Suicide and the Transgender Experience: A Public Health Crisis

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Given the rise in the visibility of the trans community, increasing attention has been paid to mental health disparities in trans populations. Specifically, research findings conclude that suicide is considered 1 of the major health disparities in trans populations. Across several studies it has been found that 40% or more of trans people have attempted suicide at least once in their lifetime. There are a multitude of reasons why trans people experience suicidal ideation and attempt suicide, with minority stress being theorized as a primary cause. To address minority stress-focused suicide, a psychologically adapted public health model is proposed. This model includes the following steps for preventing suicidal thoughts and behaviors: (a) defining the issue, (b) identifying causes and risk factors, (c) developing and testing psychological interventions, and (d) implementing psychological interventions. Key components discussed include the evidence and practice for supporting trans people through their social and medical transition processes, which have been demonstrated to improve mental and physical health outcomes. The implications of the prevention model indicate that psychologists play a key role in supporting trans people, regardless of the clinical concerns that bring them to therapy.

Public Significance Statement
This article explores the rates of suicide in the transgender community. The authors discuss the challenges faced by transgender people that may increase the risk of suicidal thinking or behavior. The authors provide recommendations for how suicidal thinking and behavior may be addressed in the clinical setting.

Due to greater social attention and representation, trans[1] people of all ages are experiencing more visibility than at any other point in U.S. history (Berberick, 2018). Content analyses demonstrated that psychological research is one area where visibility has had an upward trend (Moradi et al., 2016). Despite more recent attention, trans populations historically have been, at best, ignored (Friedrich & Filippelli, 2019) or victimized (e.g., Clements-Nolle, Marx, & Katz, 2006; Rimes, Goodship, Ussher, Baker, & West, 2019). Even with an increase in visibility, trans people continue to be at risk for violence and discrimination (James et al., 2016). These experiences contribute to trans people reporting one of the highest rates of suicide attempts of any marginalized group (see Moody & Smith, 2013; Tebbe & Moradi, 2016). The primary aim of this article is to use a public health model to explain the psychological phenomenon of suicide in trans communities and to extend this model to provide recommendations for psychological interventions. The model is used to demonstrate how the current climate for trans people contributes to a public health crisis regarding psychological outcomes in the trans community.

[1] For the purpose of simplicity, the term trans will be used and is intended to be inclusive of all transgender (not cisgender) identities including but not limited to transgender, transsexual, gender nonbinary, gender diverse, cross dresser, and gender nonconforming, and the many cultural terms (e.g., hijra, muxe, fa'a'fafine, two-spirit, kathoey) used to identify people whose gender identity is or was different than the sex they were assigned at birth.

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Specifically, this article focuses on how violence and discrimination against trans people contributes to suicidal behavior, attempts, and completions in the trans community.

Mercy, Rosenberg, Powell, Broome, and Roper (1993) theorized a foundational public health model for preventing violence. Their model includes four steps to frame prevention: (a) defining the problem, (b) identifying causes and risk factors, (c) developing and testing interventions, and (d) implementing interventions and effectively measuring prevention. In the following sections, this model is adapted to address the role of psychologists in preventing suicide in trans communities.

Defining the Problem of Suicide

Defining the problem is the first step of Mercy et al.'s (1993) model in our translation to psychologists' role in suicide prevention in trans populations. As is the case with most psychological concepts, suicide is nuanced and complicated. Suicidality affecting trans people is a public health crisis that is largely ignored outside of the trans community. For example, even though the Centers for Disease Control and Prevention (CDC) reported that there was a rise in suicidal behavior across the United States (CDC, 2018), the document provides no mention of trans people. Nationwide data demonstrate that 40% of participants ($n = 27,715$; all of whom were trans) indicated a history of having attempted suicide at least once in their lifetime, which is nine times higher than the cisgender population (James et al., 2016). These data are compared with data indicating that approximately 4% of people in the United States attempt suicide on an annual basis (CDC, 2019). Lefevor, Boyd-Rogers,

Sprague, and Janis (2019) found statistically significant differences between trans and cisgender clients' suicidal ideation and suicide attempts. The researchers stated that trans people reported more current suicidal ideation (64% nonbinary; 57% trans; 36% cis women; 37% cis men) and more lifetime suicide attempts (49% nonbinary; 45% trans; 21% cis women; 13% cis men;) than cisgender people.

