health Care Providers*](#).
- ³⁹ C.K. McGowan, 1999, *Transgender Needs Assessment*, New York, NY: New York City Department of Health, HIV Prevention Planning Unit; Xavier et al., [*The Health, Health-Related Needs, and Lifecourse Experiences of Transgender Virginians*](#); J. Xavier, M. Bobbin, B. Singer, and E. Budd, 2005, "A Needs Assessment of Transgendered People of Color Living in Washington, DC," *International Journal of Transgenderism* 8(2/3):31–47.
- ⁴⁰ G. Kenagy and W. Bostwick, 2005, "Health and Social Service Needs of Transgendered People in Chicago," *International Journal of Transgenderism* 8(2/3):57–66; J. Zians, 2006, [*The San Diego County Transgender Assessment Report*](#), San Diego, CA: Family Health Centers of San Diego, CA, accessed Sept. 7, 2010; L. Carson, 2009, *Physical and Emotional Health Needs of Transgender Individuals Living in Philadelphia: Summary of Key Findings*, Philadelphia, PA: Public Health Management Corporation; Grant et al., [*Injustice at Every Turn: A Report of the National Transgender Discrimination Survey*](#).
- ⁴¹ Center of Excellence for Transgender Health, 2011, "Insurance Issues," *Primary Care Protocol for Transgender Patient Care*, San Francisco, CA: University of California, Department of Family and Community Medicine, accessed May 7, 2011.
- ⁴² FORGE, 2011, Transgender Individuals' Knowledge of and Willingness to Use Sexual Assault Programs, unpublished survey data, Morehouse School of Medicine's Institutional Review.



RESPONDING TO TRANSGENDER VICTIMS of Sexual Assault

Message From the Director

About This Guide

Transgender 101

Sexual Assault in the
Transgender CommunityTips for Those Who
Serve Victims

JUNE 2014

Printer-Friendly Option

Text size Send

Tips for Those Who Serve Victims

- + Victim Issues
- + Perpetrator Issues
- + Standard Practices
- Notes

Five Keys

Outreach

Five Keys to Service

- [Don't Categorize; Use Your Client's Terms](#)
- [Know Why You're Asking, and Explain Why](#)
- [Consider the Whole Person](#)
- [Partner With Your Client](#)
- [Manage Your Curiosity](#)

The five keys in this section are quick reminders that will help you serve transgender clients respectfully and appropriately. Use them to build a strong working alliance with transgender clients, which will help to ensure the success of your services.

Key #1: Don't Categorize; Use Your Client's Terms

Our brains organize incoming information into categories. We automatically (and usually unconsciously) sort objects and concepts into groups; for example, animal/cat, tree/leaf, house/window. We also sort other people into boxes, generally based on their appearance (e.g., perceived gender, race, age, disability). Some aspects may not be as easily identified as others. When there are aspects about people that are harder to identify, our brains will work diligently to figure out how and where these people fit.

When learning about transgender individuals, people may seek firm definitions and distinct labels to help categorize them. For example, common questions revolve around the difference between "gender non-conforming" and "gender variant," between "transgender" and "transsexual," between "cross-dresser" and "drag king," or other terms heard via the media, coworkers, clients, or friends. Some people believe that if they know the "right" terms (and definitions), they will be able to better understand someone who is different from themselves and will be able to effectively provide them with the services they need.

Many "transgender 101" documents and trainings currently available are based on the concept that providers must know specific terms and definitions to be culturally competent. Although this approach may satisfy people who want to know the "right answer," FORGE believes that much more than terms and definitions are needed to ensure a provider is culturally sensitive and inclusive. Focusing on terms and definitions may lead to a reduced understanding of the complexity of transgender lives, which can result in increasing client discomfort.

READ MORE

In this e-pub*—

- About This Guide: [Language](#)
- Transgender 101: [Language](#)
- Tips for Those Who Serve Victims: [Preferred Language](#)

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This can be especially true if providers use terms that the client does not identify with or that do not accurately represent the client's experience.

THE TERMS PARADOX

Instead of focusing on terms and definitions, FORGE stresses the concept of the **terms paradox**:

Terms are crucial.

Finding out which terms the person uses and mirroring those terms is primary to conveying respect and openness.

AND

Terms are meaningless.

