

2021

## The Gender Freedom Model: A Framework for Helping Transgender, Non-Binary, and Gender Questioning Clients Transition With More Ease

Rae McDaniel

*Practical Audacity Gender & Sex Therapy*

Laurel Meng

*Practical Audacity Gender & Sex Therapy*Follow this and additional works at: <https://digitalcommons.unf.edu/jcssw>

Part of the [Clinical and Medical Social Work Commons](#), [Clinical Psychology Commons](#), [Cognitive Behavioral Therapy Commons](#), [Community Health Commons](#), [Community Psychology Commons](#), [Counseling Psychology Commons](#), [Counselor Education Commons](#), [Multicultural Psychology Commons](#), [Other Mental and Social Health Commons](#), [Other Psychiatry and Psychology Commons](#), [Other Psychology Commons](#), [Other Social and Behavioral Sciences Commons](#), [Psychiatric and Mental Health Commons](#), [Psychoanalysis and Psychotherapy Commons](#), [Social Justice Commons](#), [Social Work Commons](#), and the [Theory and Philosophy Commons](#)

### Recommended Citation

McDaniel, R., & Meng, L. (2022). The Gender Freedom Model: A Framework for Helping Transgender, Non-Binary, and Gender Questioning Clients Transition With More Ease. *Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education*, 3 (2), 82-93. <https://doi.org/10.34296/03021064>

This Article is brought to you for free and open access by the Brooks College of Health at UNF Digital Commons. It has been accepted for inclusion in Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education by an authorized administrator of UNF Digital Commons. For more information, please contact [Digital Projects](#).

© 2021 All Rights Reserved

# The Gender Freedom Model: A Framework for Helping Transgender, Non-Binary, and Gender Questioning Clients Transition with More Ease

Rae McDaniel

Practical Audacity Gender & Sex Therapy

Laurel Meng

Practical Audacity Gender & Sex Therapy

Transgender/non-binary experiences and identities are often represented in academic literature through narratives of distress and are often pathologized through a medical lens. This holds implications for the field of psychotherapy, as interventions aimed to support transgender/non-binary individuals often focus solely on risk mitigation. This article presents a therapeutic framework that rests on three pillars—Play, Pleasure, and Possibility—as the focal points for reimagining work with transgender/non-binary clients. This model aims to help this population explore gender transition with more ease through building practical skills, cultivating personal and collective pride, and centering pleasure equity.

*Keywords:* transgender, non-binary, transgender health, gender affirming psychotherapy, gender transition

## Introduction

The field of transgender/non-binary healthcare has a storied history of pathologizing the transgender/non-binary experience, through the assumption that being trans means something has gone wrong in the normative process of gender identity development. In this viewpoint, practitioners believe the distress associated with a transgender/non-binary identity is caused by incongruencies between sex assigned at birth and gender identity, which is eased by social, medical, and legal transition (Bockting & Coleman, 2007). Physicians began to take notice of the transgender/non-binary experience in the late nineteenth and early twentieth centuries, introducing a number of terms in medical literature that suggested the incongruence that transgender/non-binary people felt was some form of psychopathy or psychotic delusion (Stryker, 2017). Notably, this medicalized approach originated in the United States and Western Europe, with many non-Western cultures and countries celebrating gender diversity beyond the Western binary system of gender (Thorne, Yip, Bouman, Marshall, & Arcelus, 2019).

In the 1960s, health providers began to administer medical solutions for this incongruence, through hormone treatments and, what were then called, sex reassignment surgeries. The medical literature of this time treated the transgender/non-binary experience as a disorder to overcome. Controversially, the fourth edition of the Diagnostic Statistical Manual (DSM-IV) introduced the official diagnosis of gender identity disorder (GID) in 1980, which simultaneously validated the transgender/non-binary experience in the eyes of the medical establishment and further contributed to the marginalization of transgender/non-binary identities (Bockting, 2009). Over time, transgender/non-binary ac-

tivists pushed for a more affirmative understanding of the transgender/non-binary experience, arguing that diverse gender identities were not sources of pathology. Instead, the distress felt and struggles faced, such as poverty, social isolation, underemployment, and difficulty securing housing, is largely due to social stigma. A lack of financially and geographically accessible health care and a lack of affirmative, culturally competent healthcare providers may increase this distress.

Discourse around gender also began to expand the boundaries of gender identity beyond the male/female gender binary, making space for the acceptance of non-binary identities. The approach to transgender/non-binary care started to shift from a sex reassignment process to a transgender coming out process (Bockting & Coleman, 2007). Bockting (2009) names this transition as “a shift from a disease-based model...to an identity-based model of transgender health” (p. 104). In 2013, the DSM-5 replaced GID with the new diagnosis of gender dysphoria, formally disassociating pathology from transgender/non-binary identity (Stryker, 2017). This diagnosis refers to the experience of discomfort or distress caused by an incongruence between a person’s gender iden-

### Corresponding Author

Rae McDaniel  
Practical Audacity Gender & Sex Therapy  
1757 N Kimball Ave. Ste. 202  
Chicago, IL 60647  
E: rae@practicalaudacity.com  
P: (318)547-1823

tity and assigned sex at birth, rather than the act or identity of gender nonconformity itself (Coleman et al., 2012).

In recent years, the field of transgender/non-binary health-care has been increasingly adopting an informed consent model, giving transgender/non-binary people access to transition-related services without excessive gatekeeping from the medical and mental health systems. The informed consent models moves even further away from the tradition of diagnosis upheld by the World Professional Association of Transgender Health (WPATH), the International Statistical Classification of Diseases and Related Health Problems (ICD), and the DSM. The WPATH Standards of Care continues to recommend that transgender/non-binary individuals seeking medical intervention should receive an assessment from a qualified mental health professional first (Coleman et al., 2012). Although these are not strict requirements for care, many medical providers adhere to these standards by requiring clinical documentation and letters of support from a mental health professional. Major health insurance providers and state Medicaid plans embraced these Standards of Care at the policy level, requiring significant documentation in support of a Gender Dysphoria diagnosis before approving coverage for medical services (Schulz, 2017). Today, a growing number of providers are adopting an informed consent model for care, which only requires that an individual should “possess the cognitive ability to make an informed and independent decision about their health care” and should understand all the risks and benefits involved (Informed Consent for Access to Trans Health Care [ICATH], n.d.). With more providers adopting this model of care, the role of the mental health practitioner can shift from a gatekeeper of necessary services to a source of support in the client’s transition process. This shift has led to an increase in trans-inclusive and trans-affirming counseling practices that aim to provide that support to transgender/non-binary clients. Examples of such counseling practices include TA-CBT, a trans-affirming adaptation to cognitive behavioral therapy (Austin & Craig, 2015), and LGBTQ\* responsive sand tray, a creative arts approach that assists clients or students in exploring and making meaning of internalized struggles (Luke & Peters, 2019). The developers of these approaches cite the discrimination against transgender/non-binary individuals, both in society at large and within the therapeutic field, as the reason for the necessity of these tailored practices (Grant et al., 2011).