Theories Explaining Suicidality

Although the data and context are clear regarding rates of suicidality, the theoretical explanations for the rates and context are equally important to understand. This section explores interpersonal theory (IT; Joiner, 2005), minority stress theory (MST; Meyer, 1995, 2003), and intersectionality (Crenshaw, 1991).

Interpersonal Theory

Joiner's IT was developed to explain and define the reasons why people die by suicide (Joiner, 2005). Joiner noted that perceived burdensomeness and thwarted belongingness are the two primary elements that contribute to suicidal behavior. Joiner notes that the perception component of perceived burdensomeness is particularly noteworthy for this construct. Perceived burdensomeness for trans people can exist in many forms—for example, when a trans person asks for extra support in challenging discrimination or talking through experienced victimization, they may believe they are a burden to others (Testa et al., 2017).

Thwarted belongingness is the second aspect of IT (Joiner, 2005). Joiner stated "the need to belong is a human motive" (Joiner, 2005, p. 118). There are two aspects of trans people's experiences that are especially important with regard to thwarted belongingness. First, it is often the case that trans people believe that they are alone with their feelings, which can be an isolating experience. It is well documented that social connection is important in preventing suicide (Joiner, 2005; Testa et al., 2017). Second, trans people do not have protection from discrimination or other harmful behaviors (e.g., violence, mistreatment, harassment). As such, they may feel as though they do not have a place in society—which may serve to further disconnection from friends or other means of social support. Joiner indicated that social connection can be such a strong prevention technique for suicide that it often buffers perceived burdensomeness.

Minority Stress Theory

Minority stress theory was originally developed by Meyer (1995, 2003) as a way of understanding the contextual factors in the lives of lesbian, gay, and bisexual people. Meyer theorized that minority stress manifests on a spectrum: (a) distal (external) stress, (b) anticipation of distal

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stress, and (c) proximal (internalized) stress. Distal stressors are defined by experiences external to an individual that are prejudicial in nature (e.g., harassment or discrimination). Anticipation of distal stress is the accumulation of worries that something bad is about to happen. Proximal stressors include the ways that a person internalizes the challenges they face. When a trans person internalizes those difficulties it can lead to internalized trans phobia. Further, Meyer predicted that MST could be used to explain the differences in health outcomes for LGB people.

In their adaptation of MST to trans people, Hendricks and Testa (2012) theorized about suicide rates and risk in trans people. The authors noted that trans people who experienced discrimination were at elevated risk for suicide when compared with trans people who had not had those experiences. Adverse changes in federal policies and rules are examples of common distal stressors trans people face. Discriminatory policy changes set the environment for how people will and will not be treated and contribute to higher experiences of distal minority stress in LGBTQ populations (Gonzalez, Ramirez, & Galupo, 2018). As an example, one of President Donald Trump's executive orders during his presidency was a ban on trans service members from openly serving in the military (Lang, 2018; Norquist, 2019). Trans people are known to serve at higher rates than the general population (Gates & Herman, 2014; Harrison-Quintana & Herman, 2013). The executive ban has led to trans people living in fear of losing their jobs and of experiencing hostility from transphobic peers who are using the ban as a vehicle to harass trans service members (Pilkington, 2019).

Poorer general psychological outcomes have been directly linked to distal minority stress in trans populations

(e.g., Bockting et al., 2013; Lefevor, Boyd-Rogers, Sprague, & Janis, 2019; McLemore, 2018). Experiences of discrimination have been directly linked to increased suicidal ideation in trans veterans (Carter et al., 2019), "worst point suicidal ideation" in gender and sexual minorities (Salentine, Hilt, Muehlenkamp, & Ehlinger, 2019, p. 1), and suicide attempt risk in a community sample of trans people (Tebbe & Moradi, 2016).

