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Considerations for Interviewing and Intervening with Suicidal Gender Expansive Individuals

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It has been well documented that transgender individuals are at a higher risk for death by suicide compared to their cisgender peers. However, limited consideration has been given to studying suicidality in individuals who identify outside of the gender binary (non-binary, gender queer, gender fluid, etc.). Additionally, while there is considerable evidence for risk factors for suicide and protective factors against suicide, there is a lack of guidance on how to implement this information. The aim of this paper is to expand upon the literature of research that is inclusive of all gender identities and propose guidelines working with gender expansive individuals who are suicidal. Providers are encouraged to consider working with client's from a perspective on gender that is not binary in order to be affirming of all gender identities. Recommendations include intervening in a culturally sensitive manner by not assuming one's gender, inquiring about pronouns and preferred name, and utilizing gender neutral language. Additionally, providers should also consider the unique risk and protective factors amongst this community when performing crisis interventions and creating safety plans with clients.

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CONSIDERATIONS FOR INTERVIEWING AND INTERVENING
WITH SUICIDAL
GENDER EXPANSIVE INDIVIDUALS

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IN PARTIAL FULFILLMENT
IN REQUIREMENTS FOR THE DEGREE
DOCTOR OF PSYCHOLOGY

BY
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July 11, 2024

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Abstract

It has been well documented that transgender individuals are at a higher risk for death by suicide compared to their cisgender peers. However, limited consideration has been given to studying suicidality in individuals who identify outside of the gender binary (non-binary, gender queer, gender fluid, etc.). Additionally, while there is considerable evidence for risk factors for suicide and protective factors against suicide, there is a lack of guidance on how to implement this information. The aim of this paper is to expand upon the literature of research that is inclusive of all gender identities and propose guidelines working with gender expansive individuals who are suicidal. Providers are encouraged to consider working with client's from a perspective on gender that is not binary in order to be affirming of all gender identities. Recommendations include intervening in a culturally sensitive manner by not assuming one's gender, inquiring about pronouns and preferred name, and utilizing gender neutral language. Additionally, providers should also consider the unique risk and protective factors amongst this community when performing crisis interventions and creating safety plans with clients.

Keywords: Suicide, Gender Expansive, LGBTQ+, Queer, Intervention

Introduction

The purpose of this paper is to analyze current literature regarding suicide in the gender diverse community and suggest informed guidelines for future practices. While there is a growing amount of research regarding risk factors for the transgender community, limited consideration has been given to individuals who lie outside of the gender binary (man versus woman). Further, while there is considerable evidence for risk factors and protective factors for those contemplating suicide, there is a lack of guidance on how to utilize this information when working with gender diverse individuals contemplating death by suicide. My aim is to expand upon the literature that is inclusive of all gender diverse individuals and propose guidelines for interviewing and intervening with gender diverse individuals considering suicide.

Language

According to the APA Dictionary of Psychology, the APA defines gender as "the socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for different genders." They further clarify gender by describing the concept in relation to sex, stating that "sex refers to the biological status of being male, female, or intersex whereas gender implies the psychological, cultural, behavioral, and social aspects of gender." Throughout this paper the term "gender diverse" will be utilized to describe those whose gender identity lies outside of a gender binary.

"Gender diverse" refers to individuals who do not identify completely as man, woman, transman, or transwoman. This term includes individuals who feel that their gender identity is better described in other terms. Synonymous to the term "gender diverse," "gender expansive" is often utilized as an umbrella term referring to individuals with a more flexible gender identity and/or expression than what is typically associated with the gender binary. "Gender

nonconforming" is also another term utilized to describe individuals whose gender roles, appearance, and behavior does not conform to society's binary expectations of gender. However, the term "gender nonconforming" is more frequently used to describe oneself or community, rather than an identity one may claim.

Further, much of the literature referenced throughout this paper utilizes varying labels for the populations they have analyzed such as "LGBT", "LGBT+", "LGBTQ+", and queer. For the purpose of this paper, "queer" will be utilized to refer to any individual or group of people who identify as non-cisgender (someone whose gender identity consistently aligns with their gender assumed based upon their sex assigned at birth) and/or non-heterosexual. More definitions on various gender related terminology and gender identities are included in a glossary attached as an appendix at the end of this paper.

It is also important to consider the language utilized when discussing suicide. The phrase "died by suicide" should be utilized when talking about somebody who intentionally killed themselves. Historically the phrase "committed suicide" has been used to refer to individuals who intentionally have taken their life. However, this terminology is no longer utilized as it criminalizes the act of taking one's life. Being intentional about the language we use to discuss suicide may help decrease some of the stigma around talking about suicide and suicidal ideation.