Indeed, the discrimination and stigma against transgender/non-binary identities and experiences are inextricably linked with poor mental health outcomes for transgender/non-binary individuals. For example, studies found that increased risk of violence and abuse towards transgender women may be predictors of depression (Hoffman, 2014). Further, there are high rates of suicidal ideation and suicide attempts in the transgender/non-binary

population, likely due to gender-based victimization, gender-based rejection, gender-based discrimination, and identity nonaffirmation (Testa et al., 2017).

Within the therapeutic field, transgender/non-binary clients often encounter biased and unaffirming providers, discrimination, or providers who lack the training and knowledge necessary to effectively treat this population. Prior negative experiences with mental health providers, both experienced personally and learned through the reports of peers, lead many transgender/non-binary individuals to avoid seeking therapeutic services (Shipherd, Green, & Abramovitz, 2010; Mizock & Lundquist, 2016). Thus, it is imperative for mental health practitioners to become skilled in providing affirmative care to transgender/non-binary clients.

The minority stress model, which addresses the external stressors that individuals with stigmatized identities experience due to a minority social position, has inspired many intervention models for the transgender/non-binary population (Meyer, 2003). However, the literature currently lacks intervention models that emphasize the positive aspects and self-growth potential of transgender/non-binary experiences and gender nonconformity. As an expansion to the minority stress model, which suggests resilience factors can buffer against the impact of minority stressors, Matsuno and Israel’s (2017) transgender resilience intervention model (TRIM) was designed to help clinicians cultivate resilience-based interventions for transgender individuals. The model focuses on group-level resilience factors (e.g., social support, community acceptance, role models, etc.) and individual resilience factors (e.g., hopefulness, self-esteem, identity pride, etc.) as areas around which clinicians can build interventions. While this model does indicate a shift towards acknowledging and bolstering positive aspects of the transgender/non-binary experience, the researchers continue to center a response to negative stressors. For example, one resilience factor that TRIM highlights is “family acceptance,” with a suggested intervention of family therapy. This suggestion tailors an intervention around family exclusion, a common stressor that transgender people may experience while coming out, but also may perpetuate a deficit-based perspective on transgender/non-binary individuals’ coming out processes and ignores a history of resiliency in the transgender/non-binary community based on “chosen family” acceptance.

Previously, the literature on minority strengths has only focused on strengths as moderating variables for the effects of stressors on mental health outcomes. Perrin et al. (2019) offers an alternative to the minority stress model by introducing the minority strengths model, which focuses on strengths consistently found in the LGBTQ+ population and the direct and indirect effects on individuals instead of a deficit-centered model. Through the statistical validation of this model, Perrin et al. (2019) found the strengths-based vari-

ables combine and causally link with other strengths to create resilience and positive mental and physical health outcomes. Increased social support and community consciousness are strongly associated with greater identity pride and higher self-esteem, which then led to better mental and physical health outcomes. These findings suggest interventions affirming the positive aspects of LGBTQ+ community can serve to bolster this causal chain.

In an analysis of emerging positive psychology literature providing a strengths-based perspective on the LGBTQ+ population, Vaughan et al. (2014) identified a lack of literature on strengths like curiosity, with respect to the exploration of gender and sexuality, among others. Ruff et al. (2019) argues the lack of strengths-based knowledge “limits society’s ability to support [transgender women]” (p. 1992). The researchers assert that gathering more qualitative data about these strengths would allow the voices of transgender women themselves to inform societal narratives about this community, providing a more complete representation of their resilience. To address this gap, Ruff et al. (2019) conducted a photovoice study to capture narratives of agency amongst communities of transgender women of color. The study found hope, courage, and resilience played major roles for participants, arguing that fostering these strengths should lie at the center of solutions designed to support this community. A study of transgender and gender expansive youth and young adults experiencing homelessness also demonstrates personal agency and future orientation as main components of resilience in overcoming struggles and in reframing challenges as positive experiences (Shelton, Wagaman, Small, & Abramovich, 2017). These studies provide growing evidence that clinical practices serving the transgender/non-binary population must shift the focus from distress and risk-management to the cultivation of positive narratives surrounding these identities.

Furthermore, mental health practitioners must expand beyond the gender binary and accommodate non-binary identities within the clinical scope. Even as the transgender/non-binary community receives increased attention and support, there is still a lack of competence in clinical settings around supporting non-binary identities (Matsuno & Budge, 2017). The Gender Affirmative Lifespan Approach (GALA; Rider et al., 2019) is a trans-affirmative psychotherapy framework, designed for use with non-binary clients, that provides key recommendations to develop gender literacy, build resilience, expand beyond the binary, explore pleasure-oriented positive sexuality, and make positive connections to medical interventions. Clinicians have since applied this approach to other therapeutic interventions and populations, as Spencer and Vencill (2017) did in the development of a pleasure-based sexual health group therapy curriculum for clients on the transfeminine spectrum, with modules focusing on concepts such as mindfulness, sexual self-esteem, media representa-

tion, psychoeducation about sexual functioning and diverse bodies, and exploration of dating and relationships.

While Spencer and Vencill (2017) provide a valuable and grounded curriculum focusing on sexual pleasure for transgender women, the curriculum excludes non-binary and transmasculine identities and focuses heavily on the technical aspects of a positive sexuality, such as the impact of medical transition on sexuality and dating, considerations related to disclosure of a transgender identity, and psychoeducation about sexual anatomy and functioning (Spencer & Vencill, 2017). Similarly, the GALA Model (Rider et al., 2019) is a valuable resource for work with non-binary clients. The authors of this article endorse the necessity of identity-specific spaces and these important topics.

The development of the Gender Freedom Model expands on these critical works as a theoretical model that focuses on the process of gender transition from an affirming, non-pathologizing, resilience-building, and pleasure-positive perspective for all identities under the transgender umbrella, including non-binary and transmasculine identities. The Gender Freedom Model also works to expand the definitions of eroticism, intimacy, and pleasure beyond romantic and sexual relationships to create greater connection to self and others. Additionally, the inclusion of Budge’s (2017) model for facilitative coping in the transgender population is a strength of the Gender Freedom Model not included in either the GALA model (Rider et al., 2019) or Spencer and Vencill’s (2017) curriculum. The authors of the present article hope the Gender Freedom Model will serve a key role in the mental healthcare literature as a guide for clinical competence in working with transgender/non-binary clients through the process of gender transition, in a way that centers possibility and exploration.

### **Brief Overview of the Gender Freedom Model Developers**

The Gender Freedom Model is a theoretical framework grounded in the integration of psychology and sex therapy theory and literature, principles from human-centered design, as well as the authors’ clinical expertise and experience as a Licensed Clinical Professional Counselor (LCPC) and Licensed Clinical Social Worker (LCSW) in Illinois, respectively. Additionally, one author brings experience and training as a Certified Sex Therapist (CST) and lived experience as a member of the transgender/non-binary community.

### **The Three Pillars and Nine Subtopics of the Gender Freedom Model**

The Gender Freedom Model (see Figure 1) is a dynamic model consisting of three key pillars: (1) Play, (2) Pleasure, and (3) Possibility. Each of these pillars has three subtopic areas. The three key pillars are the general topic areas to focus on during gender transition within this model. The nine



subtopics dive into each general topic in a practical way. The subtopics build on skills in previous subtopics. However, clinicians and clients can go through the subtopics in any order, dependent on the client's needs. The figure represents general topic areas to cover during gender transition rather than a static, stage-based model. It is expected that clients will engage with each pillar and subtopic multiple times throughout the transition journey.

