



An Ecological Approach to Therapy With Gender Minorities

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This special series includes four articles that review important considerations for clinical work with gender minorities, including youth and young adults, individuals who are nonbinary, transgender individuals in inpatient or residential care, and transgender individuals recovering from trauma. These articles provide important insights and concrete suggestions for how to enact affirming practice, spanning across macro, mezzo, and micro levels. Ultimately, a multilevel approach to working with transgender and gender diverse individuals is essential to addressing health disparities in this population, as the work of an affirming provider goes beyond the therapy hour and the therapy office or treatment unit. In this commentary, I review the major themes from these contributions, provide a perspective on how they fit within the existing literature, and provide an overview of pressing future directions in gender minority research.

Transgender and gender diverse individuals are a wide-ranging population, including trans men, trans women, and many other groups that identify their gender in ways that differ from social expectations based on their sex assigned at birth (American Psychological Association [APA], 2015; Singh & Dickey, 2017). These other groups may hold identities such as genderqueer, nonbinary, agender, pangender, and other specific labels. It is important to note that there are many different ways that transgender people may experience and express their gender and there can be great diversity even within subgroups. For instance, not all genderqueer or nonbinary individuals may specifically identify with the label of transgender (or, trans) as noted by Matsuno (2019). As such, throughout this commentary, I will use the terms transgender and gender diverse (TGD) and gender minorities to represent this broad group that shares the experience of having gender identities that differ from that typically associated with their sex assigned at birth.

As highlighted by the articles in this special series, there is a serious deficit in training programs and the mental health field on how to provide affirming services to TGD clients (APA, Task Force on Gender Identity and Gender Variance, 2009). Furthermore, many TGD individuals encounter stigmatizing and oppressive experiences within therapy (Bauer et al., 2009; Benson, 2013; James et al., 2016; Puckett, Cleary, Rossman, Mustanski,

& Newcomb, 2018). This is even more troubling given that many medical providers require TGD people to interact with mental health professionals when seeking gender-affirming medical care, such as hormones or surgeries to affirm their gender (Hope, MocarSKI, Bautista, & Holt, 2016). Although not all TGD people have access to gender-affirming medical care or personally desire this (James et al., 2016), for those who do, this means that they are often receiving services from providers who have little to no training in even working with their communities. Even providers who self-identify as affirming may not be actually implementing practices viewed as affirming (Holt, Hope, MocarSKI, & Woodruff, 2019). As such, this special series addresses an urgent need to build awareness about how to provide affirming mental health services with TGD clients. The contributions include suggestions for specific actions that providers can take, as well as a more ambitious call for mental health professionals to create change at the macro level.

Contributions to the Special Series

The four articles on gender minority health in this special series detail how to be affirming of TGD clients in a range of settings and across a range of populations and thus move beyond general guidance for how to be affirming of TGD clients. In addition, their focus on a multilevel approach to gender minority health adds important information to the literature. To truly address health disparities for TGD people, a multilevel approach is needed that considers intervention points along the continuum from individual experiences to systemic issues (White Hughto, Reisner, & Pachankis, 2015). In

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Table 1, I have provided an overview of their recommendations across the macro, mezzo, and micro levels.

In their article, Oransky, Burke, and Steever (2019) present unique considerations for working with TGD

adolescents and young adults using an interdisciplinary model (e.g., incorporating a focus on the family unit; facilitating openness and support among family members; bridging communication across types of providers).