In addition to distal stressors, proximal (or internal) stressors provide an additional explanation for psychological distress and suicidality. Proximal stress encompasses internal stress experiences that include (a) expectations of rejection or discrimination; (b) internalized stigma; and/or (c) concealing one's gender identity (Hendricks & Testa, 2012; Meyer, 1995, 2003). Regarding expectations of rejection or discrimination, Rood et al. (2016) found that trans people expected rejection and discrimination in clearly marked gender spaces, when meeting new people, and being able to "pass"[2] in their affirmed gender. They noted that primary psychological reactions included: anxiety, fear, depression, self-loathing, anger, and exhaustion. Testa et al.'s (2017) findings indicated a direct relationship between expecting rejection and suicidal ideation. The researchers also noted a link between internalized stigma (also known as internalized transphobia) and suicidal ideation. Research has also found connections between concealing one's gender identity and psychological distress (e.g., Timmins, Rimes, & Rahman, 2017), but has yet to find an association between concealment and suicidal ideation (e.g., Testa et al., 2017). Haas, Rodgers, and Herman (2014) reported that the lack of connection between concealment and suicidal ideation or behaviors may be due to an underlying protective factor whereby trans people may experience less discrimination or rejection if they are not out or perceived as trans by others. However, it is also possible that research has not yet found a connection because there could be issues with the measurement that focuses on concealment.

Testa et al. (2017) extended Joiner's theory by exploring suicidal ideation in trans people through the lenses of the MST and IT. The authors examined how internal stressors were related to thwarted belongingness and perceived burdensomeness (Joiner, 2005). Results indicated that rejection, nonaffirmation, and victimization were related to suicidal ideation through internalized transphobia and negative expectations. Further, the results revealed that internalized transphobia and negative expectations were associated with suicidal ideation through thwarted belongingness and perceived burdensomeness.

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[2] Passing is a controversial concept in trans communities. It is never correct to assume that being able to pass is a goal for a trans person.

Intersectionality

Although MST provides a framework for why disparities exist, specifically related to trans identity, it does not provide an overall picture of how power and oppression intersect with privilege. Intersectionality theory fills this gap (see Crenshaw, 1991). In the field of psychology, intersectionality theory has primarily been seen through the lens of "weak intersectionality." Weak intersectionality is conceptualized as primarily focusing on an individual's multiple identities—for example, understanding how race, gender, and social class interact with one another for each individual person or for a group of people (Dill & Kohlman, 2011). "Strong intersectionality" highlights how systems of inequity uniquely impact individuals who hold membership in varied social groups (Dill & Kohlman, 2011; Grzanka, 2014). Using both a weak and strong intersectional approach (see Adames, Chavez-Dueñas, Sharma, & La Roche, 2018), psychologists can interpret how overall oppression and multiple identities have contributed to suicidal ideation and suicide attempts in trans populations.

From a weak intersectionality perspective, research has consistently shown that trans people with marginalized identities (e.g., race, socioeconomic status, immigration status, disability) experience social determinants of health (e.g., poverty, homelessness, chronic physical and mental health concerns; see Budge, Thai, Tebbe, & Howard, 2016). The impact of marginalization due to multiple minority statuses (trans identity plus additional minority identities) includes higher rates of HIV, unstable housing, and unemployment (James et al., 2016). Scholars have noted the importance of attending to multiple marginalized identities—specifically, they recommend the following: (a) psychologists attend to their own intersectional identities to understand how to assist trans people with multiple marginalized identities, (b) address intersectionality with trans clients, (c) challenge assumptions of trans people of color, specifically, (d) acknowledge differences, (e) assess and acknowledge resilience and strengths of trans people, and (f) provide affirming resources to trans people with multiple marginalized identities (American Psychological Association, 2015; Chang & Singh, 2016; Chang et al., 2018). Regarding strong intersectionality, Budge and Moradi (2018) noted the importance of psychologists addressing power when working with trans people. They recommended explicitly addressing gender dynamics early on in the working relationship. They also suggested privileging trans people's experiences and the need to avoid assumptions. Finally, use trans affirmative methods and a social justice framework in interventions while staying informed on how oppression and power can manifest in working relationships with trans people.