## Play

In order to transition gender with more ease, the Gender Freedom Model asserts that clients need a sense of play. The subtopics of the Play pillar are: (1) Master Your Mind, (2) Uneath Resiliency, and (3) Own Your Magic.

Much research has been done on the positive psychological effects of play on children, but the positive effects of adult play are often left out of these studies. Magnuson and Barnett (2013) found significant reductions in stress and an increase in active coping, acceptance, and positive reframing in adults who scored in the medium-high playfulness scale. Proyer (2017) defines playfulness with four main facets: (a) Other-directed; (b) Lighthearted; (c) Intellectual, and (d) Whimsical. In clinical work, this might look like engaging with gender presentation around clothing choices in a way that feels fun and less pressured by encouraging the client to thrift-shop with a friend for gender-affirming clothing and then put on a fashion show at home.

The Gender Freedom Model suggests that transgender/non-binary individuals who adopt an attitude of play while exploring gender identity and expression will experience decreased stress and an increased sense of ease, curiosity, and pleasure during the gender transition journey.

**Master Your Mind.** The subtopic Master Your Mind focuses on three key mindset shifts: self-efficacy, self-love, and transition as self-actualization. Budge et al. (2017) identifies the theme of “active engagement throughout the transition process” as a key, overarching component of trans-specific facilitative coping skills (p. 22). The emphasis on personal agency and self-efficacy throughout the gender transition journey should not ignore the significant cultural and systemic barriers that transgender/non-binary individuals face, nor should it engage in “toxic positivity” by enabling the emotional suppression of negative emotions (Chiu, 2020; Gross & Levenson, 1997). Rather, this model focuses on self-efficacy and agency, defined as the client's belief in the ability to do hard things in the face of significant personal and systemic challenges, emphasizing acceptance and moving through difficult emotions and thoughts related to both the personal experience of gender and the experience of microaggressions and aggressions related to a transgender/non-binary gender identity and gender expression (Ford, Lam, John, & Mauss, 2018). The clinician can facilitate this by combining affirming, interpersonal processing with tenets

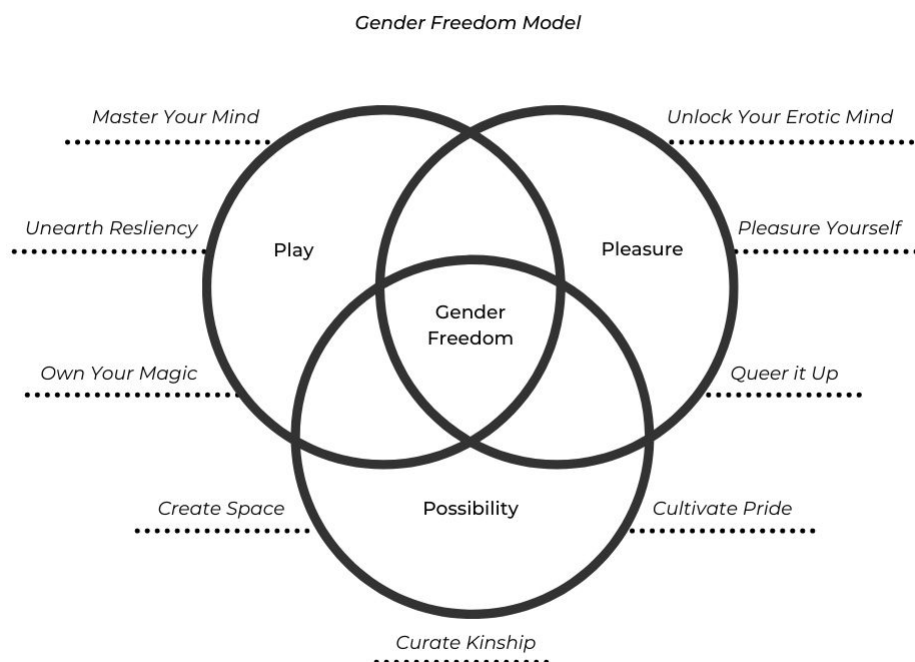
of existing therapeutic interventions such as Dialectical Behavior Therapy (DBT), Acceptance and Commitment Therapy (ACT), Cognitive Behavioral Therapy (CBT), Narrative Therapy, and Internal Family Systems (IFS) applied to the content of gender identity, gender expression, and gender transition (Austin & Craig, 2015; Budge, 2013; Budge et al., 2017; Nylund & Temple, 2017; Sloan, Berke, & Shipherd, 2017).

This subtopic suggests that self-love and self-compassion form a core mindset and value underlying positive coping skills. Allen and Leary (2010) discuss self-compassion as positive cognitive restructuring and reframing negative events or emotions with less self-critical thoughts and self-judgment. In the Gender Freedom Model, we reframe gender transition as a process of self-actualization and self-growth, positioning gender exploration and expansion as a goal-oriented process rather than risk-management (Budge et al., 2017). In this subtopic, clinicians help clients consider a “why” for transitioning beyond gender transition itself (e.g., to be more present with family or partners, to have more capacity to engage in advocacy, to have more mental space for creativity).

**Uneath Resiliency.** This subtopic focuses on moving the key mindsets discussed in the previous subtopic from theory to action. Using Budge's (2017) model, clients are able to reduce avoidant coping and increase facilitative coping throughout transition, including individual, interpersonal, and systemic factors.

In the Gender Freedom Model, we draw from human-centered design principles to frame gender transition as a wicked problem (Burnett, 2016). A wicked problem in human-centered designs is a problem that is seemingly impossible to solve because of the many intersectional factors and stakeholders involved. By using the human-centered design principles of curiosity, bias to action, reframing, awareness, and radical collaboration, clients begin to think differently and iteratively about their gender identity and expression while acknowledging and depersonalizing the cultural and systemic factors that make gender transition a process that is often emotionally difficult for the individual. This subtopic provides a reframe for uncertainty, the possibility of regret, and the fear of detransitioning often associated with anxiety and self-doubt in clients seeking to explore and expand their gender identity (Dhejne, Öberg, Arver, & Landén, 2014; Johansson, Sundbom, Höjerback, & Bodlund, 2009; Joseph-Williams, Edwards, & Elwyn, 2010; Leahy, 2005; Morain, Wootton, & Eppes, 2017; Murad et al., 2010). In this subtopic, clients critically examine the use of avoidant and facilitative coping strategies thus far in transition and intentionally begin to incorporate more facilitative coping strategies into the transition journey.

**Own Your Magic.** One interpretation of Budge's et al. (2017) study on facilitative coping in the transgender



*Figure 1.* This figure shows a Venn diagram of the three major pillars of the Gender Freedom Model, with three subtopics for each pillar directly beside the pillar it is associated with. Rather than a stage-based model, this figure displays an interconnected and overlapping circular model with Gender Freedom as the goal at the center of the figure.

community are the three highest order categories in the study: communicating about transgender identity, coming out, and dressing as coping. While the positive impact of communicating about an LGBTQ+ identity and coming out is well documented in the literature, dressing as coping is a new concept. Budge et al. (2017) asserts that transgender identity development often includes actively experimenting with gender expression. In this subtopic, clients are asked, “What makes you feel like magic?” with magic defined as congruency between who the client is at their best, desired feelings, personal beliefs, and behaviors. This subtopic focuses on clients finding the things that bring them pleasure, lights them up, and makes them feel most like themselves.

