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A Conceptual Framework for Clinical Work With Transgender and Gender Nonconforming Clients: An Adaptation of the Minority Stress Model

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In the last few years, transgender and gender nonconforming people have become more visible in our society, which has sparked a marked increase in awareness, interest, and attention among psychologists. Questions have emerged about the extent to which psychologists are able to work competently with this population. This article presents a framework for understanding key clinical issues that psychologists who work with transgender and gender nonconforming individuals will likely encounter in their clinical work. This article does not address the knowledge and skills required to provide services related to gender transition, but rather to provide other psychological services that these clients may need, in light of the high levels of gender-related victimization and discrimination to which they are exposed. An adaptation of the Minority Stress Model (Meyer, 2003) is presented and translated to incorporate the unique experiences encountered by transgender and gender nonconforming individuals. In particular, we examine adverse experiences that are closely related to gender identity and expression, resulting expectations for future victimization or rejection, and internalized transphobia. The impact of Minority Stress Model factors on suicide attempts is presented as a detailed example. Mechanisms by which transgender and gender nonconforming persons develop resilience to the negative psychological effects of these adverse experiences are also discussed. Recommendations for clinicians are then made to assist psychologists in developing competence in working with this population.

Keywords: transgender, minority stress, suicide attempt, violence, resilience

In the last several years, the popular media have paid increasing amounts of attention to people who present as transgender or gender nonconforming, effectively raising the public profile of gender identity and gender nonconformity, at least in western societies. This increased attention coincides with greater willingness of trans people to publicly divulge their identity, and sometimes even share details of their experience in public domains.[1] In turn, the increased attention and visibility have resulted in a greater awareness of gender identity issues, both by those who are trans and by society as a whole.

Concomitantly, mental health practitioners have been called upon with greater frequency to render evaluation and treatment services to people who make known that their gender identity does not conform to the sex they were assigned at birth. Such requests raise questions about whether psychologists are prepared and competent to deliver these psychological services. This article presents a framework within which psychologists may conceptualize the unique stressors often faced by trans clients and how those experiences are related to both vulnerability and resilience in the mental health of trans people. Furthermore, we offer that these experiences may also affect access to and engagement in mental health services. Clinical implications of these issues will be discussed, aiming to inform provision of competent services for trans clients.

In both anticipation of, and response to, this increased request for psychological services, the American Psychological Association (APA) has undertaken efforts both to help psychologists and other professionals to improve their understanding of gender identity and gender expression and to ascertain what psychologists need in order to competently provide services. The APA Task Force on Gender Identity and Gender Variance (2008) published its report, which included recommendations for education and training. Subsequent to this report, the APA Council of Representatives passed its Resolution on Transgender, Gender Identity, and Gender Expression Non-Discrimination (Anton, 2009), solidifying the APA's commitment to supporting the educational and training needs of psychologists to work with this population (p. 443):

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[1] In this article, we use "trans" to refer to the range of persons who identify or present as transsexual, transgender, or gender nonconforming. This term was proposed by Lev (2004) and has met with broader acceptance than many other terms that have been previously proposed or used.

- APA calls upon psychologists in their professional roles to provide appropriate, nondiscriminatory treatment to transgender and gender variant individuals and encourages psychologists to take a leadership role in working against discrimination toward transgender and gender variant individuals; . . .

- APA supports the provision of adequate and necessary mental and medical health care treatment for transgender and gender variant individuals; . . .

\• APA supports the creation of educational resources for all psychologists in working with individuals who are gender variant and transgender.

The Task Force report (2008) also recommended that APA "Establish a task force to develop practice guidelines for ethical and competent psychological work with transgender populations" (p. 83). Prompted by this recommendation, in 2011 APA formed the Task Force to Develop Guidelines for Psychological Practice with Transgender & Gender Nonconforming Clients, whose work is currently underway.

