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Transgender Affirmative Cognitive Behavioral Therapy: Clinical Considerations and Applications

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Transgender individuals report pervasive discrimination, microaggressions, and victimization across the life span, contributing to disparate rates of suicide, anxiety, and depression. Clinical interventions must be empirically supported and affirming, competently and sensitively attending to the effect of transphobic discrimination on the lives and experiences of transgender people. Transgender affirmative clinical practice acknowledges and counters the oppressive contexts in which transgender clients often experience health and mental health care. The primary aim of this article is to introduce a transgender-affirming adaptation of a cognitive behavior therapy intervention (TA-CBT) for use with transgender individuals suffering from depression, anxiety, and/or suicidality. Clinical considerations such as the historical context of transgender issues in mental health care, the minority stress framework, current mental health disparities, and resilience will be explored. Transgender-affirming practice applications focused on psychoeducation, modifying problematic thinking styles, enhancing social support, and preventing suicidality will be provided.

Keywords: transgender, cognitive behavior therapy, affirmative practice, gender identity

Members of the transgender community have distinct needs and experiences that require professionals with trans-affirmative knowledge, skill, and competency (Collazo, Austin, & Craig, 2013) as well as interventions that are empirically supported and trans affirming (Haas et al., 2011). Although many terms are found in the literature, this article will interchangeably use transgender and trans as umbrella terms inclusive of any individual whose gender identity and/or gender expression differs from societal and/or cultural norms associated with the gender binary (e.g., agender, bigender, gender nonconforming, genderqueer, gender variant, transsexual, Two-Spirit). Trans-affirmative practice refers to a nonpathologizing approach to clinical practice that accepts and validates all experiences of gender. The male-female gender binary is rejected in trans-affirmative practice because it is viewed as a marginalizing construction of gender, privileging some while oppressing others. All ways of experiencing and engaging one's gender are acknowledged as equally valuable. Trans-affirmative practitioners create space for clients to safely explore, understand, and inhabit individual experiences of gender. It is important to note that trans-affirmative practice recognizes the interpersonal, social, cultural, and political barriers to safety and well-being experienced by individuals whose experiences of gender lie outside of the gender binary and actively works to intervene upon these barriers. Although helping professionals have long been called upon to provide inclusive, nonpathologizing, and affirming care for transgender individuals (Bockting, Knudson, & Goldberg, 2006; Collazo et al., 2013; Lev, 2009; Raj, 2002), there is a disconnect between the helping professions' guiding principles (American Psychological Association, Task Force on Gender Identity and Gender Variance, 2009; Burnes, Singh, Harper, et al., 2010; National Association of Social Workers, 2008) and current practices with transgender clients (Barker & Wylie, 2008; Bess & Staab, 2009). Research suggests that clinicians hold pathologizing and/or negatively biased views about experiences of gender that lie outside of the binary (Bess & Staab, 2009; Logie, Bridge, & Bridge, 2007; Mizock & Lewis, 2008). Research further indicates a lack of trans-affirmative knowledge, skill, and training among professionals (Austin, Craig, & McInroy, in press; Logie et al., 2007; McInroy, Craig, & Austin, 2014) and a dearth of empirically supported interventions targeting the transgender community (Haas et al., 2011). The primary aim of this article is to introduce a trans-affirming adaptation of a cognitive–behavioral therapy (TA-CBT). To provide a context for understanding the fit between TA-CBT and the needs of the transgender community, literature focused on transphobic discrimination and the resulting health disparities will be discussed. For additional discussions of the fit between cognitive–behavioral therapy (CBT) and sexual and gender minority clients, please see Craig, Austin, and Alessi, 2012.