This subtopic is applicable regardless of a transgender/non-binary person’s social location, privileges, and sense of safety. While “magic” often includes actions such as wearing a new style of clothes, haircuts, and presenting in a way that feels congruent in public, this subtopic is not solely focused on external appearances. For many transgender/non-binary individuals, it is not safe (emotionally, physically, financially) to present in a congruent manner in all the areas of their lives and may lack financial resources to purchase gender-affirming clothing or services, such as a haircut or electrolysis. In

Own Your Magic, clinicians acknowledge this reality, help clients process the feelings of loss and grief that may emerge, and affirm that the most authentic way forward is sometimes to prioritize one’s safety. In this subtopic, clients explore alternative means of expressing gender that are safe, accessible, and congruent, such as wearing gendered underwear, finding private spaces where they can express gender freely, and exploring ways to express femininity and masculinity that focus on attitudes and values instead of external appearance.

### **Pleasure**

The Pleasure pillar of the Gender Freedom Model focuses on intimate justice and pleasure equity. The subtopics of the Pleasure pillar are: (1) Unlock Your Erotic Mind, (2) Pleasure Yourself, and (3) Queer it Up. McClelland (2010) coined the term *intimate justice* as a theoretical framework that examines and links how systemic oppression impacts imagination about what is possible for sexual and relational satisfaction and how individuals from marginalized identities evaluate the quality of existing sexual and romantic relationships based on what levels of satisfaction they believe they deserved. Intimate justice is a concept that raises the question for clinicians of how mental health providers can

help clients from marginalized identities achieve pleasure equity and increase their belief in how much relational and sexual satisfaction is possible and deserved (McClelland, 2010, 2017). Lorde (2007) speaks about the erotic as a place of personal power, collective power, and resistance. Feeling pleasure connects each of us to the feeling of personal power, fulfillment, and expansiveness that, once felt, experiences anything less as unacceptable. Mindfulness and a focus on pleasure compel one to action in order to create a world of infinite possibility, a world of satisfaction and pleasure. This is facilitated by a ubiquitous focus on mindfulness, a bias to action, and Human-Centered Design Thinking throughout the Gender Freedom Model, creating greater awareness of pleasurable physical and emotional feelings and an opportunity for “tiny steps” towards goals such as advocacy in the subtopic of Cultivate Pride.

**Unlock Your Erotic Mind.** Many people, especially those assigned female at birth, experience physical, emotional, and mental barriers to eroticism and pleasure and feel blocked in this area. Transgender/non-binary sexuality is often talked about in literature from a standpoint of risk. This is an important conversation as, specifically transgender women of color, often have disproportionately high rates of an HIV+ status (Ruff et al., 2019). However, pleasure-focused healthy sexuality is frequently left out of the conversation (Spencer & Vencill, 2017).

Using a biopsychosocial frame, the dual control model of sexual response, and concepts of responsive desire, this subtopic focuses on clinicians naming, normalizing, and introducing practical skills to clients in order to reduce barriers to relational and sexual satisfaction for transgender/non-binary individuals (Bancroft, Graham, Janssen, & Sanders, 2009; Brotto & Basson, 2014; Nagoski, 2015; Spencer & Vencill, 2017). In this subtopic, we introduce the concept of intimate justice and demonstrate ways to reduce anxiety, spectating, and shame related to sexuality and eroticism while simultaneously working to expand the sexual imagination and repertoire (Brown, 2015; Lacefield & Negy, 2011; McClelland, 2010; Nagoski, 2015; Spencer & Vencill, 2017). This subtopic provides psychoeducation about trans-affirming, pleasure-positive, healthy sexuality and asks clients to reflect on how sexual shame, spectating and anxiety, disconnection from their bodies, and stress are hitting the client’s sexual desire and arousal “brakes” and demonstrates practical skills for addressing each of these barriers to sexual and relational satisfaction (Nagoski, 2015).

One unique application of research from another discipline is adapting the five skills in planned happenstance learning theory (Mitchell, Levin, & Krumboltz, 1999) to sexual and relational satisfaction. The skills of curiosity, persistence, flexibility, optimism, and willingness to take risks are all highly applicable for creating change in one’s erotic life with greater ease. One application of this subtopic

might be to ask a transfeminine client to experiment with slowing down in what feels like a “safe and sexy” sexual context to allow for the possibility of responsive desire as a solution to stress/anxiety related to sexual activity and the change in sexual desire and arousal styles as a result of hormone therapy (Nagoski, 2015).

**Pleasure Yourself.** While the previous subtopic focused on the transgender/non-binary client’s cognitive and somatic barriers to experiencing more pleasure, eroticism, and satisfying sexual and romantic relationships, Pleasure Yourself focuses on the transgender/non-binary client’s relationship with their body through practical interventions.

Mindfulness-based interventions show significant efficacy for improving sexual desire, arousal, and sexual and relational satisfaction (Brotto & Basson, 2014; Nagoski, 2015; Spencer & Vencill, 2017). Pleasure Yourself suggests basic mindfulness principles and invites clients to practice clinically appropriate, sensual mindfulness exercises en vivo during session, such as experiencing an object in the room (e.g., a rock, a piece of fruit, a pen) slowly and with all five senses. This subtopic also provides participants with the basic tenets of sensate focus (Weiner & Avery-Clark, 2014) as a tool for greater sexual and relational satisfaction within relationships and by focusing on sensations of temperature, pressure, and texture while experiencing the object. This subtopic also focuses on pleasure and eroticism as a muscle built with mindful attention (Morin, 1996) and suggests clients record peak erotic experiences and keep a pleasure journal.

**Queer it Up.** The prioritization of dyadic romantic and sexual relationships as superior to friendships and other relational orientations is an idea rooted in patriarchy, misogyny, and capitalism. Marriage has historically existed as a patriarchal practice for securing financial interests and social standing, relegating wives to the status of property who existed primarily for the continuation of a bloodline (Glaeser, 2014; Ryan, 2010). With this history in mind, a critical “queering” of ideas about intimacy and the erotic as reserved for monogamous, heterosexual, committed sexual and romantic relationships is in order. Through the expansion and “queering” of the concepts of intimacy, eroticism, and pleasure beyond dyadic sexual and romantic relationships, we create space for intentionality in relationships and more opportunities for intimacy and connection (McDaniel & Twist, 2016; Michaels, 2015; Spade, 2006). Lorde (2007) speaks of the expansion of the definition of eroticism as a cornerstone of being able to use this energy collectively as connection and inspiration. Spade (2006, p. 31) captures the essence of this subtopic well:

One of my goals in thinking about redefining the way we view relationships is to try to treat the people I date more like I treat my friends, to be respectful and thoughtful and have boundaries and reasonable expectations-and to try to treat

my friends more like my dates-to give them special attention, honor my commitments to them, be consistent, and invest deeply in our futures together.