In isolation, terms do not provide any guidance about which services are appropriate for a specific person. They are given specific meaning by the individual using them, so each person uses terms differently and each person has different preferences.

How does a service provider navigate this paradox?

- Because there are no consistent definitions, always **use and reflect the clients' terms**.
- **Ask** for clarification to ensure that you have all the information you need to serve clients appropriately.

See FORGE's [Terms Paradox](#)

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Key #2: Know Why You're Asking, and Explain Why

Because a transgender person's identity label by itself won't directly provide you with useful information about treatment, you will need to more carefully think through what it is that you **do** need to know. Unfortunately, this seemingly simple advice is complicated in practice. We frequently ask insensitive, ineffective, and unnecessary questions out of habit, curiosity, or ignorance. For example, a routine intake question such as "are you married?" may work reasonably well for some clients but does not sensitively serve all clients. A health care provider asking this question might actually want to know whether someone is available to drive a patient home. On the other hand, a facility hosting support groups for survivors that offers a sliding scale based on a couple's joint income may need to know the federal marriage status of the couple to determine what rate each partner will pay for services.

Because transgender people and their loved ones are routinely asked inappropriate questions (at best) and may have been treated offensively or even violently in the past (at worst), they may be on guard when approaching a service provider. It is up to you, as the professional, to prove yourself by asking only appropriate questions and by prefacing potentially sensitive questions with an explanation of why you need the answer. For example, rather than asking "are you on hormones?," consider asking "so that I can consider potential side effects of any medication I prescribe, could you tell me which medications you're currently using?" In other words, know why you are asking a question, and explain why to your clients.

READ MORE

- [Know and Tell Why](#)

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Key #3: Consider the Whole Person

When observing others, people tend to define them by one aspect of their identity: their skin color, their religion, whether they have a disability, and so forth. When applied to transgender people, the single-focused lens of presuming that everything is related to a person's transgender history or identity can hinder appropriate and objective care.

For example, a transgender organization received a technical assistance request from a domestic violence program. The caller indicated she had a transgender client and needed the transgender organization's help. After some discussion, it became clear that the client had come to the domestic violence program seeking advice about a violent intimate partner. What this client needed was support and services related to intimate partner violence, not support or services related to being transgender. In

this example, the caller presumed that her client needed undefined services from a transgender organization, completely overlooking the client's stated need for domestic violence services.

Typically, these myopic presumptions and classifications are incomplete, and they play out in more subtle ways. For example—

- Assuming that hormone use caused a transgender individual's cardiovascular condition, when the vast majority of people with heart conditions are neither transgender nor use hormones.
- Assuming that transgender people are estranged from family because of their gender identity, when the reality is that people become estranged from family members for many reasons.
- Assuming that victims of violent crime were assaulted because they are transgender, when they could have simply been the only available target at the time.
- Assuming that gender identity is a core issue for a transgender person seeking psychotherapy.

All of us, transgender or not, have many identities, roles, labels, and needs. In addition to gender identity, each person also has a racial heritage, an educational level, an income class, a developmental history, and many, many other characteristics. Don't fall into the trap of thinking that once you know one fact about a person, you know everything you need to know; listen and consider all of their many pieces.

MASTER STATUS

Master status is the tendency of observers to believe that one label or demographic category is "more significant than any other aspect of [the observed person's] background, behavior, or performance."¹ When applied to transgender people, master status refers to assuming that everything about a transgender person must be related to their gender.

Read FORGE's [Master Status](#) for more information.

1. D. Kimmel, T. Rose, N. Orel, and B. Greene, 2006, "Historical Context for Research on Lesbian, Gay, Bisexual, and Transgender Aging," in D. Kimmel, T. Rose, and S. David, eds., *Lesbian, Gay, Bisexual, and Transgender Aging: Research and Clinical Perspectives*, New York, NY: Columbia University Press, 10.

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Key #4: Partner With Your Client

Although it is your job to provide professional services to your transgender client, keep in mind that your client likely knows much more about being transgender than you do. It is not only acceptable but good practice to ask transgender clients for their preferences when you face a gender-related question, such as whether a single-sex setting would be comfortable for them.