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Context of Mental Health Care for Transgender Clients

Transgender clients routinely experience discrimination as well as a lack of competent and affirmative care in health and mental health settings (Grant et al., 2010), which may contribute to a lack of trust in clinicians (Bess & Staab, 2009). Clients have historically viewed the clinician as an adversarial gatekeeper rather than an ally or advocate (Barker & Wylie, 2008; Bess & Staab, 2009; Lev, 2009). Several factors contribute to these negative perceptions. One critical barrier to trans-affirming experiences is the pathologization of the transgender experience by the mental health professions. Specifically, inclusion of the diagnosis of gender identity disorder (GID) within the sexual disorders section of the *Diagnostic and Statistical Manual of Mental Disorders* (third edition; *DSM-III*) in 1980 served to stigmatize transgender people by categorizing them as mentally ill and sexually deviant (Winters & Ehbar, 2010). For the ensuing 33 years, GID remained in the *DSM* (i.e., *DSM–III–R*, *DSM–IV*, and *DSM–IV–TR*). Several observers have made the point that the GID diagnosis perpetuates defamatory stereotypes of transgender and gender-nonconforming people, contributing to support for conversion therapies that have been used to inflict pain and trauma on transgender individuals (Winters & Ehrbar, 2010). Only recently, in response to pressure from transgender advocacy groups and the World Professional Association of Transgender Health (WPATH), did the *DSM-5* eliminate the GID diagnosis and replace it with the diagnosis of gender dysphoria in a new section that separates it from sexual disorders (see: American Psychiatric Association, 2013). This change was aimed at depathologizing the transgender experience. The emphasis is now on distress caused by gender incongruence and not the gender identity itself, clarifying that transgender identities are not pathological and that the role of mental health professionals is to affirm and support individuals experiencing gender dysphoria (Basu, 2012; Winters, 2012).

First developed in 1979, the Harry Benjamin Standards of Care (SOC), now in the seventh edition, offer guidance to medical and other helping professionals working to facilitate positive health and well-being among transgender people (WPATH). The SOC suggest protocols (e.g., conferring a diagnosis of GID, assessing real-life experience, writing a gender letter) for mental health clinicians working with clients interested in pursuing gender-confirming medical interventions (e.g., hormone therapy, gender confirmation top or bottom surgeries) associated with more fully integrating their internal and external experiences of gender (often referred to as transitioning; Levine, 2009; World Professional Association for Transgender Health, 2012a). Although well-intentioned, these guidelines inadvertently placed clinicians, particularly those lacking a trans-affirmative perspective, in a position of power, controlling if and when clients would be given "approval" to move forward with various gender-confirming interventions (Bess & Staab, 2009; Levine, 2009). This dynamic contributed to many transgender clients reporting feelings of distrust, resentment, and betrayal associated with relationships with mental health providers (Bess & Staab, 2009). Although the most recent version of the SOC, version 7, relaxes some standards (a letter from a clinician is no longer needed for beginning hormone therapy; World Professional Association for Transgender Health, 2012b), clinician practices have not yet fully evolved. Consequently, perceptions about the oppressive role of mental health providers persist. It should be noted that the SOC primarily focus on guiding care for transgender clients seeking hormones or gender-confirming surgery and provide little to any guidance for working with transgender clients who do not wish or who are unable to medically transition. Further contributing to challenges is the paucity of trans-specific clinical skills and training within the helping professions, resulting in clinicians feeling unprepared to work with transgender clients (American Psychological Association, Task Force on Gender Identity and Gender Variance, 2009; Erich, Boutté-Queen, Donnelly, & Tittsworth., 2007; Heck, Croot, & Robohm, 2013; Logie et al., 2007).

Framework for Trans-Affirmative Practice

Transgender-affirmative clinical practice must acknowledge and counter the oppressive contexts in which transgender clients often experience health and mental health care. A first step is to help transgender clients overcome reticence or distrust by creating a trans-affirmative culture at the onset of the clinical relationship. To facilitate this process, the clinician should (a) articulate a trans-affirmative and inclusive perspective of gender. For example, an affirming clinician might say the following:

> Welcome, I'd like to take a moment to share my approach to practice with you. In keeping with clinical practice that is affirming and inclusive, I embrace a trans-affirmative approach in which all experiences of gender are acknowledged and validated. I aim to create a space for clients to safely explore, understand, and inhabit their unique experiences of gender.