What constitutes cultural competence depends to some extent upon the type of services that psychologists are rendering. It is important to distinguish two types of services that trans clients may seek from psychologists. Some clients seek evaluation services that will further their endeavors to obtain physical modifications, such as hormone treatment and surgical procedures. In recognition of the ongoing development of understanding regarding the diversity of expressions of gender and of the variety of treatments available to trans people, The World Professional Association for Transgender Health (2011) published a substantial revision of its Standards of Care, which presents the wide range of medical treatment options that are now available and that trans clients may seek. Because current standards of care encourage psychological evaluation prior to medical transition, psychologists are often asked to write a letter to an endocrinologist or surgeon recommending the client for the indicated procedure. In this respect, the psychologist is asked to provide transition-related services. To competently provide such services, there is a need for the evaluating psychologist to have an advanced level of understanding of gender identity, gender expression, the ways that individuals might present as gender variant, and the transition options available to them (Bockting, Knudson, & Goldberg, 2006; The World Professional Association for Transgender Health, 2011). Transition-related services are therefore ideally provided by mental health professionals who have specialized knowledge and training in these areas. Provision of transition-related services is not the focus of this article.

Beyond transition-related services, trans clients also present for a full range of psychological services—just as any other client might. In these cases, clients typically seek services from psychologists based on their expertise in areas not related to transition (e.g., evaluation or treatment of mood, anxiety, or substance use disorders). It is the provision of this broader range of services in a competent and informed manner that is the focus of this article.

Competent clinical practice with trans clients unrelated to physical transition requires knowledge that exceeds a merely "Trans 101" level of education. Clinicians must understand the unique experiences related to minority stress that trans people encounter and how these experiences relate to both mental health vulnerability and resilience, as well as their ability to access and engage in care. Discussion of these experiences and their effects are not meant to pathologize trans people, but rather to highlight clinically relevant life events that occur with a sufficient frequency to warrant special attention. We offer a conceptual framework, drawing from Meyer's (2003) Minority Stress Model, for understanding how minority stress factors (rather than gender variance itself) result in higher occurrence of psychological problems in trans people, and how trans peoples' experiences may also result in resilience (Meyer, 2003).

Understanding "Trans"

Trans individuals who request mental health services span the spectrum of the various identities that loosely and incompletely fall under the trans umbrella term. For the sake of brevity, we include here all people whose gender identity, gender expression, or both, fall outside social norms. Most people's gender identity and expression are roughly congruent with the sex that they were assigned at birth. So, for example, a person assigned female at birth typically identifies as female, and the ways that she dresses and acts are fairly consistent with a culturally normative female presentation. On the other hand, a trans person is someone whose gender identity is not congruent with sex assigned at birth, or for whom an atypical gender presentation is ego syntonic. Generally, persons whose identity is cross-gender to their sex assigned at birth are referred to as "trans men" (for those who identify as male) and "trans women" (for those who identify as female). Note that these persons still identify their gender within a binary structure of either male or female.

Not all trans persons identify their gender comfortably within a gender binary structure, however (Carroll, Gilroy, & Ryan, 2002; Eyler, 2007). The specific identities by which people define themselves may challenge clinicians to step outside their gender normative paradigm and allow for the possibility of a gender identity that is not only incongruent with one's physical appearance, but may also not be binary (i.e., either male or female). These individuals may be less likely to identify as trans men or trans women and more likely to identify by some other term, such as androgynous, genderqueer, multigender, or two-spirit. Similarly, these individuals may use pronouns other than the typical gendered pronouns used in English and many other languages. This wide array of gender identities and expressions is often unfamiliar to the clinician. Psychologists must therefore understand that it is important and appropriate to ask clients about how they view or define their gender and what pronouns they would prefer that the clinician use for them.

Finally, clinicians also need to keep in mind that not all people whose gender identity or gender expression is not congruent with their sex assigned at birth identify as trans or as falling under the "trans" umbrella. Some individuals who make a complete transition, for example, identify simply as their desired gender (e.g., a person assigned male at birth who has fully transitioned may identify as female).

Mirroring this diversity in identity and expression, trans people also relate to their bodies in various ways. Some, but not all, trans

individuals report discomfort with physical characteristics of their bodies that are incongruent with their gender identity, often labeled professionally as gender dysphoria (Barrett, 2007). When gender dysphoria is present, it is often treated with medical interventions including hormone treatment and surgical procedures to make their bodies more congruent with their gender identities. While access to such interventions is increasing, many trans clients are delayed in undertaking such alterations by many barriers, including financial limitations and social concerns. Still others do not desire or seek any sort of physical alteration or transition, feeling comfortable in their bodies as they are.