Table 1
Ecological Framework for Suggestions in Special Series

Level	Response
Macro	<ul style="list-style-type: none"> • Inform policy and practice through presentations at a variety of outlets, including academic conferences and community-focused presentations, in order to engage in broad dissemination that may create direct change in sociopolitical contexts (Oransky, Burke, & Steever) • Be a consultant for agencies, organizations, or policy leaders (Oransky, Burke, & Steever) • Disrupt oppression in the various contexts that clients may be embedded within while empowering clients to take actions on their own behalf if they would like to (Oransky, Burke, & Steever; Walton & Baker; Shipherd, Berke, & Livingston) • Assist clients with navigating oppressive systems, such as legal systems involved in name and gender marker changes, and expand the understanding of the therapist's role to include settings beyond the therapy room (Oransky, Burke, & Steever; Walton & Baker) • Be educated and knowledgeable about common systemic issues, such as state-specific legislation and processes for name and gender marker changes (Oransky, Burke, & Steever; Shipherd, Berke, & Livingston) • Advocate for legislative protections and for policies that explicitly recognize the range of gender experiences (Matsuno; Shipherd, Berke, & Livingston) • Disrupt gatekeeping practices within psychology and the tendency to pathologize gender minorities (Matsuno) • Expand the discourse around trans identities to include the experiences of non-binary individuals (Matsuno) • Collective activism may be empowering for TGD people wishing to challenge mezzo and macro level systems and policies; practitioners also need to recognize the costs to engaging in activism (Shipherd, Berke, & Livingston)
Mezzo	<ul style="list-style-type: none"> • Address individual barriers that may exist for accessing care, such as the ability to pay for services (Matsuno; Oransky, Burke, & Steever; Walton & Baker) • Ensure confidentiality of services and work to minimize the invasion of privacy that may result from times when confidentiality may not be possible (Oransky, Burke, & Steever; Walton & Baker) • Make therapy services accessible through multiple routes and provide decision-making opportunities for clients to increase agency (Oransky, Burke, & Steever) • Provide a range of services that address the varied contextual influences on health, such as family services and peer-based groups (Matsuno; Oransky, Burke, & Steever; Shipherd, Berke, & Livingston) • Develop rapport with local agencies or groups working with TGD individuals (Oransky, Burke, & Steever) • Ensure that clients feel represented in the physical space of the therapist's office, including the waiting room, access to restrooms, paperwork, physical symbols of affirmation, etc. (Matsuno; Oransky, Burke, & Steever; Walton & Baker; Shipherd, Berke, & Livingston) • Train everyone in your practice, including staff (Matsuno; Oransky, Burke, & Steever; Walton & Baker) • Seek feedback about your own practice from community members and individuals in other professions (Oransky, Burke, & Steever) • Provide education and training to others outside of your workplace so that additional contexts become more affirming (Matsuno; Oransky, Burke, & Steever; Shipherd, Berke, & Livingston) • Ensure that your practice or agency has an inclusive nondiscrimination policy (Walton & Baker; Shipherd, Berke, & Livingston) • If an inpatient or residential program, establish a visitation policy that is not gendered and that is not limited to individuals who are legally recognized as family members (Walton & Baker) • If you are limited to a binary setting, such as an inpatient setting or residential program designed for men or women or segregated units, advocate for clients to receive treatment in the setting of their choosing but recognize that this does not take away the harm that may be inflicted by these binary systems (Walton & Baker) • Review your medical record systems for any needed changes (e.g., name and gender markers; Shipherd, Berke, & Livingston) • Examine your agency's intake process for any modifications needed to the process or content to make it more affirming (Shipherd, Berke, & Livingston) • Review your hiring practices to ensure that the staff and mental health providers in your agency reflect the community being served (Shipherd, Berke, & Livingston)

Table1 (continued)