(b) Use gender-neutral language and/or language that reflects the client's preferred terminology (Mizock & Lewis, 2008). A clinician may choose to facilitate this step by introducing oneself by name and preferred gender pronoun. For example, "My name is Ashley and my preferred gender pronouns are she and her. What is most comfortable for you?" (c) Clarify the clinician's role (e.g., as a trans-affirmative advocate) and primary purpose of the therapeutic relationship (e.g., to support client self-determination in the quest for well-being). Because transgender clients may seek mental health services for a myriad of reasons, such as stress, relationship challenges, and mental health issues (e.g., anxiety, depression, substance use), it is important that trans-affirming clinicians competently assess the effect of trans-specific issues on overall well-being (Bockting et al., 2006; Collazo et al., 2013).

Understanding the Effect of Transphobic Discrimination on Mental Health

It is critical that clinicians understand the magnitude and effect of transphobic discrimination on the lives and experiences of transgender people. Transgender individuals report pervasive discrimination, microaggressions, and victimization across the life span (Grant et al., 2010 Grossman & D'Augelli, 2007; Mizock, & Lewis, 2008; Nuttbrock et al., 2010). Results of the National Transgender Discrimination Survey (NTDS) indicate that nearly one fifth of transgender individuals experience homelessness as a result of their transgender status and 53% of have been verbally harassed in a public place (Grant et al., 2010). Moreover, 19% of transgender individuals have been denied medical care because of

their transgender identity. Such discrimination begins early as youth that express a transgender identity or gender nonconformity during Grades K–12 experience alarming rates of harassment (78%), physical assault (35%), and sexual violence (12%) (Grant et al., 2010). In addition, it is increasingly acknowledged that transgender people are regularly exposed to transphobic microaggressions (Austin et al., in press; Nadal, Skolnik, & Wong, 2012; Smith, Shin, & Officer, 2012), defined as "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups" (Sue et al., 2007, p. 271), from family, friends, teachers, and mental health providers, as well as in academic institutions (Austin et al., in press), community service organizations, and the media (Nadal et al., 2012).

Minority Stress Model

The Minority Stress Model (Meyer, 2003) has increasingly been used to explain the increased risk for negative outcomes and maladaptive behaviors among Lesbian, Gay, Bisexual, Questioning/Queer, and Transgender (LGBQ & T) people. This model can partly be explained by minority stress theory (Marshal et al., 2011). According to minority stress theory, members of sexual and gender minority groups experience chronic stress resulting in part from prejudicial encounters, which in turn contribute to a higher prevalence of mental health and behavioral issues (Meyer, 2003). This type of stress is unique to marginalized populations (Meyer, 2003) and is perpetuated by a conflict between one's internal self and the expectations of one's social, cultural, and political environments. Thus, for transgender individuals, the often daily onslaught of transphobic stereotypes, microaggressions, and discriminatory treatment leads to pervasive experiences of minority stress that may contribute to the development of emotional and behavioral issues. The minority stress model helps to contextualize the disparities in mental health experienced by transgender individuals.

Mental Health Disparities

Results from NTDS reveal that transgender individuals attempt suicide at drastically higher rates than the general population (41% vs. 1.6%, respectively; Grant et al., 2010). Suicide risk was particularly pronounced among transgender individuals who had been victimized, bullied, and harassed (Grant et al., 2010; Nuttbrock et al., 2010) and among individuals who experience parental/familial rejection (Grant et al., 2010; Grossman & D'Augelli, 2007). In specific, NTDS indicates disproportionately high suicide rates for trans persons who were sexually assaulted (78%), physically assaulted (68%), and harassed or bullied (54%) during college. Likewise, in a study of trans youth, rates of attempted suicide were nearly double for participants who experienced family rejection (57%) compared with participants who reported strong family relationships (31%) (Grant et al., 2010). There is also evidence that transphobic stigma and discrimination is linked to depression (Nuttbrock et al., 2010) and feelings of shame, low self-esteem, anxiety, and powerlessness (Spicer, 2010).