Minority Stress

Trans people, like the general population, have general life stressors that may result in a wide range of reasons for presenting to a psychologist for care. However, on top of general life stressors, trans people are subjected to alarmingly high rates of discrimination, violence, and rejection related to their gender identity or expression. We understand the higher prevalence of mental disorders in trans individuals to be related to these experiences. This is consistent with the parallel work of Meyer (2003), who proposed that the higher incidence of mental disorders found among lesbian, gay and bisexual (LGB) people, was essentially the result of a "hostile and stressful social environment" (p. 674) to which LGB people are subjected as a result of their sexual minority status. We will outline this model, as presented by Meyer and then examine the parallels for trans individuals.

Meyer (1995) proposed three processes by which LGB people are subjected to minority stress. First are the environmental and other external events that occur in the individual's life as a result of that person's minority status (LGB) and that create overt stress in the person's life. Meyer described these events as objective, since they are observable and verifiable. They are also the most distal sources of stress to the individual. Examples might include discrimination and threats to the person's safety or security.

The second set of processes are the anticipation and expectation that the individual has that external stressful events will occur, and the vigilance that the person must maintain because of this expectation. As a result of this vigilance, LGB people may, for example, expect rejection or more serious recriminations because of their sexual minority status and so hide their identity in order to protect themselves from psychological or physical harm. When this occurs, the negative expectations themselves create distress for the person; but efforts to hide one's identity create additional distress. Because this process involves an intricate interaction between the individual and the individual's environment, it is more proximal in nature.

Third are the processes in which negative attitudes and prejudices from society are internalized, resulting in the most proximal of the three processes. For LGB people, the epitome of this is internalized homophobia; for trans people, the epitome of this is internalized transphobia. This internalized sense of stigma is more subjective in the sense that it is not directly observable, but is also potentially the most damaging, because it can have direct negative effects on the individual's ability to cope with external stressful events and ultimately reduces the individual's resilience in the face of negative events.

Meyer (2003) delineated the various pathways by which these processes contribute to an increased level of psychopathology, including substance abuse and dependence, mood disorders and suicidal ideation and attempts. However, Meyer pointed out that not all of the effects of minority stress are negative. Members of minority groups typically develop coping and resilience in response to prejudice and other insults. In particular, by coalescing around a minority identity, minority members avail themselves of "important resources such as group solidarity and cohesiveness that protect minority members from the adverse mental health effects of minority stress" (p. 677). One way that minority members accomplish this is by creating a within-group identity against which they may then compare themselves, rather than using those whose prejudice they face as their comparison group. In this process, minority members begin to "evaluate themselves in comparison with others who are like them rather than with members of the dominant culture" (p. 677). This reappraisal allows members access to validation that might not otherwise be available to them. As a group, minority members create a positive view of themselves that effectively counteracts stigma.

Group members typically are able to access these resources when they clearly and openly identify as a member of the group. For LGB persons, access can be hindered when individuals hide their identity, both because concealment leaves the person invisible to the minority community and because it makes the task of identification with other members of the minority group more challenging. Hence, coming out in at least some settings increases the individual's ability to capitalize on the resources available within the minority community that facilitate coping and resilience. For trans persons, being "out" may have different meanings, particularly at different points in time. For example, transsexuals who share their authentic gender identity prior to full transition may reveal more than sharing the same identity after transition, when their gender identity may closely match their physical appearance. For posttransition transsexuals, being open about gender history is often more revealing than simply asserting an authentic gender identity.

Application of the Minority Stress Model to Trans Populations

Stressful Events and Mental Health

As noted earlier, the most easily observed stress processes in the Minority Stress Model are those external events that occur in the individual's environment and are related to either knowledge or perception of the individual's minority status. It is these events that have been the most documented in transgender populations. A number of needs assessment studies and surveys conducted with transgender populations in the last several years have consistently demonstrated that members of this population report high levels of both physical and sexual violence (Clements-Nolle, Marx, & Katz, 2006; Kenagy & Bostwick, 2005; Lombardi, Wilchins, Priesing, & Malouf, 2001; Xavier, Bobbin, Singer, & Budd, 2005), with reported rates of physical violence ranging from 43% to 60% and reported rates of sexual violence ranging from 43% to 46%. Needs assessments and other surveys that utilize community-based sampling methods have a tendency to disproportionately reach espe-

cially vulnerable sectors of targeted populations. As a result, respondents often represent status in more than one minority group and so face oppression on multiple levels. This offers the advantage of illustrating minority stress by reaching those whose experience of stress is intensified.