Risk Factors Contributing to Suicide in Trans People

After defining the issue, the second phase of Mercy et al.'s (1993) model is to identify risk factors. Beyond understanding suicide rates and the underlying reasons for the disparity in those rates, it is also important to consider both risk *and* protective factors. Mercy et al. (1993) address only risk factors. It is important to address protective factors when working with people who are at risk for suicide as these may be the difference in acquiring support or attempting suicide. A risk factor is a "characteristic, variable, or hazard that increases the likelihood of development of adverse outcome" (Mościcki, 1997, p. 500). General risk factors for suicidal behaviors include prior suicide attempts, mental health concerns, substance abuse, neurochemical make-up, family risk factors, possession of firearms, physical illness, specific types of medications, and oppression because of one's marginalized identity (Mościcki, 1997). Protective factors are those experiences which make it less likely that a person will attempt to end their life. Protective factors in trans populations include support from family and friends, optimism, and resilience (Moody & Smith, 2013). It is a limitation that Mercy et al. (1993) focused only on risk factors in their model. After providing information about risk factors in this section, protective factors will also be discussed.

According to the CDC (2018), there are several factors that contribute to suicidal thoughts, attempts, and completions. These factors include (but are not limited to): relationship problems, crises in the past or in the upcoming 2 weeks, physical health problems, criminal or legal problems, loss of housing, job or financial problems, or problematic substance use (American Foundation for Suicide Prevention, 2020; Chen & Roberts, 2019). James et al. (2016) reported staggering statistics for many of these factors as they are experienced by trans people—these types of loss are related to distress and can happen at any phase in a trans person's identity process but may be especially salient when coming out (Budge et al., 2013).

Individual Risk Factors

Psychological distress and substance use. In one of the earliest studies of suicidality in trans communities, Clements-Nolle, Marx, and Katz (2006) reported that 32% of the people who participated in their study had attempted suicide. The authors noted that depression and history of substance use were predictors of suicide attempts; no differences were found between trans men or women in this sample. Tebbe and Moradi (2016) found an association between increased suicide risk and depression, mediated by minority stress factors. The study also noted that 72% of the sample reported suicidal ideation in the past 12 months and that 20.5% indicated that it was likely or very likely they

would attempt suicide in the future. Cochran and Cauce (2006) examined data that explored the differences in substance abuse between heterosexual and LGBT individuals who sought treatment for substance abuse. LGBT people were more likely to "endorse a higher frequency" (Cochran & Cauce, 2006, p. 143) of substance use than their heterosexual counterparts. LGBT people were also more likely to have experienced homelessness, reported physical health problems, been a victim of domestic violence, and have a history of mental health concerns (Cochran & Cauce, 2006). Haas et al. (2010) findings indicated that as many as 800 in 100,000 trans people died by suicide, with one of the primary risk factors being substance use.

Relationship loss.   Relationship loss or stress is one of the primary stressors that contributes to suicidal ideation and attempts (Stack & Scourfield, 2015; Yip, Yousuf, Chan, Yung, & Wu, 2015). Relationship loss, often described as a loss of social support, in the trans community can contribute to suicidal ideation and attempts (Budge et al., 2013; Nemoto, Bödeker, & Iwamoto, 2011). Having a connection to friends and family is an important protective factor against hopelessness and suicide in the trans community (Moody & Smith, 2013).