Resilience Among Transgender Individuals

Transgender individuals demonstrate notable resilience in the face of disproportionate levels of minority stress (Singh, 2013; Singh, Hays, & Watson, 2011; Singh & McKleroy, 2011). Accumulating qualitative research identifies several unique aspects of resiliency among diverse samples of transgender individuals, such as evolving a self-generated definition of self, embracing self-worth, awareness of oppression, connection with a supportive community, cultivating hope for the future, social activism, and being a positive role model for others (Singh et al., 2011; Singh & McKleroy, 2011). Additional sources of resiliency for younger transgender individuals may include an awareness of adultism in their lives, self-advocacy within educational institutions, finding a place within the LGBQ & T community, and using social media to affirm identity (Singh, 2013). Engaging specific sources of resiliency within clinical interventions is as important as targeting transgender-specific risk factors. TA-CBT was developed with attention to supporting and further developing sources of resilience among transgender clients.

Heterogeneity Within the Transgender Community

It must be acknowledged that the transgender community is not a homogenous group. Rather, represented within the transgender community are a diversity of perspectives, experiences, identities, and expressions of gender. Moreover, intersecting racial/ethnic minority identities may affect important aspects of risk and resilience (McFadden, Frankowski, Flick, & Witten, 2013) and have implications for intervention. For example, within the transgender population, transwomen of color are at the greatest risk for various traumas including sexual assault, physical assault, and HIV infection (Grant et al., 2010), and resiliency among trans persons of color is developed in response to a context of marginalization associated with race/ethnicity and gender identity (Singh, 2013; Singh & McKleroy, 2011). In addition, it appears that individuals with nonbinary gender identities may uniquely experience marginalization within the community and within social service settings (Riley, Wong, & Sitharthan, 2011). A recent study exploring risk and resilience found differential predictors of risk/resilience among transgender individuals with differing trans identities (Testa, Jimenez, & Rankin, 2014). Ample attention should be paid to clients' individual experiences and to experiences associated with multiple marginalized identities (Singh, 2013).

TA-CBT

Mental health providers should engage transgender clients with sensitivity and understanding and utilize interventions uniquely developed to address the risk and sources of resiliency relevant to well-being among members of the transgender community. Extant evidence indicates that CBT is an efficacious intervention for treating existing mental health issues such as depression (Rosselló & Bernal, 2009; Treatment for Adolescents with Depression Study [TADS], 2004), anxiety (Compton et al., 2004; Hoffman & Smits, 2008), and suicidal ideation (Stanley et al., 2009; Treatment for Adolescents with Depression Study [TADS], 2004) in general-population adolescents and adults.

Although CBT has long been established as an effective intervention to address many mental health challenges, it is important

that CBT interventions be modified to address the specific minority stressors (e.g., victimization, discrimination, microaggressions) routinely experienced by members of the transgender community. Mounting evidence suggests that effectively adapting empirically supported interventions, such as CBT, for use with specific minority populations can improve efficacy (Cardemil, 2010; Interian, Martinez, Rios, Krejci, & Guarnaccia, 2010; Rossello′ & Bernal, 2009). Moreover, to address the practice gaps associated with mental health treatment for transgender and sexual minority populations, Haas and colleagues (2011) recommend "adaptations to LGBT people of mental health interventions and therapies that have been established to be effective among the general population" (p. 36). Although CBT has yet to be studied empirically with transgender clients, it represents a promising approach to address stressors associated with poor mental health among minority clients (see Austin & Craig, in press; Craig et al., 2012; Duarté-Vélez, Bernal, & Bonilla, 2010).

Clinical Considerations and Applications

The following section discusses an adapted TA-CBT for use with transgender individuals suffering from depression, anxiety, and/or suicidality. The development of TA-CBT was part of a larger project to develop affirmative CBT interventions for youth and young adults experiencing stress as a result of intersecting cultural and sexual or gender minority identities (Austin & Craig, in press). Within the context of an Adapt and Evaluate framework (Feldstein Ewing, Wray, Mead, & Adams, 2012) for intervention development, a community-based participatory approach was used to guide the process. The adaptation process included the integration of content garnered from focus groups conducted with culturally diverse sexual and gender minority youth. Moreover, in an effort to further ensure the relevance of the adaptations to transgender individuals as well as lesbian, gay, bisexual, and queer persons, the project development team included both transgender and cisgender identified members.