Rosser, Oakes, Bockting, and Miner (2007) have pointed out, however, the limitations of using community samples, which may overrepresent targeted problems. While not inquiring about experiences of violence or discrimination, these authors developed an Internet-based approach to population sampling of hidden minority groups, such as transgender persons. In a large Internet-based study, Beemyn and Rankin (2011) found that 27% of respondents reported having been harassed because of their gender identity or gender expression within the past year. Similarly, Bradford, Xavier, Hendricks, Rives, and Honnold (2007), using a mixed-methods (paper and Internet) approach, found that 20% of their sample reported having been denied a job because of their transgender status, 13% reported having been fired because of their transgender status and a quarter reported having been homeless at some point in their lives. Using a different approach, Factor and Rothblum (2007) surveyed transgender participants and their nontransgender siblings. They found that the transgender participants were significantly more likely to report having experienced harassment and discrimination than their siblings.

Another area of study has been the mental health effects or outcomes of negative stress on transgender and gender nonconforming people. A few studies (Clements-Nolle et al., 2006; Xavier et al., 2005) have found high rates of substance abuse, suicidal ideation and suicide attempts among transgender respondents. Xavier et al. (2005), for example, reported a substance abuse rate of 48%, suicidal ideation rate of 38% and suicide attempt rate of 16%. Clements-Nolle et al. (2006) reported a substance abuse treatment rate of 28% and a suicide attempt rate of 32%. As a comparison, suicide rates in the general U.S. population are generally reported to be in the range of one to six percent (Moscicki, 1995; Weissman et al., 1999). A recent Institute of Medicine (2011) report reflects these and similar health-related disparities, though data specific to transgender populations are scarce.

Current research analyzing data from the Virginia Transgender Health Initiative Study (Bradford et al., 2007) has begun to make the connection between the external events that are well-documented and the negative health outcomes. For example, Testa, Sciacca, Wang, Hendricks, Goldblum, Bradford, and Bongar (in press), found that transgender individuals who had experienced physical or sexual violence were approximately four times more likely than those who had not to have made a suicide attempt. These individuals also reported a greater number of suicide attempts than those who had not experienced physical or sexual violence. These relationships were evident for both trans men and trans women separately. They also reported a significant relationship between history of physical and sexual violence and a history of alcohol abuse.

In another analysis of the Virginia data set, Goldblum, Testa, Pflum, Hendricks, Bradford, and Bongar (in press) examined the relationship between having been subjected to hostility or insensitivity based on their gender identity or expression in school and suicide attempts. They found that those in the overall sample who reported having been the victim of such gender-based hostility were approximately four times more likely to have made a suicide attempt than those who did not report being so victimized. Individuals who faced hostility had also made significantly more suicide attempts. As with the results in the previously reported article, this relationship was true for both trans men and trans women.

While the data from the Virginia study do not offer the possibility of determining a definitive causal link between the external negative stressful events (i.e., victimization related to gender identity or expression) and the related outcome measures (e.g., alcohol abuse, suicide attempts), they do indicate a clear correlation. Furthermore, the strength of the relationships that were demonstrated in these studies offer support for a transgender application of the Minority Stress Model.

Proximal Minority Stress Factors and Mental Health

All of these studies have examined the most distal processes of the Minority Stress Model and their effects on mental health. To date, very little research assessing the two more proximal processes of the model—expectations of violence and discrimination and internalized transphobia—has been published. Most directly, in Beemyn and Rankin's (2011) survey of trans people, more than half of participants indicated that they "intentionally concealed their gender identity to avoid intimidation" (p. 100). Elevated expectations of violence and discrimination are implied by research finding low rates of reporting of gender-based violence to police (Testa et al., in press) and low rates of accessing available health care among trans populations (Balsam, Cochran, & Simpson, 2006). Yet, research directly assessing internalized transphobia remains nonexistent. Despite scant research on these factors, there is ample reason based on basic understanding of the effects of expectancies and cognitions about the self to believe that these proximal factors in the model would be equally significant factors in trans populations' mental health, similar to the development of internalized homophobia in Meyer's (1995, 2003) presentation of the model.