Transgender people know—quite well, in fact—that they confound many gender-based systems and may need individualized solutions. Chances are good that they have already found a way around the challenge, or at least know how they would prefer to have it handled. When you encounter a service-related question that you don't know how to answer, ask your clients about it. Their knowledge and experience, coupled with your professional knowledge and skills, will result in a respectful, workable solution that meets everyone's needs.

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Key #5: Manage Your Curiosity

Your job is to serve clients. Transgender people, just like other consumers, expect professionals to provide the services they hire them to supply. They do not expect to provide services to their providers. When providers ask their transgender clients (directly or indirectly) to educate them about their lives or experiences as transgender people, they have stepped outside of their professional role.

There may be a time—after you've served your clients' needs and have developed a strong, positive bond with them—when it is acceptable to ask these types of questions. Transgender people may be willing—and some are eager—to educate professionals, as long as they get their immediate needs met first and the subsequent conversation remains respectful. The individuals who are open to educating

providers know that the more trans-savvy professionals there are, the better it is for other transgender people.

If you are unclear on what is or is not an appropriate question to ask, consider whether you might be able to get the information from another source. For example, if you are a therapist working on sexual function problems with a client and have questions about the effects of hormones on sexual function, you can find this information through an academic, medical, or advocacy organization.

Also consider whether you would ask a non-transgender client the same question—or how you would feel if someone asked you the question. "Do unto others as you would have others do unto you" is a good guiding principle for managing your curiosity and maintaining a solid, professional, respectful, and service-focused relationship with your client.

To learn more about transgender people, see [Transgender 101](#), in this e-pub.

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- Notes

Five Keys

Outreach

Outreach: Connecting to the Transgender Community

- [Consider the Transgender Perspective](#)
- [Assess Your Readiness](#)
- [Find the Transgender Community](#)
- [Take the First Step](#)
- Get Visible: [Their Turf, Your Turf, Someone Else's Turf](#)
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Consider the Transgender Perspective

More than 50 percent of transgender people experience sexual violence at some point in their lives.¹ This is more profound when coupled with the fact that transgender victims of sexual assault are even less likely to seek help than are other types of sexual assault victims. Why is this the case?

On the one hand, transgender people who have had (or have heard of others having) negative experiences with health care professionals, service providers, and law enforcement may decide not even to ask for help. Sexual assault service providers, on the other hand, often have limited experience with transgender victims and little to no training on their special needs. These two factors all too often discourage providers from reaching out to this underserved population and from creating services that are targeted for transgender victims.

Before they enter the doors of a program, transgender people must see evidence that the program has taken proactive steps to learn how to appropriately serve transgender people. Likewise, before sexual assault service providers can effectively reach out to the transgender community, they have to feel confident that they are aware of the unique needs transgender people have and how they can appropriately meet those needs.

It is important to note that many (if not most) transgender people are not active in transgender organizations. Although outreach efforts must be made to organized transgender groups, targeted outreach to these groups alone is not enough. Mainstream outreach efforts must also include explicit mention of transgender and other marginalized groups your agency is committed to serving because someone who would never read a brochure that has "transgender" in the title might pick up one for "sexual violence survivors."

In 2011–2012, FORGE, with support from an OVC grant, extensively worked with four demonstration sites to identify barriers, build collaboration teams, and heighten communication between sexual assault service providers and the transgender community. The four sites—Iowa City, Iowa; Boulder, Colorado; Boston, Massachusetts; and the State of Maine—developed goals, priorities, and a workplan on how to improve services and healing for transgender survivors. These communities continue to collaborate and

expand on their original goals. We encourage other communities to work together formally or informally to increase access to respectful services for transgender survivors of sexual assault.

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Assess Your Readiness

Before you make formal outreach efforts to the transgender community, you may need to assess your agency's readiness and capacity. Although many steps in this section can be taken with minimal financial, staff, or other capacity, broader scale outreach may require an internal review of staff attitudes, your agency's ability to fund a potential influx of new clients and to adapt its internal policies and procedures for these clients as needed, and a willingness to follow through with outreach efforts.

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Find the Transgender Community

The first step in reaching transgender people in your community is to locate meeting and communication venues. If your locale is large enough, there will probably be transgender-specific organizations and events. In smaller places and rural areas, transgender people may not be "out" as transgender, might be found in mixed LGBT spaces, or may be active members of the town's community (e.g., attending church, playing bridge with neighbors, participating in their child's Parent-Teacher Organization).