Cognitive theory provides the foundation for CBT approaches, which suggests that our emotions and behaviors are influenced by how we perceive events (Beck, 1993). CBT encourages individuals to formulate alternative ways of thinking about situations and problems, which in turn prompts emotional and behavioral changes (Beck, 2006). CBT approaches focus on identifying, evaluating, and changing maladaptive thoughts and behaviors. As result of being consistently exposed to transphobic attitudes, beliefs, and behaviors, transgender individuals may develop negative patterns of thinking about themselves and their futures, which in turn affect emotional and behavioral responses. Helping clients view their identities, circumstances, and futures in alternative, more trans-affirming ways will affect feelings of despair, hopelessness, and anxiety. In turn, this will influence maladaptive behavioral responses associated with these emotions, such as substance use, isolation, and suicidal behaviors. Given the minority-identity based stressors regularly experienced by transgender individuals, the minority stress model and a trans-affirmative perspective are used as the orienting frameworks to guide the adaptation. A full review of TA-CBT is beyond the scope of this manuscript; however, Table 1 provides a summary of the eight-session TA-CBT model. Although TA-CBT is a manualized intervention, it is intended to be implemented flexibly to meet the distinct needs of each client. Furthermore, it is expected that clinicians recognize the diversity within the transgender community and thus differentially engage dimensions of risk and resilience within the clinical practice setting based on client circumstances. The ensuing sections illustrate the implementation of various components of TA-CBT in a manner that is relevant and affirming for transgender clients.

Psychoeducation

Particularly critical to TA-CBT is a focus on helping clients recognize and understand the relationship between transphobic experiences and feelings of stress, anxiety, depression, hopelessness, and suicidality. The psychoeducational component of TA-CBT is critical to creating a safe, trans-affirmative environment in which a client's experiences with discrimination, harassment, microaggressions, and violence can be voiced, acknowledged, and validated.[1] Moreover, these experiences can be processed through a minority stress lens, allowing clients to better understand the development and maintenance of their own mental health issues. In this way, clients begin to move away from a view of themselves as "disordered" and "pathological" toward an affirming view of themselves as "doing their best to cope with complex and often hostile external circumstances."

As one component of the psychoeducational sessions in TA-CBT, the clinician uses a trans-discrimination inverted pyramid worksheet to illustrate the effect of transphobic discrimination on feelings of stress and distress among transgender people. This serves to affirm the existence of discrimination and connect it to mental health stressors. For instance, a clinician might describe the worksheet in the following manner:

> On the top level, we have the cultural beliefs or the messages of discrimination from society (e.g., transgender people are disordered). Then we have the institutional level which is about how laws, government, businesses, media, churches, and other big systems send negative messages what it means to be transgender (e.g., being transgender is a sin; absence of legal protections in the workplace related to gender identity). Next is the interpersonal level which is how friends and family and other people treat us and/or react to our transgender identities (e.g., being kicked out of the house for cross-dressing; being bullied at school; being laughed at in public places). Finally, we have the individual level which is how we think about ourselves and how we feel inside (e.g., There is something wrong with me; I feel hopeless about my future). When we are inundated with negative messages about what it means to be trans, we start to believe the messages that we hear, and feel bad about ourselves. We may even want to hurt ourselves. All these layers of antitransgender sentiment weigh heavily on us, creating negative thoughts, and feelings of stress, depression, anxiety, and hopelessness.

The psychoeducational phase of TA-CBT proceeds to explore the various ways in which individuals can affect transphobic discrimination by introducing the idea of empowering oneself to adaptively challenge transphobic barriers in oneself (e.g., negative self-beliefs, maladaptive behaviors) and society (e.g.,

[1] This approach was informed by curricula and training materials previously developed at The Network/La Red, Boston, MA, and the Boston Alliance for Gay Lesbians and Transgender Youth (see Quinn, Santiago, Nichols, & Leventhal, 2010).