Resilience

The literature contains very few studies on the coping and resilience effects of identification with minority group membership for trans populations. Indeed, one of the very few studies of this sort is a qualitative analysis of male-to-females' process for building social support (Pinto, Melendez, & Spector, 2008). In this study, the authors interviewed African American and Latina trans women who were receiving services at a community-based health clinic. They found that many of these women developed their trans-specific social networks within the clinic, and that these networks then served as the basis for an in-group identification that facilitated clients' development of coping strategies.

In another qualitative study, Singh and McKleroy (2010) interviewed 11 ethnic minority trans persons who had all experienced traumatic events, in a phenomenological investigation of the resilience strategies employed to cope with trauma. Six themes emerged that were common to all participants: "(a) pride in one's gender and ethnic/racial identity, (b) recognizing and negotiating gender and racial/ethnic oppression, (c) navigating relationships with family, (d) accessing health care and financial resources, (e) connecting with an activist transgender community of color, and

(f) cultivating spirituality and hope for the future" (p. 5). While Singh and McKleroy did not directly relate these findings to development of resilience in the Minority Stress Model, their discussion of each of these six strategies clearly relates to different aspects of Meyer's model. For example, they defined pride in one's identity as "a process [that] included overcoming many barriers such as transphobia and racism" (p. 5).

Minority Stress and Suicide Risk in Trans Individuals

While there are myriad mental health effects of minority stress, perhaps the most alarming statistics regard the exceptionally high rates of suicide attempt in trans populations. Because of both the high rates of occurrence of suicide risk and its profound clinical impact, we discuss the nature of the relationship between minority stress and suicide attempt in greater detail here.

Recent studies offer some insight into the particular elements of minority stress that may result in some trans people being at higher risk for suicide attempts. Specifically, Testa et al. (in press) and Goldblum et al. (in press) demonstrated that those who had experienced particular forms of violence or other victimization related to their transgender status were at higher risk for suicide attempt than those who had not experienced such negative external events. Clements-Nolle et al. (2006) found that suicide attempts were associated with, among other factors, recent unemployment, forced sex or rape, verbal and physical victimization related to gender and low self-esteem. In general, those who attempt suicide are at markedly higher risk for suicide completion than those who ideate about suicide but do not attempt (Joiner, 2010; Van Orden, Witte, Cukrowicz, Braithwaite, Selby, & Joiner, 2010). In a population-based study in Sweden, Dhejne et al. (2011) found that postsurgical transsexuals were about five times as likely to attempt suicide and 19 times as likely to die by suicide when compared to a matched cohort. In a Dutch study, transsexuals treated with hormones were found to be about nine times as likely to die by suicide, compared with the general population (van Kesteren, Asscheman, Megens, & Gooren, 1997).

Together, these studies support a relationship between minority stress processes identified in the Minority Stress Model and suicide attempt. The Interpersonal Theory of Suicide, developed by Joiner (2010), offers further explanation for the connection between these negative external events and suicide risk. According to the Interpersonal Theory, suicide risk is predicted by the confluence of thwarted belongingness, perceived burdensomeness and the capability to kill oneself (Joiner, 2010). The Minority Stress Model helps to understand each of these components for trans individuals and their relationship to suicide risk.

Van Orden et al. (2010) conceptualized thwarted belongingness as social isolation, which is essentially a lack of social connectedness. They also noted that social isolation has proven to be one of the strongest predictors of suicide risk, regardless of whether the construct that is being measured is suicidal ideation, suicide attempts or lethal suicidal behavior. Thwarted belongingness is comprised of two primary dimensions: loneliness or social disconnectedness, and an absence of reciprocal care or the lack of social support (Van Orden et al., 2010). Among the situations that can contribute to loneliness are a disconnection from one's family and having few social supports. For trans persons, loneliness may result from rejection by family members, friends, or coworkers who are unwilling to accept their trans status. Isolation may be compounded by few options for support in a society that is generally not accepting of gender nonconformity. Thwarted belongingness may start early and continue through adulthood, as research indicates high levels of exposure to harassment, violence, and discrimination in children and adolescents as well as adults (Goldblum et al., in press; Grossman & D'Augelli, 2006; Grossman & D'Augelli, 2007; Testa et al., in press). In addition, even without exposure to overt rejection, discrimination, or violence, individuals who do not see people like themselves represented in their community or society may develop a sense of not belonging.