Physical health.   Physical health concerns have been directly connected to increased suicidal ideation and attempts (Chen & Roberts, 2019). For many trans people, physical health and medically related transition care are important (James et al., 2016). The disparity regarding a lack of insurance coverage for trans people may be directly related to physical health-related distress (e.g., dickey, Budge, Katz-Wise, & Garza, 2016). There are 36 states and four U.S. territories that have no protections for trans people with regard to health insurance (Movement Advancement Project, 2020). Twenty-four states have no policy regarding Medicaid coverage and eight states prohibit coverage of trans-related health care through Medicaid (Movement Advancement Project, 2020). dickey et al. (2016) reported that trans people were more likely than cisgender people not to have health insurance or a primary health care provider. As a result, trans people were more likely to use the emergency department or urgent care to access basic health care services. Basic health care services would typically be accessed through a primary care provider (e.g., physician, nurse practitioner, endocrinologist), but trans people often avoid seeking health care due to discriminatory experiences by health care providers (Jaffee, Shires, & Stroumsa, 2016), which often leads to even worse outcomes, including increased suicidality (Kattari, Walls, Speer, & Kattari, 2016).

Socioeconomic status.   Economic concerns such as the loss of a job, homelessness, and legal issues can all contribute to feelings of hopelessness and despair, which in turn can lead to suicidal ideation and attempts (Chen & Roberts, 2019). Economic concerns are relatively common for trans people and

have been demonstrated to be related to suicidal ideation and attempts (Tebbe & Moradi, 2016; Testa et al., 2017).

Gender-based victimization.   An additional correlate of suicide attempts include gender-based victimization (Goldblum et al., 2012). The authors reported that participants who had experienced gender-based violence were four times as likely to have attempted suicide than those who had not. They stated that psychologists must address victimization at "individual, school, family, and community" (p. 472) levels. Clements-Nolle et al. (2006) noted that a history of forced sex and gender-based discrimination and victimization predicted suicidal ideation in their sample.

Stigma.   Perez-Brumer, Hatzenbuehler, Oldenburg, and Bockting (2015) reported that 32% of their sample had attempted suicide at one point in their lives and that the findings included direct associations of lifetime suicide attempts with structural and internalized stigma. This was in addition to having a history of attempting suicide in the past 12 months. Bauer, Scheim, Pyne, Travers, and Hammond (2015) argued that it may be more important to attend to recent suicide attempts (within the past 12 months) to understand how to intervene. Although the authors did not delineate what providers should focus on with their trans clients with a recent history of suicide, gaining an understanding of the stressors faced by a client and the resources the client has to address those stressors may help the trans person to avoid acting on suicidal thoughts in the future. Research indicated that individuals who have attempted suicide in the last 12 months are 78% more likely to attempt in the upcoming year (Borges et al., 2006). The recency of past suicide attempts being related to risk of additional suicide attempts can be linked to the numerous risk factors that may be clustered together in time (e.g., job loss, relationship loss, etc.). Bauer et al. (2015) reported that 35% of participants had experienced suicidal ideation over the past year and 11% had attempted suicide. Their results revealed that trans people with more social support and less internalized stigma were at reduced risk of suicidal ideation and attempts.

Protective Factors

Resilience.   Resilience as a personal characteristic has been identified as a key protective factor in preventing suicide in trans populations (Johnson, Gooding, Wood, & Tarrier, 2010; Moody & Smith, 2013). Resilience can manifest at individual and community levels (dickey, 2017; Perrin & Tabaac, 2017). Individual resilience is related to the manner in which a person, through their own grit and determination, is able to bounce back from a difficult situation (Singh, 2012). As a community, trans people exhibit resilience when they engage in community events such as support groups, trans marches, and international days of awareness (e.g., attending the Transgender Day of Remem-

brance or the Transgender Day of Visibility; Singh, 2016). These events not only bring people together, but they also provide visibility for the community. Research has shown that many trans people exhibit resilience in reaction to oppression and systemic barriers (Singh, 2012; Singh, Meng, & Hansen, 2014). According to Johnson, Gooding, Wood, and Tarrier (2010), resilience buffers suicide risk by providing a cognitive process for an individual to incorporate positive self-appraisals in moments that are paired with suicidal ideation. Their results demonstrated that participants who were experiencing stressful life events were able to decrease their suicide risk if they integrated more positive self-appraisals.