Table 1
Transgender-Affirming Cognitive Behavior Therapy (TA-CBT) Curriculum Summary

Session	Theme	Activities
1	Introduction to CBT and understanding minority stress	• Introductions • Discussing the theory and purpose of CBT approaches • Exploring stress and minority stress • Understanding the causes of stress in our lives
2	Understanding the effect of antitransgender attitudes and behaviors on stress	• Check in and review • Examining transphobia at the individual, institutional, and cultural level • Identifying how transphobia affects thoughts, feelings, and behaviors • Fostering strategies for coping with and combating transphobia at all levels
3	Understanding how thoughts affect feelings	• Check in and review • Distinguishing between thoughts and feelings • Exploring how thoughts influence feelings and behaviors • Identifying counterproductive thinking patterns • Recognizing negative self-talk and feelings of hopelessness • Learning thought stopping
4	Using thoughts to change feelings	• Check in and review • Increasing positive thinking and feelings of hope • Changing negative thoughts to positive thoughts • Challenging negative thinking and internalized transphobia through the ABCD method
5	Exploring how activities affect feelings	• Check in and review • Examining the effect of various activities on feelings • Identifying supportive and identity-affirming activities • The effect of trans-affirming activities on feelings
6	Planning to overcome counterproductive thoughts and negative feelings by building hope	• Check in and review • Distinguishing between clear and unclear goals • Identifying short-, mid-, and long-term goals • Fostering hope for the future (hope box)
7	Understanding the effect of minority stress and antitransgender attitudes/behaviors on social relationships	• Check in and review • Antitransgender discrimination can lead to less contact with others; being less assertive; or feeling shy, angry, or uncomfortable around others • Responding to discrimination or harassment in social situations • Learning to be assertive
8	Developing safe, supportive, and identity-affirming social networks	• Check in and review • Maintaining a healthy social network: Attending to thoughts, expectations, feelings, and behaviors within relationships • Identifying a plan for building a supportive network

joining a trans advocacy group, starting a blog about being genderqueer; writing letters to the editor to challenge transphobia, participating in transgender awareness events). Trans-specific psychoeducation is imperative for affirmative practice aimed at helping transgender clients recognize, sometimes for the first time, the effect that discrimination and stigma have on mental health and the transformational power of challenging negative self-beliefs, connecting to a supportive community, and advocating for oneself and one's community (Craig et al., 2012). It must be recognized that although we are presenting psychoeducation as one of the first phases of treatment, psychoeducation may continue throughout the intervention or be introduced at any point within the intervention on the basis of the individual client's needs.

Challenging Transphobic Negative Self-Beliefs

TA-CBT focuses on changing maladaptive behaviors by recognizing and modifying problematic ways of thinking about issues that may be particularly salient for transgender individuals. Being transgender in a transphobic society can negatively affect thoughts and beliefs about oneself and in turn cause feelings of low self-worth, anxiety, and depression. Acknowledging and challenging one's negative thoughts about being transgender in a safe and supportive environment may decrease transphobic thoughts and feelings. For example, a transgender individual who feels "unlovable," " deviant," and "disordered" can learn to challenge these thoughts and replace them with more trans-affirming ones (e.g., I am unique and lovable, there are infinite, equally valuable ways of experiencing gender). TA-CBT helps facilitate the recognition of the effect that certain thoughts (e.g., "I am worthless," "I don't deserve happiness") have on emotions (e.g., angry, despairing, hopeless) and eventually behavior (e.g., engaging in unprotected sex, using drugs, withdrawing from the world). TA-CBT also facilitates the development of improved coping skills. Transgender clients are taught to replace maladaptive coping behaviors (e.g., isolating, engaging in substance use) with more effective and

affirming coping skills (e.g., listening to or playing music, attending a transgender support group, accessing two-spirit support online) (Beck, 2006; Collazo et al. 2013).