Joiner's second construct that contributes to suicide risk is perceived burdensomeness, which is comprised largely of liability (thinking that one would be more valuable dead than alive) and self-hate (Van Orden et al., 2010). Life events or situations that can contribute to a sense of liability include homelessness and unemployment. As noted above, studies have already demonstrated a high incidence of each of these in trans populations. Factors that contribute to self-hate include self-blame and low self-esteem. In the Minority Stress Model, these represent one of the most proximal processes of stress—internalized transphobia. Self-blame and low self-esteem may develop as a result of gender-related victimization, such as childhood bullying, rejection by one's family, employment or housing discrimination, or intimate partner violence based on one's gender identity or expression. For example, violence related to an aspect of one's identity may cause the individual to engage in a negative appraisal of that aspect of the self and, subsequently, the self as a whole—leading ultimately to self-loathing. Further, for trans individuals who internalize societal transphobia, this could lead to a loss of the sense of community that the individual could otherwise enjoy from being connected to other trans individuals. With this connection severed, the individual also experiences a decrease in the sense of belongingness. This loss of self-worth, combined with the need for community resources that results from the victimization, may lead to thoughts that simply being transgender presents as a burden to society.

Joiner's (2010) final component of suicide risk is an acquired capability for lethal self-harm. An important aspect of this acquired capability is an enhanced tolerance for physical pain (Van Orden et al., 2010) that can develop as a result of repeated acts of self-harm, from a history of physical abuse or assaults, or from any other repeated exposure to pain that gradually increases the individual's ability to withstand pain without seeking to terminate the cause of that pain. As noted earlier, studies conducted in the last few years have demonstrated that trans persons have a high rate of multiple suicide attempts and have reported having higher incidence of physical and sexual assaults than most other populations studied. Through such experiences, the individual learns that pain can be sustained and tolerated. This learned tolerance of pain contributes to the development of the capability to engage in serious self-harm, including suicide attempts or completed suicide.

Recommendations for Clinicians

Increase Understanding of Trans Identities and Experiences

The specific identities by which people define themselves may challenge clinicians to step outside their gender normative para-

digm to allow for the possibility of gender identity that is not only incongruent with one's physical appearance, but may not be binary (i.e., either male or female). Thus psychologists are called upon to reexamine their own understanding and assumptions about gender to identify and address any biases that they may have toward this population.

Beyond this personal examination, psychologists will also need to ensure that they are adequately educated and trained to provide the requested services. Attaining such cultural competence surpasses mere acceptance of trans people. Consistent with the APA resolution passed in 2008, clinicians must ensure that they are able to comfortably and effectively communicate with their trans clients and are able to understand and empathize with the psychological issues that trans clients may present. Because few clinicians have much experience working with trans populations, we suggest that clinicians (a) disclose their level of knowledge and comfort with issues of transgenderism and their willingness to educate themselves with appropriate resources, (b) consult with others who have experience with these populations, and (c) increase their familiarity with trans people and trans-related issues through accessing the many valuable books, videos, and educational programs on this topic.

Suggested references are included in the Appendix.

Provide Culturally Competent Assessment and Treatment

It is imperative that clinicians, when working with trans clients, specifically assess for factors described in the Minority Stress Model, including prior discrimination or victimization, expectations of future victimization or rejection, internalized transphobia, and resilience. Study after study has demonstrated that trans individuals are subject to negative life events directly related to their gender variance and that these events have potentially dire mental health effects, including anxiety, mood disorders, substance abuse, and suicidal behaviors. (Clements-Nolle et al., 2006; Goldblum et al., in press; Testa et al., in press). Potential mental health sequelae must therefore also be closely assessed. Specific assessment tools to address Minority Stress Model factors in trans individuals have not yet been developed, though Bockting et al. (2006) have provided a framework within which various areas that address these factors might be explored. Advances in this area will be valuable. In the meantime, it is recommended that clinicians familiarize themselves with the Minority Stress Model and common experiences of trans populations, to inform their assessment in this area.