Social support.　Social support is considered a key factor in preventing suicide (Kleiman & Liu, 2013). Research focused on trans populations noted that social support may be one of the most important factors in reducing suicidal ideation and suicide attempts (see Mustanski & Liu, 2013; Trujillo, Perrin, Sutter, Tabaac, & Benotsch, 2017). Social support mediated the relationship between minority stress and suicidality (Tebbe & Moradi, 2016).

Sociopolitical climate as a risk factor.　Examining the sociopolitical climate can also provide an understanding of how hopelessness and despair can be conceptualized in the trans community. During the 8 years of the Obama administration, numerous legal protections were implemented for trans people. These protections included, but are not limited to: (a) recommendations for school administrators as to how to address the needs of trans students (National Center for Transgender Equality [NCTE], n.d.); (b) changes in the rules in the Department of Defense that allowed trans people to serve openly in the military (Kerrigan, 2012); and (c) rules regarding Medicare coverage of trans-related health care (NCTE, 2020).

In 2016 when President Trump took office, he and his administration began dismantling the recently implemented protections for trans people (Mezey, 2020). Though there are multiple examples of how the administration has dismantled protections, a few examples stand out. In 2017, the administration issued a memorandum indicating that Title VII does not prohibit discrimination based on gender identity. In 2017, President Trump issued a directive to ban transgender people from serving in the military. Finally, in 2018 the U.S. Department of Health and Human Services provided a definition to indicate that gender was based on biology (indicating that sex assigned at birth should be the main factor in the definition; Cobb & McKenzie-Harris, 2019). A major theme of these rule and policy changes is that trans people have lost or will lose protections at the federal level, which is inherently discriminatory (Wilson, 2018). The accumulation of these changes puts trans people at further risk for psychological distress, including suicide, due to the loss of protection under federal law (Flaskerud & Lesser, 2018).

Develop, Test, Implement, and Assess Prevention Strategies

The final two steps in Mercy et al.'s (1993) public health approach are to develop, test, and implement interventions and to assess the effectiveness of prevention efforts. For the purposes of this work, these steps have been combined. Using a social-ecological model (National Center for Injury Prevention and Control [NCIPC], 2019) this section will explore the manner in which suicide can be addressed on individual, relationship, and societal levels. Psychologists are expected to provide support to clients in ways that are supportive, avoid harm, and collaborate with other providers (American Psychological Association, 2017). Scholars have indicated that psychologists (and other health care providers) must attend to the ways that sociocultural risk factors impact the lives of trans people (Chang et al., 2018).

Prevention Strategies Focused on the Individual

According to the NCIPC (2019), prevention strategies at the individual level promote attitudes, beliefs, and behaviors that will assist in preventing violence (in this case, suicide, or self-violence). Counseling and psychotherapy must be considered as a first-line intervention. Psychotherapy is not limited to treating suicidal behavior and attempts but is considered one of the foremost strategies at the individual level in preventing suicidal ideation and behaviors (Zalsman et al., 2016). Little attention has been paid to psychotherapy as a primary intervention tool for trans people (Budge, Israel, & Merrill, 2017), let alone as a specific tool to prevent suicide. A content analysis indicated that only 10 studies had been published that discussed the role of psychotherapy in trans people's lives and that, as of 2018, no psychotherapy intervention studies had ever been published regarding trans people (Budge & Moradi, 2018).

One particular psychotherapy study shows promise regarding general improvement in psychological functioning and suicidal ideation. Budge, Sinnard, and Hoyt (2018) conducted a randomized controlled trial that compared a trans affirmative therapy (TA) intervention to a building awareness of minority stressors (BAMS + TA) therapy intervention. Results indicated that both groups demonstrated clinically significant improvement in psychological outcomes, whereas the BAMS group showed slight improvements over the TA group in reducing minority stressors. As well, 74% had a change in psychological diagnoses, such that they had met criteria for a *Diagnostic and Statistical Manual of Mental Disorders* (*DSM–5*; American Psychiatric Association, 2013) diagnosis at baseline but did not meet criteria at termination. The suicide statistics are slightly more nuanced—at baseline, 26% of participants reported suicidal ideation and at termination 42% reported suicidal ideation. At the 6-month follow-up 16% of participants reported suicidal ideation. Qualitative results indi-

cated that clients reported a reduction in suicidal ideation throughout the course of treatment, but that termination of therapy caused fears about an individual's ability to cope—the follow-up results indicated that clients' self-efficacy improved over the course of time. No clients attempted suicide during the trial or during the 6-month follow-up. Even if the interventions in the trial were not specifically designed to address suicidality, they address psychological distress and minority stress—both factors that contribute to the high rates of suicidality in trans populations.