Level	Response
Micro	<ul style="list-style-type: none"> ● Acknowledge and express understanding about the history of psychology and how this may influence clients' perceptions of therapists while working to establish trust and rapport at the individual level (Matsuno; Oransky, Burke, & Steever; Walton & Baker) ● Be transparent about your policies and views, while acknowledging the legitimacy of a client's hesitancy to trust the mental health profession given the complicated history of the field and the high rates of exposure to negative experiences within medical and mental health services (Oransky, Burke, & Steever; Walton & Baker) ● Be explicit about your conceptualization of clients and how you incorporate a focus on sociopolitical and contextual factors (Matsuno; Oransky, Burke, & Steever; Walton & Baker) ● Provide psychoeducation to clients to help them also contextualize their mental health (Oransky, Burke, & Steever) ● Attend to the self by using supervision and consultation to address potential biases therapists may hold and seek out additional trainings (Oransky, Burke, & Steever; Walton & Baker) ● Given the importance of relationships and interpersonal supports, foster an openness that is transformative to the client and create opportunities for interactions with peers and supportive others (Matsuno; Oransky, Burke, & Steever) ● Adapt evidence-based practices, such as DBT and CBT, to recognize the unique experiences of TGD people (Matsuno; Oransky, Burke, & Steever; Walton & Baker; Shipherd, Berke, & Livingston) ● Create an affirming space through actions that convey an understanding of gender diversity and of the unique challenges that nonbinary trans individuals encounter, such as asking for a client's pronouns, sharing your own pronouns, and having inclusive forms (Matsuno; Walton & Baker) ● Do not impose an understanding of a client's gender identity or their identity development process or trajectory (Matsuno) ● Practice using gender-inclusive language and gender neutral pronouns so that you are less likely to make mistakes with clients (Matsuno) ● When mistakes occur, acknowledge them and make a repair while not overly focusing on this, blaming clients, or eliciting guilt by focusing on the perceived difficulty of using gender neutral language (Matsuno; Walton & Baker) ● Be wary of overly or under-focusing on gender and reflect about the accuracy of your conceptualization (Matsuno; Walton & Baker) ● Externalize negative messages and help clients to make connections between their internal experiences and the oppression experienced by TGD people (Matsuno; Shipherd, Berke, & Livingston) ● Always refer to TGD clients in their affirmed name and using affirmed pronouns, unless they have communicated a need for privacy or have expressed a desire to be referred to in other ways (Matsuno; Oransky, Burke, & Steever; Walton & Baker) ● Validate and express understanding for the negative impact of minority stress (Matsuno; Oransky, Burke, & Steever; Shipherd, Berke, & Livingston; Walton & Baker) ● Expose the client to positive messages related to being a gender minority (Matsuno) ● Identify ways of coping with rejection related to one's gender identity (Matsuno; Oransky, Burke, & Steever; Shipherd, Berke, & Livingston) ● If you are limited to a binary setting, such as an inpatient setting or residential program designed for men or women or segregated units, have open discussions about this with your TGD clients and determine how they would like to navigate this system (Walton & Baker) ● If in a setting where you may interact with TGD clients around other clients, such as inpatient or residential settings, be sure not to out the client to others (Walton & Baker) ● Communicate the agency's nondiscrimination policy to all clients so that TGD clients are respected by other clients in the setting (Walton & Baker) ● If in a treatment setting where clients may establish relationships with one another, such as inpatient or residential settings, these relationships may be an important focus of therapy (Walton & Baker) ● Consider how traumatic events that meet Criterion A in the DSM may interact with minority stress and/or when minority stressors may meet Criterion A and incorporate this into your case conceptualization (Shipherd, Berke, & Livingston) ● Assess exposure to microaggressions and incorporate into conceptualization and treatment as appropriate (Shipherd, Berke, & Livingston) ● For micro-level interventions that reflect in the room experiences, incorporate an understanding of the inherent connections to social and political factors at the mezzo- and macro-levels in explicit ways in your conceptualization and treatment (Shipherd, Berke, & Livingston) ● Understand the adaptive function of some experiences that may be inaccurately conceptualized as symptoms of psychopathology, such as adaptive vigilance (Shipherd, Berke, & Livingston)

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Table 1 (continued)

Level	Response
	<ul style="list-style-type: none"> • Recognize the ways that intervention at the macro-level may lead to micro-level changes for the TGD person or be a focus of therapy, such as the development of connection with other TGD people and a sense of pride (Shipherd, Berke, & Livingston) • Use best available practices for the assessment and treatment of: trauma (and associated symptoms of vigilance, intrusive thinking, sleep problems, substance use), discrimination sequelae, microaggressions sequelae, minority stressors (Shipherd, Berke, & Livingston)

Note. All citations in table reference this issue. Readers should consider the ways that each item may span multiple levels (e.g., micro level interventions also benefit from situating experiences within mezzo and macro levels).