This subtopic focuses on bringing intentionality into relationships of all kinds through a critical queer lens and suggests clients use the key mindsets of human-centered design, introduced earlier in this model, to evaluate what types of relationships would feel good (Burnett, 2016).

### Possibility

Research shows that individuals with marginalized gender and/or sexual identities struggle to imagine positive futures and limit themselves (Hirsch, Cohn, Rowe, & Rimmer, 2016). The subtopics of the Possibility pillar are: (1) Create Space, (2) Curate Kinship, and (3) Cultivate Pride. This pillar focuses on envisioning a positive future, addressing internalized transphobia, helping clients develop a sense of personal and collective pride in a transgender/non-binary community, and developing a strong foundation of support.

**Create Space.** One common fear for clients exploring gender identity and expression is a fear of being a burden on their family, friends, and work relationships with the impact of gender transition (Testa et al., 2017). This subtopic focuses on directly addressing this fear and normalizing gender transition as a time that requires intense self-reflection and a focus on self-growth. Through this, we seek to help clients bring intentionality to the creation of space for this process and remind clients that the discomfort of others is not synonymous with harm.

It is also the authors' experience that many transgender/non-binary clients, as they begin to experience a more congruent gender identity and expression and develop skills related to self-efficacy and boundaries, also begin to notice other parts of their life that are incongruent with their values or how they want to live their lives. For example, clients have quit jobs, pursued new jobs, started or ended relationships, moved, began new hobbies, pursued creative endeavors, and become more involved in advocacy.

This subtopic suggests clients assess their lives holistically to determine what is feeling good and what is not and develop Specific, Measurable, Achievable, Relevant, and Time-bound (S.M.A.R.T.) goals to address areas that do not feel good and to further invest in areas that do feel good (Lawlor & Hornyak, 2012). In this subtopic, clinicians normalize and demonstrate compassion towards the thoughts and behaviors that have served to protect clients in the past but are now holding clients back.

**Curate Kinship.** For many in the transgender/non-binary community, family is a complicated topic. Research shows that familial and social support is a key resiliency factor (Matsuno & Israel, 2018; Puckett, Matsuno, Dyar, Mustanski, & Newcomb, 2019; Scandurra,

Amodeo, Valerio, Bochicchio, & Frost, 2017). However, many transgender/non-binary individuals experience rejection from their family of origin. The colloquial term *chosen family* is often used to describe the deep and rooted relationships that many LGBTQ+ individuals form with loved ones (Weston, 1991). While social acceptance for LGBTQ+ people has grown and legal barriers to relationship recognition and parenthood have decreased in recent years, notably, the year 2021 is the worst year on record since 2015 for anti-transgender legislation (Human Rights Campaign, 2021). The concept of chosen family continues to resonate and be a source of emotional safety amongst LGBTQ+ communities, evidenced by prominent featuring of chosen family members in study respondents' definitions of family (Hull & Ortyl, 2018). This subtopic focuses on chosen family and reimagining what kinship can look like. In this subtopic, clinicians help transgender/non-binary clients give themselves permission to set boundaries that reinforce their needs. Using questions like "What has felt good in past relationships?" and "What do you want more of?" clients can focus on what they can obtain, rather than what the limits are in existing relationships. Additionally, Curate Kinship utilizes Brown's (2018) trust factors to evaluate quality of relationships.

**Cultivate Pride.** This subtopic focuses on both individual and collective pride, as well as self-compassion and relational resilience. Identity pride was identified as an inherent strength in minority populations in the minority strengths model (Perrin et al., 2019). Sánchez and Vilain (2009) discuss collective self-esteem and positive feelings about the transgender/non-binary community as a powerful resiliency factor for transgender/non-binary individuals.

Continuing to be challenged by systemic oppression, especially for those with multiple intersecting marginalized identities, is disheartening for many. However, cultivating self-compassion as a primary response to inequity and discrimination helps clients recognize that transgender/non-binary identities are not inherently lacking or deficient and reaffirms that the difficulties related to a transgender/non-binary identity are often a response to a world that does not celebrate these identities and actively perpetuates systemic oppression. Self-compassion is "compassion directed inward" and facilitates resilience by moderating reactions to negative experiences (Germer & Neff, 2013, p. 856).

In this subtopic, the authors of this article discuss pride as a process—based in both a grounded confidence and in actions that affirm one's worth (Brown, 2018). To combat learned helplessness, this subtopic suggests clients take action, broadly defined as that which centers one's own agency that still exists, even in an oppressive world. Building relational resilience instead of prioritizing individualized resilience is a strong focus of this subtopic. This can look, for example, like advocacy for the larger transgender/non-binary



community by using personal experiences as a model for others, connecting with folks at different places in their gender journeys, and engaging in political activism. In this subtopic, clinicians invite clients into basic narrative work—building new ways to tell our stories and making meaning out of adversity, while imagining a future worth having (Meyer, 2015; Puckett et al., 2019; Singh, Hays, & Watson, 2011).

### **Aims of the Gender Freedom Model**

With the Gender Freedom Model, the authors of this article aim to provide a research-based, comprehensive, practical, and integrative theoretical framework for providing transgender/non-binary affirming care that challenges the ubiquitous narrative that gender transition is, by definition, a process that centers on great suffering, anxiety, and self-doubt. Drawing from positive psychology and research on facilitative coping and resiliency, this model focuses on both asking and beginning to answer the question, “How can clinicians support transgender/non-binary/gender questioning clients in transitioning gender with a sense of ease, joy, curiosity, and pleasure?” (Budge et al., 2017; Vaughan et al., 2014). In order to decrease distress and improve quality of life, this model uses clinical interventions that acknowledge the systems of oppression creating barriers to surviving and thriving for transgender/non-binary individuals while focusing on strengths-based coping skills, resiliency, personal agency, and self and community care (Ford et al., 2018; Sloan et al., 2017).

With this model, the authors of this article intend to make gender transition easier by building the client’s confidence, personal agency, and resiliency skills while acknowledging and integrating the client’s intersectional identities and the importance of community care on the transition journey (Budge, Thai, Tebbe, & Howard, 2016). Through this model, clinicians can address common sources of anxiety throughout transition and use practical and evidence-based psychotherapy interventions to help clients feel more comfortable in their gender identity and expression. By creating a “bias to action” for exploring the client’s desire and readiness to medically/socially/legally transition and come out (if the client desires to come out), the Gender Freedom Model demonstrates how to develop and implement facilitative coping skills at each phase of transition (Budge et al., 2017; Burnett, 2016).

By learning practical skills for helping clients decide how to identify and express their gender to themselves and to the world, the authors of this article will continue the conversation about how to change the narrative of gender transition into a process of self-growth, curiosity, and discovery. This model focuses on pleasure equity, personal and collective pride, as well as practical therapeutic skills for guiding transgender/non-binary clients through the transition journey.

### **Clinical Applications**

As a theoretical framework, a formal academic research study has not been completed on the Gender Freedom Model. In clinical applications of this model, the authors found, through informal feedback surveys and informal conversations with clients and participants in a group program utilizing the Gender Freedom Model, that clients feel more able to take actionable steps towards their transition goals and are able to hold more positive narratives about themselves than before beginning treatment. While any definitive conclusions about this model’s efficacy require further empirical testing, the Gender Freedom Model has shown promise as a practical and comprehensive theoretical framework that focuses on personal and collective empowerment and resiliency in the experience of the authors, clients, and participants in a group program utilizing the Gender Freedom Model.