Being exposed to negative messages about and stereotypes of transgender people may lead to the adoption of negative self-beliefs. Adapting cognitive strategies put forth by Leahy (2003) to target trans-specific issues can be very useful for this component of TA-CBT. Negative self-beliefs can be challenged by looking for variations in a transphobic-specific belief. For example, if a client shares the following belief—"I will never live a normal life because I am trans"—then the clinician can help the client identify and thoroughly explore instances when this thought is challenged for them and/or when they believe this thought less. For instance, a female-to-male (FTM) transgender client might acknowledge that watching YouTube videos of transgender individuals documenting their successful transitions has affirmed his trans identity and gives him a sense of hope. Likewise, a male-to-female (MTF) client may share that watching shows or reading about successful transgender women (e.g., Lynn Conway, PhD; Laverne Cox, Amanda Simpson) helps to erode her own negative self-beliefs. Furthermore, a clinician might create an opportunity for a Two-Spirit identified individual to recount the pride felt when reading historical accounts of Two-Spirit persons being revered and honored in traditional native cultures. Negative thinking and hopelessness may be particularly ingrained for clients that have experienced high levels of minority stress. This underscores the importance of clinicians that are firmly grounded in a trans-affirmative perspective and well educated about the diversity of trans-specific resources and supports so that specific prompts relevant to the distinct needs and experiences of each client may be provided.

Hopelessness and Suicidality

TA-CBT is particularly well suited to help modify cognitive cycles that promote hopelessness. For many transgender clients there are periods of time in which they feel hopeless about ever being able to live happily as their "true" or "authentic" selves (e.g., achieving congruity between internal and external experiences of gender); hopelessness is one of the primary predictors of suicidality (McMillan, Gilbody, Beresford, & Neilly, 2007; Ribeiro, Bodell, Hames, Hagan, & Joiner, 2013). TA-CBT helps clients recognize the flaws in their thinking. For instance, if a client is thinking "I will never be able to transition; it will never happen for me," then they can learn to modify their thinking style in the following way: "Although it may be challenging, I will be able to transition; many others have done so and I can too." Likewise, if a genderqueer client who does not ascribe to the gender binary is thinking "There is no place for me in this world; I will never fit in," then they can learn to modify their thinking as follows: "There are people who will accept me exactly as I am; there are other people who feel like I do; I am not alone."

New thinking strategies are taught, modeled, and reinforced consistently throughout the intervention process. This repetition is particularly important for transgender clients who, as result of pervasive experiences of discrimination, may have had many of their negative expectations realized, resulting in fear, distrust, and hopelessness about a positive future.

One CBT strategy particularly useful for reducing hopelessness associated with suicide is the use of a Hope Box (Brown et al., 2005). The clinician works with the client to create a box containing personalized objects or symbols that symbolize life experiences, reasons for living, aspects of life that are valued, and sources of social support and interpersonal connection (Brown et al., 2005; Ribeiro et al., 2013). Because many transgender individuals, particularly transgender youth, may feel a sense of hopelessness that things will ever change or get better, such a strategy may prove particularly beneficial.

Consistent with the rationale for the "It Gets Better" media campaign, which was aimed at preventing despair and suicide among LGBQ & T youth by providing tangible, visual evidence of hope that things can and do get better Craig, McInroy, Allaggia, & McCready (2014) a Trans-Affirmative Hope Box can provide tangible and/or symbolic reminders that increase feelings of worthiness and belonging and challenge hopelessness (Ribeiro et al., 2013). Examples of items that may be included in a Trans-Affirmative Hope Box are photos of supportive friends or family members, photos of items associated with pets (e.g., tag), a list of future goals or plans (e.g., college they want to attend, trips they intend to take, plans to speak at a transgender awareness event), photos or logos associated with safe and joyful places (e.g., LGBQ & T community center logo, genderqueer pride button, postcard from a vacation), favorite things (e.g., card from favorite restaurant, lyrics to favorite song, card from the surgeon they intend to use for gender-confirming surgeries), role models (e.g., Dean Spade, Lana Wachowski, Laverne Cox), self-affirmations and encouraging mantras (e.g., I am a survivor, I can create the life of my dreams, I am a proud gender rebel), and sources of success or pride (e.g., report card, recognition at work, original poem or song). Because each client's stressors and inspirations are unique, it is important for clinicians to work closely with clients to help them identify personalized, meaningful items for inclusion. To maximize the benefits of this activity, clients should be instructed about the importance of reviewing the material included in their Hope Box when they are feeling particularly isolated, disconnected, and hopeless (Brown et al., 2005; Ribeiro et al., 2013).