Although their focus is on youth and young adults, many of their recommendations apply to any age group, therapy context, or provider (e.g., creating an affirming clinic environment; ensuring that micro-level interventions incorporate a focus on the social context). Throughout their article, it is clear that they value transparency when working with TGD clients—an aspect of clinical practice that should not be overlooked when working with marginalized populations. Their recommendations for having explicit discussions with clients about power dynamics and their affirming, social-justice-oriented approach are noteworthy. Finally, there are several points where the authors highlight the need for community-informed practices and this is something that many settings may benefit from incorporating. TGD people are the ultimate experts on their experiences and many cisgender mental health providers may need to learn how to listen to the community and respond to their needs in ways that feel affirming.

Matsuno (2019) provides an excellent review of how to approach therapy in a way that will be affirming for nonbinary individuals. They provide an overview of issues that may uniquely affect nonbinary people, as well as examples of how to tailor therapy practices to be affirming for this population. Their incorporation of cultural humility and the basic components of culturally competent care (i.e., building awareness and knowledge) are reminders that we must seek our own personal growth in understanding diverse gender experiences and be self-reflective. Their contribution also stresses privileging the lived experiences of clients rather than preconceived notions about how gender is experienced, embodied, or expressed. It also is important to recognize that although some of the suggestions may seem simple on the surface (e.g., asking clients about their pronouns or using gender neutral language), they should not be disregarded. These fundamentals around interactions and communication within therapy are the very issues that many TGD people report being problematic (Puckett et al., 2018). Ultimately, the mental health field at a broad level has yet to move beyond even the basics of

speaking about and to nonbinary people in affirming ways.

Walton and Baker (2019) reflect on the unique nature of working with TGD clients in inpatient and residential treatment programs. One issue that they address is that we should evaluate the full experience of a TGD client within the setting to ensure that their care is affirming. On an inpatient unit or in a residential treatment program, this means considering everyone a client will interact with and every setting the client will spend time in. The authors also discuss how to respond to other clients who may be in the treatment program with TGD clients in order to simultaneously create an affirming setting and protect the privacy of TGD clients. They also mention the importance of empowering clients to make decisions around their care in ways that build trust and rapport. That said, we also must recognize that inpatient and residential treatment centers are often very binary in their setup and approach to gender. Given this, some suggestions still centralize a binary understanding of gender (e.g., their recommendation for inquiring about sexual behaviors only recognizes the existence of men and women; the limited acknowledgment that binary housing options or treatment facility options for men and women still do not provide a space for nonbinary and other gender diverse people). The state of care within these settings is still vastly inadequate for TGD people. Much of this care is still specific to certain gender groups or separated by gender and, because of this, some efforts to empower and develop agency for TGD clients still support cisnormative systems. TGD people are being asked to fit themselves into these existing frameworks rather than those very frameworks being forced to change. These suggestions, however, can help to support TGD people in the immediate future while broader level changes are sought to how these systems are organized.

Last, Shipherd, Berke, and Livingston (2019) provide a much needed description of how to disentangle traumatic experiences that may meet DSM-level criteria of a traumatic event from other clinically significant experiences of TGD people that may also be

a focus of treatment, such as microaggressions. They provide several specific recommendations for the best available practices in assessment and treatment of symptoms or conditions that may relate to trauma recovery, such as hypervigilance (while also distinguishing this from adaptive vigilance). This contribution also provides guidance on how to incorporate the minority stress model and a strengths-based approach into treatment of trauma with TGD clients. Importantly, similar to the other contributions, these authors also emphasize the ethical imperative that therapists recognize the importance of their actions as agents of social change at the mezzo and macro levels.