The Gender Freedom Model provides a validating, accepting, and playful environment for exploration of gender identity and expression. It is the clinician’s responsibility to educate themselves on transgender/non-binary identities, concepts, and language in order to provide holistic, gender-affirming care. This is essential for utilizing the Gender Freedom Model effectively.

One of the strengths of the Gender Freedom Model is the reliance on existing evidence-based theoretical frameworks and interventions. Many psychotherapists will have existing education and skills in many of the modalities discussed, such as mindfulness-based practice, dialectical behavior therapy, cognitive behavioral therapy, acceptance and commitment therapy, and narrative therapy. The application and integration of these evidence-based theories and interventions creates a strong foundation for psychotherapeutic work in an under-researched community.

Therapists who use this model in its entirety will need at least a basic understanding of sex therapy and sexual health topics such as anatomy, arousal, responsive and spontaneous desire, sensate focus, and mindfulness applied to sexuality.

### **Limitations and Future Directions**

The Gender Freedom Model is a theoretical framework developed from integrated research within the fields of transgender health, psychology, positive psychology, and sex therapy, as well as from fields outside of psychology such as human-centered design, community knowledge, and the clinical experience of the authors. The Gender Freedom Model is new and iterative. It will require refinement and clarification over time, as well as empirical testing. The Gender Freedom Model needs a formal study on the full impact of this intervention model on mental health outcomes for transgender/non-binary clients. The authors are not affiliated with an academic institution, which creates barriers and a lack of resources for conducting independent research

studies.

The existing scholarly literature on transgender/non-binary experiences is narrow in scope, lacking in funding, and often limited to small, qualitative studies. Much of the research cited in this article is older than the typical 5– to 10-year range used in academic articles because of the lack of significant literature on this population. Affirming language and concepts change quickly in the transgender/non-binary community, and finding research studies that reflect the current lived experience of the transgender/non-binary population and/or do not focus on a deficit model, as described in this article, is difficult.

This may be, in part, due to the fact that there is a long history of oral tradition and mutual aid in the transgender/non-binary population for distributing knowledge and coping skills for surviving and thriving. Discussion of these resources often occurs in non-academic settings such as online message boards, community conversations, and self-published work. The prioritization of formal academic studies in professional journals and academia creates barriers for researchers and mental health/medical providers to receive this community-based knowledge, with lived experience and community-based knowledge being undervalued. As queer and transgender authors with extensive clinical experience, our community knowledge, personal experience, and clinical observations are a powerful source of knowledge that the authors of this article maintain is not only valid, but necessary.

The “queering” of what knowledge and voices are valid is a hegemonic consideration for academic literature about transgender/non-binary folks. The authors developed the Gender Freedom Model as a response to the lack of research on transgender/non-binary thriving and the positive mental health aspects of transition. Most research on this population focuses on risk factors or resilience related to coping with minority stress. It is the authors’ hope that the Gender Freedom Model will inspire more research and therapeutic interventions that center the inherent strength factors of the transgender/non-binary population.

### Conclusion

As the field of transgender/non-binary health care grows and wrestles with challenging conversations about the institutional pathologization of transgender/non-binary identities, the need for competent and affirming psychotherapy remains. The three pillars of the Gender Freedom Model—Play, Pleasure, and Possibility—make up a radically affirmative framework for reimagining therapeutic work with transgender/non-binary clients. In creating this model, the authors of this article held the positive assumption that transgender/non-binary clients can transition with more ease, in whatever way is most affirmative for them. In order to address the significant health disparities and the risk for negative mental health outcomes in this population, the Gen-

der Freedom Model is an assertion that the necessary center and focus of the work is holding the core humanity of transgender/non-binary people in high regard and cultivating hope for a positive, gender-affirming future for all.

### References

- Allen, A. B., & Leary, M. R. (2010). Self-compassion, stress, and coping. *Social and Personality Psychology Compass*, 4(2), 107–118. doi:[10.1111/j.1751-9004.2009.00246.x](https://doi.org/10.1111/j.1751-9004.2009.00246.x)
- Austin, A., & Craig, S. L. (2015). Transgender affirmative cognitive behavioral therapy: Clinical considerations and applications. *Professional Psychology: Research and Practice*, 46(1), 21–29. doi:[10.1037/a0038642](https://doi.org/10.1037/a0038642)
- Bancroft, J., Graham, C. A., Janssen, E., & Sanders, S. A. (2009). The dual control model: Current status and future directions. *Journal of Sex Research*, 46(2-3), 121–142. doi:[10.1080/00224490902747222](https://doi.org/10.1080/00224490902747222)
- Bockting, W. O. (2009). Transforming the paradigm of transgender health: a field in transition. *Sexual and Relationship Therapy*, 24(2), 103–107. doi:[10.1080/14681990903037660](https://doi.org/10.1080/14681990903037660)
- Bockting, W. O., & Coleman, E. (2007). Developmental stages of the transgender coming out process: Toward an integrated identity. In R. Ettner, S. Monstrey, & E. Eyler (Eds.), *Principles of transgender medicine and surgery* (p. 185–208). Haworth Press.
- Brotto, L. A., & Basson, R. (2014). Group mindfulness-based therapy significantly improves sexual desire in women. *Behaviour Research and Therapy*, 57, 43–54. doi:[10.1016/j.brat.2014.04.001](https://doi.org/10.1016/j.brat.2014.04.001)
- Brown, B. (2015). *Rising strong*. New York: Spiegel & Grau.
- Brown, B. (2018). *Dare to lead: brave work, tough conversations, whole hearts*. Random House.
- Budge, S. L. (2013). Interpersonal psychotherapy with transgender clients. *Psychotherapy*, 50(3), 356–359. doi:[10.1037/a0032194](https://doi.org/10.1037/a0032194)
- Budge, S. L., Chin, M. Y., & Minero, L. P. (2017). Trans individuals’ facilitative coping: An analysis of internal and external processes. *Journal of Counseling Psychology*, 64(1), 12–25. doi:[10.1037/cou0000178](https://doi.org/10.1037/cou0000178)
- Budge, S. L., Thai, J. L., Tebbe, E. A., & Howard, K. A. S. (2016). The intersection of race, sexual orientation, socioeconomic status, trans identity, and mental health outcomes. *The Counseling Psychologist*, 44(7), 1025–1049. doi:[10.1177/0011000015609046](https://doi.org/10.1177/0011000015609046)
- Burnett, B. (2016). *Designing your life : how to build a well-lived, joyful life*. New York: Alfred A. Knopf.
- Chiu, A. (2020). Time to ditch ‘toxic positivity,’ experts say: ‘it’s okay not to be okay.’. *The Washington Post*. Retrieved from <https://www.washingtonpost.com/lifestyle/wellness/toxic-positivity>