On an individual level, Matsuno and Israel (2018) noted the importance of focusing on resilience as a prevention strategy for trans clients in psychotherapy. For example, they supported the importance of hope-based or positive psychology interventions for trans clients (e.g., Budge, Orovecz, & Thai, 2015; Feldman & Dreher, 2012). They pointed out that interventions that focus on self-compassion (see Neff & McGehee, 2010) can improve self-worth and self-acceptance for trans clients.

Additional individual interventions that have been shown to reduce suicide include medical interventions. There is a body of research that has demonstrated a relationship between trans individuals obtaining transition-related care (e.g., hormones and gender confirmation surgery [GCS]) and a reduction in suicidal ideation. In their study, Tucker et al. (2018) found that trans individuals who had undergone hormone therapy and GCS reported lower suicidal ideation within the past year and past 2 weeks when compared with transgender individuals who had not received any medical treatments or only one medical treatment. Additional studies have indicated that suicidal ideation is significantly lower for transgender individuals who receive hormone therapy versus those who do not (see Bauer et al., 2015; Wilson, Chen, Arayasirikul, Wenzel, & Raymond, 2015). Regarding surgeries, some studies have found that even though there is a decrease in the trans sample's suicidal ideation, the suicidal ideation rates remained higher than the general population (e.g., Dhejne et al., 2016; Haas et al., 2014). In response to these findings, Bauer et al. (2015) conducted analyses to determine the relative risk reduction postsurgery and found that there was a 62% relative risk reduction postsurgery for the trans sample in their study. Additionally, Wilson, Chen, Arayasirikul, Wenzel, and Raymond (2015) found trans women who had breast augmentation reported lower suicidal ideation than those who had not had surgery or hormones.

Psychologists often play a key role in trans people obtaining hormone therapy and/or gender confirmation surgery. The World Professional Association of Transgender Health created the Standards of Care (SOC) for medical and mental health professionals' roles in assisting trans people with navigating medically necessary transition-related care (see Coleman et al., 2011). The role of psychologists in the SOC is often met with mistrust and wariness from trans clients (see Budge, 2015;

Chang et al., 2018) and with good reason. Mental health professionals are placed in a "gatekeeping" role whereby they must assess a trans person's competency to consent to medical treatment. Research indicated that many trans people had negative experiences with therapists in the role as gatekeepers (Mizock & Lundquist, 2016; Morris et al., in press), which provides an evidentiary basis for scholars detailing the reasons why this is the case (APA, 2015; Chang et al., 2018). James et al. (2016) noted that when mental health professionals have tried to stop trans people "from being trans," this increased suicide attempts by 149%. Though stopping someone from being trans could be interpreted in many ways, one way of interpreting this construct is to understand that mental health professionals may be stopping trans people from being trans by thwarting their medically necessary care. Thus, individual prevention strategies not only include ethical assistance for trans people in obtaining medically necessary transition care, but also include specific training for therapists who are in the gatekeeping role to understand the weight of this role (and the history and expectations for this role).

Prevention Strategies Focused on Relationships

Strategies that focus on suicide prevention at the relationship level can include family focused prevention (e.g., parenting skills), mentoring, and peer support. All of these interventions are designed to minimize conflict, enhance problem solving skills, and improve healthy relationships (NCIPC, 2019). One example of such an intervention was tested by Matsuno (2019). Matsuno (2019) created an online intervention to assist parents with specific skills regarding how to support their trans/nonbinary children. The intervention contained three modules that focused on emotional experiences, changing negative attitudes/beliefs, and changing behavioral intentions and self-efficacy. Pilot results indicated acceptability and feasibility; initial qualitative findings suggested that the intervention can assist parents of trans youth with increasing knowledge and empathy. Edwards, Goodwin, and Neumann (2019) proposed a family therapy framework for trans youth and their caregivers/parents. The framework was grounded in ecological theory to provide a conceptual model of how families can support trans people in any phase of their identity process.