Reflecting on the content of these contributions, there are three areas that I will expand upon: (a) shifting the field from pathologizing to affirming TGD identities while acknowledging the lasting impact of the field's history on the lives of TGD people; (b) strengthening our understandings of minority stress to more fully capture the lived experiences of TGD people; and (c) the importance of therapists as social change agents.

Documenting Drivers of Health Disparities While Moving Beyond Psychology's History of Pathologizing TGD People

Much of the current literature focused on TGD health has concentrated on documenting mental health issues that are disproportionately experienced by TGD people, such as suicidality (James et al., 2016), depression (Witcomb et al., 2018), anxiety (Bockting, Miner, Romine, Hamilton, & Coleman, 2013; Budge, Adelson, & Howard, 2013; Olson, Durwood, DeMeules, & McLaughlin, 2016), and other health issues (Fredriksen-Goldsen et al., 2014). In addition, much of the current research focuses on minority stressors (i.e., unique stressors that may influence health outcomes for minority groups; Meyer, 1995, 2003) and how these negative events adversely affect TGD people (Bradford, Reisner, Honnold, & Xavier, 2013; Testa, Habarth, Peta, Balsam, & Bockting, 2015). Notably, the examination of predictors of health outcomes for TGD people signifies a shift in the field. This research deviates from the pathologizing and inaccurate view of diverse gender identities as signifying illness to a view that prioritizes understanding social and contextual factors that influence the mental health of this marginalized population.

One reason why the growth in affirming gender minority research is so recent is likely tied to the history of the mental health field and the historical (and in some cases, current) ways that psychology and related fields have pathologized TGD individuals (Dickey, Hendricks, & Bockting, 2016; Singh, 2016; Winters, 2009). There has been a history of seeing gender-nonconforming behavior through a pathological lens and the diagnoses of Gender

Identity Disorder and Gender Dysphoria have played a role in this. A system that frames one's experience of their gender as pathology inherently negates efforts to research what social and contextual factors may influence mental health, what it means to be affirming of TGD clients, or evaluating the effectiveness of interventions tailored for this population. This in some ways parallels the history concerning the classification of homosexuality (the term used at this time) as a mental illness. Before this was removed from the Diagnostic and Statistical Manual of Mental Disorders, it ran counter to the dominant understandings of sexual minorities to write about or research affirming practices with lesbian, gay, bisexual, queer, or other nonheterosexual groups (Hooker, 1993). In some ways we are at a similar juncture where the dominant field and major organizations, such as the American Psychological Association, have now embraced diversity in gender experiences and affirmed their stance that being a gender minority is not a sign of pathology. These social shifts have now created the professional space to focus on ways to provide affirming therapeutic practices that are also evidence based.

Although shifts have certainly happened and we see broadened understandings within the general population about what it means to be TGD and in media representations of TGD individuals (McInroy & Craig, 2015), this history cannot be forgotten. The diagnosis of Gender Identity Disorder and now Gender Dysphoria have left a mark on how TGD people view mental health providers, as well as how the general public understands TGD people. This has particular implications for our interactions with clients as they may have reactions to individual providers that are rooted in this lingering history and providers will need to be able to understand and empathize with such reactions rather than be dismissive or defensive when this happens.

Another shift that we see happening is the expansion around social narratives and understandings of TGD people's experiences of their genders. As explained by Matsuno (2019), many providers may have internalized the narrative that TGD individuals are seeking to affirm their gender in binary ways (e.g., assuming someone female assigned at birth would be affirming their gender as a man) or narratives that emphasize that all TGD people know since early on in life that their gender is different than social expectations. These narratives are restrictive and lead to the invalidation of the diverse gender experiences of TGD people and we must actively work to expand our understandings of gender. These limiting and rigid understandings of gender are connected to psychology, psychiatry, and medicine with outdated practices like the real-life experience and gatekeeping when TGD people are seeking medical ways to affirm their gender. Again, these histories

continue to shape in subtle and blatant ways how TGD people are understood socially and within the field.