- mental-health-covid/2020/08/19/5dff8d16-e0c8-11ea-8181-606e603bb1c4\_story.html
- Coleman, E., Bocking, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., ... Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism*, 13(4), 165–232. doi:10.1080/15532739.2011.700873
- Dhejne, C., Öberg, K., Arver, S., & Landén, M. (2014). An analysis of all applications for sex reassignment surgery in Sweden, 1960–2010: Prevalence, incidence, and regrets. *Archives of Sexual Behavior*, 43(8), 1535–1545. doi:10.1007/s10508-014-0300-8
- Ford, B. Q., Lam, P., John, O. P., & Mauss, I. B. (2018). The psychological health benefits of accepting negative emotions and thoughts: Laboratory, diary, and longitudinal evidence. *Journal of Personality and Social Psychology*, 115(6), 1075–1092. doi:10.1037/pspp0000157
- Germer, C. K., & Neff, K. D. (2013). Self-compassion in clinical practice. *Journal of Clinical Psychology*, 69(8), 856–867. doi:10.1002/jclp.22021
- Glaeser, K. (2014). "till death us do part": The evolution of monogamy. *Oglethorpe Journal of Undergraduate Research*, 4(2), 1–27. Retrieved from <https://digitalcommons.kennesaw.edu/ojur/vol4/iss2/2/>
- Grant, J. M., Mottet, L. A., Tanis, J., Herman, J. L., Harrison, J., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey*. National Center for Transgender Equality and National Gay and Lesbian Task Force. Retrieved from [https://transequality.org/sites/default/files/docs/resources/NTDS\\_Report.pdf](https://transequality.org/sites/default/files/docs/resources/NTDS_Report.pdf)
- Gross, J. J., & Levenson, R. W. (1997). Hiding feelings: The acute effects of inhibiting negative and positive emotion. *Journal of Abnormal Psychology*, 106(1), 95–103. doi:10.1037/0021-843x.106.1.95
- Hirsch, J. K., Cohn, T. J., Rowe, C. A., & Rimmer, S. E. (2016). Minority sexual orientation, gender identity status and suicidal behavior: Serial indirect effects of hope, hopelessness and depressive symptoms. *International Journal of Mental Health and Addiction*, 15(2), 260–270. doi:10.1007/s11469-016-9723-x
- Hoffman, B. (2014). An overview of depression among transgender women. *Depression Research and Treatment*, 2014, 1–9. doi:10.1155/2014/394283
- Hull, K. E., & Ortyl, T. A. (2018). Conventional and cutting-edge: Definitions of family in LGBT communities. *Sexuality Research and Social Policy*, 16(1), 31–43. doi:10.1007/s13178-018-0324-2
- Human Rights Campaign. (2021). *2021 officially becomes worst year in recent history for lgbtq state legislative attacks as unprecedented number of states enact record-shattering number of anti-lgbtq measures into law*. Author. Retrieved from <https://www.hrc.org/press-releases/2021-officially-becomes-worst-year-in-recent-history-for-lgbtq-state-legislative-attacks-as-unprecedented-number-of-states-enact-record-shattering-number-of-anti-lgbtq-measures-into-law>
- Informed Consent for Access to Trans Health. (n.d.). *About ICATH*. Author. Retrieved from <https://icath.info/>
- Johansson, A., Sundbom, E., Höjerback, T., & Bodlund, O. (2009). A five-year follow-up study of Swedish adults with gender identity disorder. *Archives of Sexual Behavior*, 39(6), 1429–1437. doi:10.1007/s10508-009-9551-1
- Joseph-Williams, N., Edwards, A., & Elwyn, G. (2010). The importance and complexity of regret in the measurement of 'good' decisions: a systematic review and a content analysis of existing assessment instruments. *Health Expectations*, 14(1), 59–83. doi:10.1111/j.1369-7625.2010.00621.x
- Lacefield, K., & Negy, C. (2011). Non-erotic cognitive distractions during sexual activity in sexual minority and heterosexual young adults. *Archives of Sexual Behavior*, 41(2), 391–400. doi:10.1007/s10508-011-9792-7
- Lawlor, K. B., & Hornyak, M. J. (2012). Smart goals: How the application of smart goals can contribute to achievement of student learning outcomes. *Developments in Business Simulation and Experiential Learning*, 39, 259–267. Retrieved from <https://journals.tdl.org/absel/index.php/absel/article/view/90/86>
- Leahy, R. (2005). *The worry cure : Seven steps to stop worry from stopping you*. New York: Harmony Books.
- Lorde, A. (2007). *Sister outsider : essays and speeches*. Berkeley: Crossing Press.
- Luke, M., & Peters, H. C. (2019). LGBTQ\* responsive sand tray: Creative arts and counseling. *Journal of Counseling Sexology & Sexual Wellness: Research, Practice, and Education*, 48–59. doi:10.34296/01011002
- Magnuson, C. D., & Barnett, L. A. (2013). The playful advantage: How playfulness enhances coping with stress. *Leisure Sciences*, 35(2), 129–144. doi:10.1080/01490400.2013.761905
- Matsuno, E., & Budge, S. L. (2017). Non-binary/genderqueer identities: a critical review of the literature. *Current Sexual Health Reports*, 9(3), 116–120. doi:10.1007/s11930-017-0111-8
- Matsuno, E., & Israel, T. (2018). Psychological interventions promoting resilience among transgender in-