We are not proposing that the clinical interventions and treatment methods necessary for mitigating the effects of traumatic events or addressing specific disorders are different from those that would be used with any other population of similar characteristics (e.g., appropriate to the age of the client). However, since many trans clients face negative past experiences and resulting distressing thoughts that are related to gender identity and expression, such treatments will likely touch on Minority Stress Model factors during the course of therapy. Since the Minority Stress Model suggests factors that promote resilience in facing these stressors, we recommend that clinicians support and encourage clients' engagement in those factors that promote resilience. Primarily, Meyer suggested that minority group members can access "group-level coping" through engaging with and identifying with other members of their minority group. Through community, individuals receive skills and support in buffering the effects of discrimination and violence. Psychologists can therefore assess in what ways their trans clients feel connected to other trans people. Because trans individuals may not be visible in high numbers in every community, many find that trans social resources and groups are best accessible online, and in trans support groups that exist in some locations. Psychologists can be helpful by increasing awareness of the available opportunities for their clients' engagement with the trans community and supporting their clients' accessing resilience factors through such involvement.

In approaching assessment and treatment, it is useful for the clinician to be aware of factors that may influence trans clients to be less willing or able to divulge information to clinicians and engage fully in the treatment setting. For one, trauma histories and negative expectancies about reactions to trans identity status may lead to increased vigilance and hesitancy in speaking about a range of topics. In some cases, trans individuals may even have developed such a heightened level of internalized transphobia that they either dismiss the relevance of their trauma history or question whether they should receive any compassion for having been so victimized. To facilitate assessment and therapy, clinicians may therefore find it helpful to find a way to indicate their understanding of trans identities and experiences, as well as employ generally useful strategies for developing rapport with clients who have a history of trauma or rejection.

Second, clinicians must consider the frustration and hurt that many trans individuals feel concerning the diagnosis of Gender Identity Disorder in the *DSM–IV–R*. This frustration, combined with histories of discrimination and violence inside and outside of health care settings, means trans individuals may come into therapy expecting some negative or pathologizing judgments to be made about them. Clinicians must therefore take extra care to conduct such conversations in a sensitive way that cannot be construed as judgmental of that person's identity. Again, comfort with terminology and overt signals of trans acceptance will likely be helpful in building rapport despite this starting point of potential distrust or guardedness.

Finally, trans clients who wish to obtain medical transition services (e.g., hormone treatment or surgery) may be particularly reticent to divulge the extent of prior victimization, future expectations, internalized transphobia, and related distress. These clients are acutely aware from their own research via the Internet or through direct contact with other trans persons that certain types or levels of psychopathology can interfere with obtaining a letter that recommends them for medical transition. Because there have been a sufficient number of instances in which trans clients have been denied such letters because of any level of psychopathology that is not attributable directly to gender dysphoria, these concerns are very real. All psychologists who work with trans clients may therefore need to spend some time and energy in the assessment process clarifying their position with regard to psychopathology and its relationship to transition.

In sum, trans individuals are exposed to high levels of victimization and discrimination related to their gender identities and expressions. The Minority Stress Model depicts how these experiences have serious effects on the mental health of trans people, supported by findings on the relationship between victimization and suicide attempt presented by Goldblum et al. (in press) and Testa et al. (in press) and the

relationship between intimidation and concealing trans identity (Beemyn & Rankin, 2011). In light of this, there is a critical need for psychologists to provide competent mental health services to trans clients. Psychologists can prepare themselves to fulfill this need by increasing their understanding of trans people and experiences, and considering how prior victimization, discrimination, and rejection impact the assessment and therapy process. Finally, psychologists should make sure to draw upon and encourage trans-specific resilience factors.

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Appendix

Suggested Resources

Publications

Beemyn, G., & Rankin, S. (2011). *The lives of transgender people*. New York, NY: Columbia University Press.

Bockting, W. O., Knudson, G., & Goldberg, J. M. (2006). Counseling and mental health care for transgender adults and loved ones. *International Journal of Transgenderism, 9,* 35–82. doi:10.1300/J485v09n03_03, which can be accessed at http://transhealth.vch.ca/resources/careguidelines.html

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Videos

Beautiful Boxer **(2004)**
Boys Don't Cry **(1999)**
Ma Vie en Rose **(1997)**
Markova: Comfort Gay **(2000)**
TransGeneration **(2005)**

Websites

Gender Spectrum: www.genderspectrum.org
GenderTalk: http://www.gendertalk.com/
National Center for Transgender Equality: Http://transequality.org/
PFLAG's (Parents and Friends of Lesbians and Gays) Transgender Network: http://community.pflag.org/page.aspx?pid=380
Trans Youth Family Allies: http://imatyfa.org/
World Professional Association for Transgender Health: http://www.wpath.org/

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