This history also has macro- and mezzo-level implications. Prior to joining the faculty at Michigan State University, I worked as an Assistant Professor at the University of South Dakota for 3 years. Living there, it felt like TGD individuals' experiences were constantly up for political debate with the rights of this community frequently brought into question and targeted. My first year there, this was no exception. In that year, the legislators in the state of South Dakota voted that students in K-12 public schools should only be allowed to use the restroom of their sex assigned at birth and not the facilities that aligned with an affirmed identity. This was later vetoed by the governor, but leading up to this vote, one of the legislators (Senator David Omdahl) was giving comment at a public forum discussing this proposed bill. His statement has stayed with me as a clear example of how pathologizing gender minorities within the field has supported anti-TGD, prejudiced acts such as this bill. In his comments, he stated, I'm sorry if you are so twisted you don't even know who you are. They're treating the wrong part of the anatomy. They ought to be treating it up here (said while motioning to his head; Ferguson, 2016). Although he was not necessarily pointing to our diagnostic manual as evidence for his perspective, the connections to the field's history are undeniable. Thus, the actions of our profession, field, and the people who have come before us have significant implications for macro-level policies and interactions with others at the mezzo level. Although a full review of this history is beyond the scope of this commentary and is not entirely easily compiled, mental health professionals and researchers who are working with TGD individuals may greatly benefit from considering this past, along with other histories that apply to our work with clients, such as that of racial and ethnic minorities (Martn-Bar, 1994).

Where Do We Go From Here? Building on Existing Models to Understand Gender Minority Stress

The minority stress model that is often utilized in research to understand gender minority health was originally developed with sexual minorities in mind (Meyer, 1995, 2003). Meyer's model included distal and proximal stressors that help explain mental health disparities for lesbian, gay, and bisexual cisgender people.¹ Distal stressors refer to the more overt actions that negatively affect sexual minorities, such as discrimination, violence, and harassment. Proximal stressors are

usually the result of distal stressors and include internalized stigma, identity concealment, and expectations of rejection or marginalization.

Although aspects of Meyer's model are useful for understanding stressors for gender minorities (Hendricks & Testa, 2012; Rood et al., 2016; Rood et al., 2017a, b; Testa et al., 2015), some stressors within the existing framework may be uniquely experienced by TGD people. For instance, the minority stressor of identity concealment may need particular nuanced consideration when applied to gender minorities. As Rood et al. (2017a) found, TGD people may not have disclosed their trans identity to others or affirmed their gender and so may be in positions of initially disclosing their trans identity. However, it also may be that TGD people are not readily perceived as being transgender and are insituations where they are disclosing their transition history. These may represent unique experiences although common practice at this stage in TGD research is to combine these into an identity concealment variable without necessarily questioning if this is a unitary construct.

Furthermore, researchers have highlighted additional stressors that are not captured by this model, such as misgendering (DuBois, 2012; McLemore, 2018) or non-affirmation of a person's gender identity (Testa et al., 2015). Researchers have expanded Meyer's model to include the stressor of nonaffirmation (Testa et al.) but other stressors remain missing, such as vicarious exposure to stress narratives about TGD people (Perry & Alvi, 2011) or heightened vigilance regarding encountering minority stress (Shipherd et al., 2019).

Arguably, we have become boxed into understandings of what constitutes stress for TGD people. This is not an issue with the theory of minority stress but with the ways that it has been applied to the lives of TGD people. When we examine gender minority individuals' experiences through a lens that was developed to bring into focus the stressors that sexual minorities experience, we are bound to miss important considerations for TGD people. As such, we need to return to foundational research about the types of stressors that manifest in the lives of TGD people, how they are experienced and embodied, and develop ways of measuring and assessing these novel stressors that move beyond the existing options. Furthermore, this foundational research should include participants across a range of racial groups given that most existing research has included primarily White TGD samples. Until we have models and frameworks that centralize TGD people's experiences instead of fitting them into a framework that was meant for cisgender people, we will lack adequate understandings of minority stress for TGD people. As a result, we will fail to capture many of the lived experiences of this community and our clinical research will remain in a state of infancy.