There are many places you can start:

- **Trans-focused support groups.** FORGE maintains a list of more than 300 transgender-focused social support groups across the country. [Contact FORGE](#) for a group near you.
- **LGBT community centers.** If you live in a city with an LGBT community center, that center is a great resource of information. Check [CenterLink's directory of LGBT community centers](#) to find one near you. Please note, however, that your local LGBT community center may not be particularly transgender friendly and may not be able to tell you how to get in touch with all (or even any) of your area's transgender organizations or community.
- **Providers.** To gain access to hormones and surgery, or to pursue a legal name change, many transgender individuals are first required to see a therapist to get a letter of referral. As a result of this gatekeeping function, there are mental health providers throughout the country who specialize in serving transgender clients. Your community may have one (or many) local therapists who have contact with many transgender individuals and organizations. Some even sponsor their own groups. These providers are often willing to pass along information from you to their transgender clients. FORGE maintains a nationwide list of more than 900 therapists. [Contact FORGE](#) for a resource near you.
- **Social media.** Use social media. If you are on Facebook, Twitter, MySpace, Tumblr, YouTube, Instagram, LinkedIn, or LiveJournal or you belong to other social media, search for "transgender" and your city/state to connect to transgender organizations.
- **Social venues.** Find out where your local LGBT bars, bookstores, and gathering places are. Larger communities have parts of the city that are more LGBT-populated, with many stores or coffee shops that have a large LGBT clientele. Your local LGBT community center and local LGBT newspaper are good sources for finding these venues. In rural areas, transgender people may travel to larger cities to access social and support venues. Others in rural areas may be active members in their churches, schools, volunteer networks, or other types of local community engagement.

READ MORE

In this e-pub*—

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- Tips for Those Who Serve Victims: [Mistrust of Professionals](#)
- [Sexual Assault in the Transgender Community](#)

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READ MORE

- [Open Minds Open Doors](#)
- [Is Your Agency Ready to Serve Transgender Survivors?](#)
- [Creating a Trans-Welcoming Environment](#) (webinar)

- **Google.** Use a search engine to search "transgender" and your city, state, or region. (Unfortunately, some companies restrict their employees' ability to fully search for needed information. Frequently, Web sites with transgender content are blocked by search-safe software for being pornographic due solely to the topic, even if they do not have any explicit sexual content.)
- **Press.** If your community has a local LGBT newspaper or Web site, check to see if it lists transgender groups, events, or therapists in the calendar, advertising, or display advertising sections. A partial list of LGBT newspapers and Web sites is available at [Gay Media Database](#).

In addition to LGBT press, communities may have alternative press newspapers that cater to people who are young, concerned about health or environmental issues, or committed to the arts or that are neighborhood specific. Transgender individuals who are not part of an organized transgender community may read these rather than LGBT newspapers.

Some churches in smaller towns produce regular newsletters that list activities hosted at their church and around the community. More liberal churches and other religious venues host meetings, which may include groups like PFLAG (Parents, Families and Friends of Lesbians and Gays).

- **Educational institutions.** Check with nearby universities, many of which have LGBT centers and organizations. They may sponsor their own transgender meetings or caucuses, bring in transgender speakers (who attract a transgender audience), or may be able to point you to other community resources. High schools that have Gay/Straight Alliances (GSAs) may also be worth contacting, as young people are likely to be bullied (and worse) based on their gender identity. These organizations may welcome information about sexual assault response services and the agencies that provide them.
- **National anti-violence organizations.** Check the [National Coalition of Anti-Violence Programs](#) (NCAVP) to see if there is an anti-violence program in your city or region. If so, contact them, as they are usually quite transgender savvy and may be able to point you in a helpful direction. You may also be able to build a collaborative relationship with an anti-violence program, which could be beneficial to you and to your clients.
- **State sexual assault/domestic violence coalitions.** Check with your state's sexual assault and domestic violence (SA/DV) coalitions, which may have LGBT committees or designated outreach persons. Some of these may be able to help you reach transgender individuals. (Unfortunately, some "LGBT" SA/DV coalitions have little or no contact with gay/bisexual men's or transgender organizations.)
- **Employer LGBT groups.** If your employer is a large institution, check to see if there is an LGBT employee group you can contact for leads and introductions.