As technology becomes increasingly critical to clinical service provision, a Virtual Hope Box (VHB) app for smart phones and corresponding downloadable clinician's manual have been created to support contemporary mental health needs (http://www.t2.health.mil/apps/virtual-hope-box). Because the items within any VHB can be codeveloped by the client and clinician working together, and clients can have access to their VHB wherever they are, it may represent a particularly relevant and effective way to engage clients in the Trans-Affirmative Hope Box activity.

Encouraging Trans-Affirming Social Connectedness

As a result of feelings of discomfort and anxiety because of a history of discrimination related to a transgender identity, some transgender individuals struggle for a sense of belonging and social connectedness (Grant et al., 2010; Ryan, Russell, Huebner, Diaz, & Sanchez, 2010). TA-CBT aims to help transgender clients understand how prior experiences with transphobic discrimination lead to current experiences of isolation and disconnectedness and to develop the skills necessary to create and maintain a support network. A clinician can provide examples of behavioral responses

for clients to explore such as (a) less contact with people (e.g., being afraid that people will judge or harass you so avoiding all people); (b) feeling uncomfortable, shy, or angry with other people (e.g., having bad past experiences can make you afraid to connect with someone new); (c) being less assertive (i.e., not expressing what you like or do not like, e.g., being afraid to stand or speak out because you do not want to risk being noticed or ridiculed); and (d) being more sensitive to being ignored, criticized, or rejected (e.g., anytime someone is rude to you, you think, "Is it because I am a transgender?").

Because disconnectedness is related to hopelessness and even suicide (Ribeiro et al., 2013), an important aspect of TA-CBT is helping clients find people, places, or activities that "affirm" who they are. One strategy for doing so is to have client's identify and develop their support network. A client is asked to create a visual representation of her/his/their support network using a diagram or ecomap. The client is then asked to assess whether the support network is adequate. If it is too small, then new ways to grow the support network can be explored. Going to local transgender events, groups, or volunteering and joining online support groups, blogs, or social networking sites (e.g., Facebook, Tumblr, YouTube channels) can be effective ways to meet transgender friends and supportive allies.

In addition to developing a supportive social network, an emphasis is also placed on maintaining these important relationships. The clinician assists in identifying strategies for sustaining supportive relationships, such as maintaining frequent contact (even if just by phone social media, or e-mail), challenging negative thoughts that could undermine the relationship (e.g., she did not call me last week so that means she is sick of me; they will not want to go out with me after they get to know the real me), and learning to communicate thoughts and feelings honestly and assertively (rather than passively or aggressively).

Conclusion

Empirically supported interventions such as CBT are recognized as the gold standard for addressing serious mental health concerns (Chambless & Hollon, 1998; Chambless & Ollendick, 2001). However, when working with minority populations, empirically supported interventions may need to be adapted to ensure that targets of intervention specific to that minority group are addressed (Cardemil, 2010). For the transgender community, this includes attention to the effect of transphobia on multiple aspects of well-being (e.g., self-perception, feelings of hopelessness, experiences of discrimination, and victimization). Moreover, successful applications of adapted interventions require that the intervention be rooted in a culturally affirming worldview (e.g., a trans-affirmative approach to practice). This article offers a framework for successfully engaging in TA-CBT in clinical practice. Given the effect of transphobic discrimination and victimization on the mental health of transgender clients and the increasing visibility of transgender-identified individuals in contemporary society who may seek mental health services, clinicians have an ethical responsibility to identify and utilize the best available clinical interventions. Although it is important to acknowledge that TA-CBT is in the early phases of development, with no published efficacy data, the approach is rooted in a trans-affirming perspective and incorporates targets of intervention consistent with the minority stress model while retaining the core components of traditional CBT approaches. The authors are in the process of analyzing data associated with a one group pretest, posttest design pilot study assessing the acceptability, feasibility, and preliminary effectiveness of affirmative CBT for subgroups of transgender, lesbian, gay, bisexual, and queer youth in Canada ($n = 34$). However, it is critical that future research more rigorously examine the level of empirical support for TA-CBT through randomized clinical trials. Nevertheless, because there is a paucity of scholarly articles discussing the clinical application of interventions for transgender individuals, this article represents an important contribution to advancing clinical work with an underserved population.

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