- dividuals: Transgender resilience intervention model (TRIM). *The Counseling Psychologist*, 46(5), 632–655. doi:[10.1177/0011000018787261](https://doi.org/10.1177/0011000018787261)
- McClelland, S. I. (2010). Intimate justice: A critical analysis of sexual satisfaction. *Social and Personality Psychology Compass*, 4(9), 663–680. doi:[10.1111/j.1751-9004.2010.00293.x](https://doi.org/10.1111/j.1751-9004.2010.00293.x)
- McClelland, S. I. (2017). Conceptual disruption. *Psychology of Women Quarterly*, 41(4), 451–464. doi:[10.1177/0361684317725985](https://doi.org/10.1177/0361684317725985)
- McDaniel, R., & Twist, M. L. C. (2016). Designer relationships: a guide to happy monogamy, positive polyamory, and optimistic open relationships, edited by mark a. michaels and patricia johnson. *Sexual and Relationship Therapy*, 33(3), 364–366. doi:[10.1080/14681994.2016.1192596](https://doi.org/10.1080/14681994.2016.1192596)
- Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin*, 129(5), 674–697. doi:[10.1037/0033-2909.129.5.674](https://doi.org/10.1037/0033-2909.129.5.674)
- Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity*, 2(3), 209–213. doi:[10.1037/sgd0000132](https://doi.org/10.1037/sgd0000132)
- Michaels, M. (2015). *Designer relationships : a guide to happy monogamy, positive polyamory, and optimistic open relationships*. Jersey City, New Jersey: Cleis Press.
- Mitchell, K. E., Levin, S. A., & Krumboltz, J. D. (1999). Planned happenstance: Constructing unexpected career opportunities. *Journal of Counseling & Development*, 77(2), 115–124. doi:[10.1002/j.1556-6676.1999.tb02431.x](https://doi.org/10.1002/j.1556-6676.1999.tb02431.x)
- Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counseling and psychological practice. *Psychology of Sexual Orientation and Gender Diversity*, 3(2), 148–155. doi:[10.1037/sgd0000177](https://doi.org/10.1037/sgd0000177)
- Morain, S. R., Wootton, S. H., & Eppes, C. (2017). A devastating delay — Zika and the implementation gap. *New England Journal of Medicine*, 377(16), 1505–1507. doi:[10.1056/nejmp1707273](https://doi.org/10.1056/nejmp1707273)
- Morin, J. (1996). *The erotic mind : unlocking the inner sources of sexual passion and fulfillment*. New York: HarperPerennial Publishers.
- Murad, M. H., Elamin, M. B., Garcia, M. Z., Mullan, R. J., Murad, A., Erwin, P. J., & Montori, V. M. (2010). Hormonal therapy and sex reassignment: a systematic review and meta-analysis of quality of life and psychosocial outcomes. *Clinical Endocrinology*, 72(2), 214–231. doi:[10.1111/j.1365-2265.2009.03625.x](https://doi.org/10.1111/j.1365-2265.2009.03625.x)
- Nagoski, E. (2015). *Come as you are : the surprising new science that will transform your sex life*. New York: Simon & Schuster Paperbacks.
- Nylund, D., & Temple, A. (2017). Queer informed narrative therapy: Radical approaches to counseling with transgender persons. In *Social justice and counseling* (pp. 159–170). Routledge.
- Perrin, P. B., Sutter, M. E., Trujillo, M. A., Henry, R. S., & Pugh, M. (2019). The minority strengths model: Development and initial path analytic validation in racially/ethnically diverse LGBTQ individuals. *Journal of Clinical Psychology*, 76(1), 118–136. doi:[10.1002/jclp.22850](https://doi.org/10.1002/jclp.22850)
- Proyer, R. T. (2017). A new structural model for the study of adult playfulness: Assessment and exploration of an understudied individual differences variable. *Personality and Individual Differences*, 108, 113–122. doi:[10.1016/j.paid.2016.12.011](https://doi.org/10.1016/j.paid.2016.12.011)
- Puckett, J. A., Matsuno, E., Dyar, C., Mustanski, B., & Newcomb, M. E. (2019). Mental health and resilience in transgender individuals: What type of support makes a difference? *Journal of Family Psychology*, 33(8), 954–964. doi:[10.1037/fam0000561](https://doi.org/10.1037/fam0000561)
- Rider, G. N., Vencill, J. A., Berg, D. R., Becker-Warner, R., Candelario-Pérez, L., & Spencer, K. G. (2019). The gender affirmative lifespan approach (GALA): A framework for competent clinical care with nonbinary clients. *International Journal of Transgenderism*, 20(2-3), 275–288. doi:[10.1080/15532739.2018.1485069](https://doi.org/10.1080/15532739.2018.1485069)
- Ruff, N., Smoyer, A., & Breny, J. (2019). Hope, courage, and resilience in the lives of transgender women of color. *The Qualitative Report*, 24(8), 1990–2008. Retrieved from <https://nsuworks.nova.edu/tqr/vol24/iss8/11>
- Ryan, C. (2010). *Sex at dawn : the prehistoric origins of modern sexuality*. New York: Harper.
- Sánchez, F. J., & Vilain, E. (2009). Collective self-esteem as a coping resource for male-to-female transsexuals. *Journal of Counseling Psychology*, 56(1), 202–209. doi:[10.1037/a0014573](https://doi.org/10.1037/a0014573)
- Scandurra, C., Amodeo, A. L., Valerio, P., Bochicchio, V., & Frost, D. M. (2017). Minority stress, resilience, and mental health: A study of Italian transgender people. *Journal of Social Issues*, 73(3), 563–585. doi:[10.1111/josi.12232](https://doi.org/10.1111/josi.12232)
- Schulz, S. L. (2017). The informed consent model of transgender care: An alternative to the diagnosis of gender dysphoria. *Journal of Humanistic Psychology*, 58(1), 72–92. doi:[10.1177/0022167817745217](https://doi.org/10.1177/0022167817745217)
- Shelton, J., Wagaman, M. A., Small, L., & Abramovich, A. (2017). I'm more driven now: Resilience and resistance among transgender and gender expansive youth and young adults experiencing homelessness.



- International Journal of Transgenderism*, 19(2), 144–157. doi:[10.1080/15532739.2017.1374226](https://doi.org/10.1080/15532739.2017.1374226)
- Shipherd, J. C., Green, K. E., & Abramovitz, S. (2010). Transgender clients: Identifying and minimizing barriers to mental health treatment. *Journal of Gay & Lesbian Mental Health*, 14(2), 94–108. doi:[10.1080/19359701003622875](https://doi.org/10.1080/19359701003622875)
- Singh, A. A., Hays, D. G., & Watson, L. S. (2011). Strength in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling & Development*, 89(1), 20–27. doi:[10.1002/j.1556-6678.2011.tb00057.x](https://doi.org/10.1002/j.1556-6678.2011.tb00057.x)
- Sloan, C. A., Berke, D. S., & Shipherd, J. C. (2017). Utilizing a dialectical framework to inform conceptualization and treatment of clinical distress in transgender individuals. *Professional Psychology: Research and Practice*, 48(5), 301–309. doi:[10.1037/pro0000146](https://doi.org/10.1037/pro0000146)
- Spade, D. (2006). For lovers and fighters. In M. Berger (Ed.), *We don't need another wave : dispatches from the next generation of feminists* (p. 28-39). Seal Press Distributed by Publishers Group West.
- Spencer, K. G., & Vencill, J. A. (2017). Body beyond: A pleasure-based, sex-positive group therapy curriculum for transfeminine adults. *Psychology of Sexual Orientation and Gender Diversity*, 4(4), 392–402. doi:[10.1037/sgd0000248](https://doi.org/10.1037/sgd0000248)
- Stryker, S. (2017). *Transgender history : the roots of today's revolution*. New York, NY: Seal Press.
- Testa, R. J., Michaels, M. S., Bliss, W., Rogers, M. L., Balsam, K. F., & Joiner, T. (2017). Suicidal ideation in transgender people: Gender minority stress and interpersonal theory factors. *Journal of Abnormal Psychology*, 126(1), 125–136. doi:[10.1037/abn0000234](https://doi.org/10.1037/abn0000234)
- Thorne, N., Yip, A. K.-T., Bouman, W. P., Marshall, E., & Arcelus, J. (2019). The terminology of identities between, outside and beyond the gender binary – a systematic review. *International Journal of Transgenderism*, 20(2-3), 138–154. doi:[10.1080/15532739.2019.1640654](https://doi.org/10.1080/15532739.2019.1640654)
- Vaughan, M. D., Miles, J., Parent, M. C., Lee, H. S., Tilghman, J. D., & Prokhorets, S. (2014). A content analysis of LGBT-themed positive psychology articles. *Psychology of Sexual Orientation and Gender Diversity*, 1(4), 313–324. doi:[10.1037/sgd0000060](https://doi.org/10.1037/sgd0000060)
- Weiner, L., & Avery-Clark, C. (2014). Sensate focus: clarifying the masters and johnson's model. *Sexual and Relationship Therapy*, 29(3), 307–319. doi:[10.1080/14681994.2014.892920](https://doi.org/10.1080/14681994.2014.892920)
- Weston, K. (1991). *Families we choose : Lesbians, gays, kinship*. New York: Columbia University Press.