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Take the First Step

After determining where transgender people congregate and find support, contact these organizations either in person or by letter, phone, or e-mail. You could simply add an organization or business contact to your mailing list, but that tactic is much less effective than contacting the organization directly and may even be viewed as impolite. At a minimum, call or e-mail the transgender contacts you have found and tell them your agency is interested in serving the transgender community. Ask if you can add them to your mailing list and send them periodic news about events and programs. Better yet, ask to meet someone for coffee so you can get to know them and their organization and they can start developing trust in you.

Asking transgender contacts for a brief face-to-face meeting has many benefits. Perhaps most important is that your willingness to leave your office—to go to them—shows your genuine interest in serving this population. Do note, however, that some transgender people are so aware of the potential for anti-transgender violence or discrimination that they may be reluctant to discuss transgender topics in public places. Similarly, some transgender individuals simply prefer more privacy regarding their transgender status or history. (Remember, too, that the person you meet may not be transgender themselves, but may be a vibrant part of the transgender community or a service provider who has an established involvement with the community.) Have a backup venue in mind, such as your office or a private study room at the library. Meeting in person also puts a face to a name, which may encourage

transgender contacts to pay attention to future mail you send or may encourage them to refer someone in the transgender community to you for services.

Ask contacts to bring a copy of any information they may have about their organization, events, or community so you can learn more about their organization. When introduced, use the name the person gives you. If you are unsure about which pronoun they prefer, ask. Consistently using their name and their preferred pronoun will help build a stronger relationship.

Consider bringing one of [FORGE's "It's never too late..." brochures](#) to your meeting. (You may want to have a stack of them in your office, as well.) Transgender people may not realize how prevalent sexual assault is in the transgender community, so bringing such documentation will help establish why you are interested in this population and will give them a place to start if they want to learn more. In addition, bringing materials developed by a transgender organization will give you some credibility in their eyes. They will know you have done your homework and are not looking for them to educate you. Then, go over the services offered by your agency (and elsewhere in the community, if possible), noting that you would like the information to be passed along to anyone who needs it. Answer any questions about your agency or how sexual assault survivors are served in your agency or community.

Explicitly ask if you can add their name to your mailing or e-mail lists, and whether it would be okay if you or someone from your agency contacted them again should an issue about a transgender survivor come up. Let them know if mailings from your agency are in plain or marked envelopes (since it may be of concern to some people). Also make sure to ask if they need a specific (different) name on mailings to them, as some transgender people use one name in some venues and another name for mailings and official business. Many transgender leaders do not have official offices and run groups or events out of their homes. Find out, too, if your agency needs to use discretion when calling; make a note of their answers and make sure you follow the directions they give you. Finally, don't end without asking if they know of other transgender groups in the area or other transgender leaders they think you ought to contact. Some larger urban areas have multiple transgender groups, some of which are not listed in resource guides. You may also want to ask if any local bars cater to transgender people, as those may be good places to conduct in-person outreach or to place a flier or brochure, if the owner consents.

How much you want to ask them about their organization depends a lot on what else you are considering doing. Their organizations may have formal or informal speakers bureaus comprising individuals who volunteer to share their personal stories and answer questions to help educate the public. Some are proactive in their educational efforts and have a formal "Transgender 101" training they could offer your agency. Others may have enough interest and expertise to make them excellent candidates for some of the ongoing projects discussed later in this section.

Remember, first meetings can be awkward for everyone. People may feel a bit hesitant to share and open up immediately. Knowing that it is normal for the first meeting (or first several meetings) to feel a bit clumsy may help ease overall feelings of discomfort and overcome any resistance to pursuing a working relationship. Be patient and know it can get better.

Follow up with a thank you note, which should include a confirmation of whether you've added the individual, or the organization they represent, to your mailing list and an open invitation to contact you if they have any additional questions or concerns. Include at least one of your business cards.

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Get Visible: Their Turf

Several of the following suggestions refer to "LGBT" rather than just "T." Because the transgender community can be so small, and because some transgender people and their partners just feel more comfortable in "LGBT space," you will often find as many or more transgender people in LGBT groups as you will in transgender-specific groups.