Regarding romantic relationships, Spencer, Iantaffi, and Bockting (2017) described specific recommendations for psychologists who are assisting clients with the process of dating, having safer sex, and who are in different stages along the life span. In their study focusing on romantic relationships where at least one person identified as trans, Rossman, Sinnard, and Budge (2019) recommended communication practice, specifically discussing sexuality, gender roles, expectations, jealousy, and needed areas of support. May, Crenshaw, Leifker, Bryan, and Baucom (2019) indicated that couples-based suicide prevention techniques

can be useful in instances where one or more individuals in a relationship are experiencing suicidal ideation—these techniques, in alignment with recommendations from trans-specific relationship communication practices, may be useful ways to engage in suicide prevention.

Prevention Strategies Focused on Societal Issues

Strategies that focus on suicide prevention at the societal level should focus on limiting or eliminating social isolation, improving the climate, and developing processes and policies within school and workplace settings (NCIPC, 2019). Broader societal prevention strategies should focus on changing social norms (NCIPC 2019)—in this case, challenging systems that support discrimination and pathologization of trans people.

One strategy to challenge systemic issues is to focus on depathologizing gender identity. Because gender dysphoria is in the *DSM–5* (American Psychiatric Association, 2013) many trans people feel pathologized when they receive this diagnosis (Bockting & Ehrbar, 2005; Chang et al., 2018). Even though there were changes in the details of the diagnosis (e.g., change in the name, change in the location within the *DSM*, removal of the sexual orientation specifiers) the diagnostic criteria did not change. Further, the fact that gender dysphoria is considered a mental health disorder is problematic in that gender concerns have typically existed for much of a person's lifetime even if they do not come to understand this until later in life. For some people, the only way they are able to access medical care is to have a diagnosis of gender dysphoria. To address this issue, the World Health Organization made the decision to remove gender dysphoria from the listing of mental health disorders in the International Classification of Diseases (ICD; Version 11; World Health Organization, 2020). Rather than gender dysphoria, the condition is labeled gender incongruence and is located in a chapter of medical issues that are concerned with sexual health. Although this is a move in the right direction, being trans is not a sexual disorder. Most people who make a medical transition do so by engaging in hormone therapy (James et al., 2016). As such, scholars and advocates have indicated that using codes to identify the biological condition and not the identity are most appropriate, such as the commonly used nontrans specific ICD code 259.9 (unspecified endocrine disorder; Proctor, Haffer, Ewald, Hodge, & James, 2016). Similarly, there are codes used for genital surgery (e.g., 6241) for people who were born with an intersex condition or for people who have experienced an injury to their genitals that do not conflate surgery with gender dysphoria (Lane et al., 2018). Unless a psychologist is working in a health care setting, they are unlikely to use these diagnostic codes. However, as psychologists collaborate with medical providers, they can encourage the use of less pathological diagnostic procedures.

Psychologists are encouraged to talk frankly with their clients when there is a need to include a gender-specific diagnosis (e.g., referral for surgery or hormones). Clients may have strong feelings about being diagnosed with gender dysphoria (Chang et al., 2018). Having a conversation with clients about the use of a diagnosis may help to ease some distress. This conversation should not be belabored, but clients deserve an honest discussion so that they have the chance to voice their concerns.

Closing

In summary, this article explores the ways that trans people are significantly overrepresented in the numbers of people who attempt suicide. As mental health providers, psychologists are well-positioned to provide support to their trans clients and to work to change the unfavorable landscape that places trans people at risk for suicide. Until the needs of trans people are truly supported, be it through legislation or other institutional policy; trans people will remain at risk.

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