¹ Although TGD people can also be sexual minorities (meaning that they may also identify as lesbian, gay, bisexual, queer, and other non-heterosexual identities), the minority stress model for sexual minorities was initially focused on cisgender individuals' experiences.

Moving this discussion of minority stress to a more applied perspective, another aspect that stands out about these articles is their focus on learning to listen to TGD clients, learning to hear what TGD clients share, and learning to validate and honor the legitimacy of TGD people's experiences. Often, TGD people have their experiences questioned or minimized by others, sometimes being told that they are overreacting to events or similar stigmatizing messages. Yet, in reality, it is more common than not that a TGD person is experiencing oppression, being targeted, or other forms of marginalization. Many of the expectations of rejection or negative evaluations and cognitions that TGD people may have are likely accurate reflections of the world they are living in as opposed to cognitive distortions. Therapists must learn to recognize the social and contextual factors that are influencing TGD individuals' lives and incorporate that understanding into therapy with this population. If researchers and theorists can develop more fitting and in-depth understandings about how minority stress manifests in the lives of TGD people, mental health providers will also likely be better prepared to listen and understand their TGD clients.

Therapists as Agents of Change

Last, therapists and researchers are tasked with exploring how they can be agents of social change. Each of the articles in this special series highlight that macro- and mezzo-level interventions are needed if we are to ever truly address the mental health disparities experienced by TGD people. Without changes to the social and political context in which TGD clients are living, they will continue to be faced with stigma and marginalization and the subsequent mental health concerns that arise. Even so, more research is needed to help us understand what gets in the way of mental health professionals and researchers taking on this call or how to move individuals in our field into action.

I think this also leaves us with the question of what to do when advocacy on the part of providers, researchers, or clients does not result in positive social change either at the policy level or the individual level. As highlighted by Shipherd, Berke, and Livingston (2019), advocacy can come with a cost. How do we then help our clients to navigate a world where they have expressed their needs effectively and are told sometimes explicitly that these needs do not matter and will not be met, or are ignored? We need to talk more about how to navigate the challenges when people do not respond in supportive ways. There are few repercussions for people who continue to uphold hierarchies that marginalize TGD people. These are the behaviors that are rewarded implicitly or explicitly. We also should consider how this might differentially impact TGD therapists and

researchers compared to cisgender therapists and researchers who are engaging in advocacy efforts. Much attention also needs to be paid to the intersecting identities of clients as they may be experiencing oppression across other aspects of identity, such as race, ethnicity, social class, ability, and others.

Key Future Directions to Improve Mental Health Services with TGD Clients

Although there is much research to be done, there are a few prominent areas that can be addressed. For one, there is a clear need for more research on what types of minority stressors TGD people experience (including conceptual understandings of these stressors, measurement, revision of existing models, etc.). This has the possibility to greatly enhance the accuracy and specificity of future TGD research. In addition, the theoretical and conceptual writing on how to apply various therapy approaches, such as cognitive-behavioral therapy, to working with TGD clients has grown (e.g., Austin & Craig, 2015; Skinta & Curtin, 2016). Researchers should continue to evaluate the effectiveness of these approaches with TGD clients (e.g., Austin, Craig, & D-Souza, 2018; Maguen, Shipherd, & Harris, 2005). Another future avenue for research is to evaluate the best practices in training future mental health professionals to become affirming providers for TGD clients. Last, there is extremely little psychotherapy process research with TGD individuals (Budge, Israel, & Merrill, 2017). Research concerning the interpersonal dynamics between therapists and clients, processes underlying change in therapy, and many other areas would strengthen practice with TGD clients.

Conclusions

The articles in this special series take our field another step forward in identifying affirming practices with TGD clients across a range of settings. Each of the authors has offered concrete suggestions that mental health professionals can implement into their practice to better meet TGD clients' needs. In addition, these contributions urge therapists and researchers to enact social change and live out social justice values within the profession. How can we answer this call?

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