Come One and All events. Although there has been a slow and steady increase, business and mainstream agencies' interest in and participation at LGBT events is still so rare in most places that their

presence at an LGBT event gets a lot of notice. Does your community host a pride event in June, or are there special events such as health or street fairs? Consider staffing a booth there. A small investment of time and money can really pay off.

Extra! Extra! Read all about it! Advertising. Local LGBT community centers or other agencies may maintain referral lists, which could be publicly available (on a Web site, for instance) or could be for internal use only. Make sure you are listed in any such guides, with a note that you specifically serve transgender clients.

Consider placing a small, regular advertisement in local LGBT newspapers or Web sites. Definitely place classifieds when you have job openings, which tells the community you are not only willing to serve them but are willing to be their coworker as well.

Tack it up: Bulletin boards. Does the local LGBT community center (or other LGBT gathering place) have a bulletin board or an area where brochures are displayed? If so, see if you may display your materials there. While you're there, look at what else is posted, taking note of those organizations that hold events or produce publications with many sponsors or cosponsors. Let those groups know that your agency might be willing to cosponsor future events (often all a transgender or LGBT organization wants is the agency's name; no money or staff attendance is required).

Give a little! Contribute. Think about whether you or your agency has a service you could offer to encourage people to walk in your door, such as a free massage or holistic service.

Talk about it! Guest speakers. Find out if you can be a guest speaker at upcoming events. Possible topics follow:

- How the local sexual assault response system works.
- Coping with long-term effects of childhood sexual assault.
- Crime victims' rights.
- Self-defense skills (recruit a professional if you need to and cosponsor the event).

SOME WORDS ABOUT LANGUAGE

When addressing groups that include transgender people, it is probably safest to steer clear from gendered words when referring to your audience. In fact, this approach is **always** appropriate, because you never know if there is a transgender person sitting in your audience. Instead of "ladies and gentlemen," use "hello, everyone." Talk about "people," "individuals," and "human beings," not "men and women." Consider words like "parent" (instead of "mother"/"father") or "spouse" or "partner" (rather than "husband"/"wife"). Avoid calling all victims "she" and all perpetrators "he."

Some transgender groups ask everyone to identify their preferred pronoun during introductions. Even the most diligent guest will not be able to record and then reference the correct pronouns during discussion time. To avoid this problem, you may want to ask everyone to make and wear nametags with their first name written in large letters or practice referring to people without pronouns or genders: "The person who just spoke said...."

You may also want to propose being part of a panel of guest speakers, made up of professionals who serve the transgender community.

Stay in touch: Mailing lists. Ask to be put on local transgender groups' mailing and e-mail lists and watch for public events. Showing up at a transgender event will get you noticed and get people talking ... exactly what you want.

Be a peacock: Fliers. A very worthwhile and inexpensive investment is a flier specifically for transgender or LGBT sexual assault survivors. It is not necessary to have a slick, full-color brochure. The goal of letting transgender people know you want to serve them can as easily be met by black

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print on a sheet of colored or regular copy paper. Once prepared, keep a small supply available to take with you whenever you do public outreach.

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Get Visible: Your Turf

Make a good first impression. When approaching a new agency for the first time, transgender people may carefully scope it out to get a feel for how the staff will treat someone who is transgender or gender non-conforming. First impressions are critical and will determine whether a potential client becomes a served client, or if they will simply turn around and walk out the door.

A study of lesbian, gay, and bisexual people—a population with concerns about a service provider's bias that often mirror the concerns of transgender people—found that 95 percent "reported studying their provider's behavior for cues of acceptance, and 85 percent assessed the environment of the office for signs of lifestyle affirmation."² Reflecting this finding, a guide for those who want to serve LGBT clients advises that—

every aspect of the environment contributes to patients' impressions about the office and the kind of welcome they can expect. The experience begins with their initial telephone call to book an appointment, continues with the greeting they receive from the receptionist when they enter the office, includes messages conveyed by questions on intake forms and educational brochures in the waiting room, and culminates with the quality of the interaction they have with their provider.³

Put on a public face: Web sites and beyond. Make sure your Web site explicitly says you serve LGBT people, transgender people, and both male and female survivors. You may want it to also address common fears by noting that clients can choose what they want to disclose or withhold and whether or how much they undress (if you provide physical examinations). Images and decorations used on your Web site, printed materials, and in your waiting room should always be checked for the subconscious messages they convey. If people are pictured, are they all white? All women? All in heterosexual pairs? Make sure you are not accidentally sending a message that "these are the only kinds of people we serve."

A prominently placed statement of nondiscrimination (or a routine handout to clients) that also includes gender identity/expression and sexual orientation is a good idea.⁴ More "coded" signals of LGBT friendliness are rainbow flags and symbols, pink triangles, and certain organizations' logos, such as one from your local LGBT organization. If your waiting room displays brochures on health issues and local support or information programs, make sure you include a brochure or two that explicitly has transgender in its title. (Similarly, you may want to add some transgender-specific resources to your Web site.) You may also want to subscribe to your local LGBT newspaper (which will help you track what's happening locally and connect with LGBT-friendly referral sources), and leave a copy in the waiting room. Otherwise, if local publications or brochures are not available, consider subscribing to national LGBT publications.

Knowledge is power: Empower your staff. Staff training is a critical part of making your agency or practice welcoming to transgender clients. One off-hand remark from a receptionist can literally send a transgender client out the door, never to return. (That off-hand comment may also send away non-transgender clients as well, if they perceive the agency's overall attitude to be dismissive, discriminatory, or prejudiced.) Staff training is important not only for the clients you serve, but for your staff as well. Training "may also relieve anxiety and confusion among employees who are unfamiliar with and do not feel prepared to serve" transgender clients.⁵

A physician who is himself FTM (female-to-male) advises other health care professionals, "The unfamiliar and unknown seem odd and even sometimes threatening to all of us. Providing even a small amount of familiarity with transgender medicine may therefore significantly impact the way patients are treated...."⁶

Where to go?: Bathrooms. Although having a unisex restroom won't automatically brand your office

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- [Tips for Those Who Serve Victims: Mistrust of Professionals](#)

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"trans-friendly," it will significantly reduce some transgender clients' anxiety levels. A Virginia study found that 11 percent of transgender participants marked "lack of appropriate restroom facilities" as a barrier to receiving health care.⁷ An added bonus to having gender-neutral bathrooms is the benefit to parents with small children, people with disabilities, older adults, individuals who have care assistants, or those who are naturally shy and prefer a bit more privacy.

It's all in the paperwork: Forms, policies, and

confidentiality. Intake forms are critical. They help clients see who you are while also getting information from your clients. If you ask "gender" and give a line to be filled in, or include a "transgender" or "other" option, transgender people will know you know they exist. Asking "gender/gender identity" with a blank line signals that you may be familiar with terms they write down. Keep in mind that when new clients fill out intake forms, they are still forming an opinion of you and your agency and may well hold back some critical information. It may help to give clients a clearly worded, detailed statement about your agency's confidentiality procedures before you give them the intake form. (Placing your confidentiality policy online might help convince a Web-surfing potential client to come in).

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Think like Michelangelo: Creativity goes a long way. Do you have underused meeting rooms? A local transgender group might jump at the offer of free meeting space. Can you offer any in-kind services such as limited photocopying or free safer sex supplies such as dental dams and condoms? Can you invest in inexpensive items like pens or magnets with your agency's name on them and ask your transgender contacts to hand them out at various gatherings if you are not attending yourself? Could you hold an open house and invite community members—including your transgender contacts—to come see your space and meet your staff? Don't forget to provide (and advertise) food . . . everyone agrees that food is a great way to boost attendance.

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Get Visible: Someone Else's Turf

Show off your diversity. Transgender people attend the same range of public events as anyone else. If you have a table or booth or speak at a "mainstream" event, make sure that you bring along any of your population-specific materials (e.g., transgender or LGBT) and prominently display them. Take this opportunity to review your mainstream materials, too. Are all the pictures of women? Does your "all are welcome" statement need to be supplemented by something that more explicitly welcomes all genders and sexual orientations?

Get listed. If your state sexual assault coalition or other group publishes a resource guide, see if you can add a comment that your agency welcomes transgender clients (as well as the rest of the LGBT community). If your staff is trained on LGBT issues, mention that.

Play well together—creatively. You can also create events. In 2009, FORGE borrowed a concept developed by Kleenex and sponsored a "blue couch" at its local PrideFest. A blue couch is staffed by a skilled listener with a box of tissues. As people walk by they are invited to sit down and talk about whatever they'd like to talk about. At FORGE's event, the topics ranged from the very mundane ("I'm tired") to intimate (one person saw their past abuser at the event; another had been verbally attacked by another fairgoer). FORGE recruited licensed mental health professionals to be on call as emergency backups (they were not needed), and some also volunteered to staff the couch. Everyone—volunteers, staffers, and visitors—raved about the idea and was thrilled with the sense of caring and belonging that the couch helped to create. You could suggest this idea to your local groups and offer your staff as trainers for volunteer listeners or as volunteer listeners themselves.

FORGE also created a therapists' panel event. Because many transgender people are required to see a therapist before their doctors will prescribe hormones or perform surgery, the transgender community has a particularly high interest in "investing well" by learning about providers. At FORGE's event, six

therapists who had moderate to extensive experience with transgender clients gave brief self-introductions and then answered questions from both the moderator and participants. The therapists were as thrilled with the event as the attendees were, because it gave them the rare opportunity to learn about each other and how they approached common issues. Cosponsoring an event such as this with a transgender group would allow your colleagues to learn more about area therapists—to whom they may be able to refer clients.

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Cultivate Relationships

If you end up meeting transgender people with legal, accounting, fundraising, or other appropriate skills and an interest in serving sexual violence survivors, consider inviting them to be on your board of directors or community advisory council. It almost never works to recruit people just because they represent a marginalized group, but adding someone with skills as well as contacts and viewpoints can be extremely beneficial for everyone.

Consider making transgender groups aware of any volunteer or intern positions you may have. These can be particularly attractive to transgender people who may be experiencing employment discrimination and need to develop references and contacts. (It is also a great way to help reduce the loneliness and isolation that many transgender people experience.)

When you attend community coalition or task force meetings, ask yourself if the group might be of interest to local transgender leaders. FORGE's invitation to join a community health worker task force ended up leading to an ongoing partnership with a hospital and helped raise the consciousness of a whole range of local health-related agencies.

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Notes

¹ FORGE, 2005, Sexual Violence in the Transgender Community Survey, unpublished data; G. Kenagy, 2005, "The Health and Social Service Needs of Transgender People in Philadelphia," *International Journal of Transgenderism* 8(2/3):49–56; G. Kenagy and W. Bostwick, 2005, "Health and Social Service Needs of Transgendered People in Chicago," *International Journal of Transgenderism* 8(2/3):57–66.

² Using the term "lifestyle" when referring to people who are transgender, lesbian, gay, or bisexual is often viewed as pejorative; many say it erroneously equates core identities with much more superficial things like the colors someone has chosen for their walls. K. McGarry, M.R. Hebert, J. Kelleher, and J. Potter, 2008, "Taking a Comprehensive History and Providing Relevant Risk-Reduction Counseling," in H.J. Makadon, K.H. Mayer, J. Potter, and H. Goldhammer, eds., *Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health*, Philadelphia, PA: American College of Physicians, 421.

³ Ibid., 420–421.

⁴ Gay and Lesbian Medical Association, 2006, [*Guidelines for Care of Lesbian, Gay, Bisexual and Transgender Patients*](#), Washington, DC: Gay and Lesbian Medical Association, 3.

⁵ J. Potter, H. Goldhammer, and H.J. Makadon, 2008, "Clinicians and the Care of Sexual Minorities," in H.J. Makadon, K.H. Mayer, J. Potter, and H. Goldhammer, eds., *Fenway Guide to Lesbian, Gay, Bisexual and Transgender Health*, Philadelphia, PA: American College of Physicians, 17.

⁶ R.N. Gorton, J. Buth, and D. Spade, 2005, *Medical Therapy & Health Maintenance for Transgender Men: A Guide for Health Care Providers*, San Francisco, CA: Lyon-Martin Women's Health Services, 75.

⁷ J. Xavier, J.A. Honnold, and J. Bradford, 2007, *The Health, Health-Related Needs, and Lifecourse Experiences of Transgender Virginians*, Richmond, VA: Community Health Research Initiative, Center for Public Policy, Virginia Commonwealth University, 12.

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