Suicide & Risk Factors

According to the World Health Organization (WHO), approximately 785,000 deaths by suicide occur annually (Tureckia et al., 2019). The most frequently known and documented risk factors for suicide include previous attempts, having a psychiatric illness, prior psychiatric hospitalizations, having experienced trauma, grief and loss, social isolation, health challenges, and a history of suicide within the family (Freedenthall, 2017). Additionally, demographic risk

factors to suicide include being male, Native American, Alaskan Native, or being white; being part of the queer community; experiencing homelessness, poverty, or unemployment; and owning a firearm. These factors are typically static, longstanding, and speak to suicide risk in the long term (Freedenthall, 2017). Another study (Tureckia et al., 2019; Tureckia et al., 2016) also found that geographical location, sociocultural norms, disruption to social structure and/or values, economic turmoil, social isolation, media reporting of suicide, access to lethal means, and poor access to mental health services are all considered risk factors for suicide.

Tureckia and colleagues (2019) took a biopsychosocial approach to analyzing risk factors for suicide. They reported that globally the amount of suicides has decreased between the years of 2000 and 2016. Yet, in the United States and Brazil, suicide rates increased by 35%. The study separated risk factors for suicide into three categories: predisposing, developmental, and precipitating factors. They identified predisposing factors to include early life adversity, epigenetic changes, genetics, and family history of suicide. Data indicated that family clustering of suicidal behavior supports the general hypothesis of a genetic link to suicide, yet no single gene or group of genes has been shown to increase suicide risk (Tureckia et al., 2019). However, suicidal behavior tends to be higher in those who have experienced a family member's death by suicide.

Further, developmental history in this study analyzed early-life adversity, which they defined as neglect, physical abuse, and/or sexual abuse. Early life adversity is also associated with suicidal behavior later in life. Early life adversity may elicit epigenetic changes which may impact one's predisposition to depressive symptoms and suicidal behavior. The study also found that genetic and epigenetic changes, chronic substance misuse, and certain personality traits increase one's risk for suicide (Tureckia et al., 2019). Individuals who are impulsive, aggressive,

and have a negative affect (those who experience more negative emotional states such as depression, sadness, worry, etc.) may be more vulnerable to stress and suicidal behavior. Additionally, lack of social connection and environmental factors play a vital role in suicide risk and prevention.

Precipitating factors, or warning signs, to suicide include distressing life events, psychopathology, and biological factors. The most common psychological disorders in those who die by suicide include major depressive disorder (MDD), bipolar disorder, substance use disorders, and schizophrenia. Further, one's level of insight into their schizophrenia, early-stage illness, mixed-state episodes, and irritable dysphoric states for bipolar disorder as well as the number, intensity, and duration of episodes for MDD put those at higher risk for suicidal ideation, behavior, and death by suicide (Hor. K & Taylor M. 2010; Holma et al., 2014;Tureckia et al., 2019). Depression, dysregulated mood, hopelessness, feelings of entrapment, and behavioral disinhibition have been found to be key factors which contribute to suicidal behavior.

It is important to recognize the difference between static risk factors for suicide and warning signs for suicidal behavior. As mentioned earlier, risk factors tend to be static, chronic, and unchanging. However, warning signs and precipitating factors, are more fluid and may indicate more acute and immediate risk for suicidal behaviors. Risk factors may include increased frequency and intensity of suicidal thoughts, talking or writing about suicide, making preparations for suicide, rehearsing behaviors to complete suicide, hopelessness, agitation, anger, dramatic mood changes, feeling trapped or like a burden to others, a sense of having no purpose in life, no identifiable reasons for living, increased substance uses, withdrawal or disconnection from others, and an increase in high-risk behaviors and exposure to violence (Freedenthal, 2017).

According to Joiner's interpersonal theory of suicide perceived burdensomeness and thwarted belongingness precede suicidal ideation (Joiner et al.,2012). Thwarted belongingness is composed of perceived isolation, loneliness, and a lack of mutually beneficial/positive relationships. Perceived self-hatred, low self-esteem, and feeling like a liability to others contributes to one's level of perceived burdensomeness. The factors which contribute to feelings of thwarted belongingness have a tendency to be more dynamic and are influenced by things such as interpersonal relationships and relationship with oneself such as affect and beliefs about oneself. When either perceived burdensomeness or thwarted belongingness are perceived as static, or stable and unchanging, hopelessness develops.

Hopelessness then proceeds the formation of passive suicidal ideation, or thoughts of wanting to die without intention of acting on these thoughts. However, acquired capability must occur prior to acting on suicidal thoughts. This is often done through lowered fear of injury, pain, and death. Decreased fear of death and injury increases the risk of intention to kill oneself. Further, increased pain tolerance increases one's acquired capability for a lethal suicide attempt.

Minority Stress Theory

The minority stress model, or minority stress theory, analyzes the "discrepancy or conflict that arises between the values of a minority group and the dominant culture or society (Comprehensive Clinical Psychology, 2022)." "Minority stress theory has been utilized as a theory to understand social, psychological, and structural factors accounting for mental health inequalities facing sexual minority populations (Frost & Meyer, 2023)." However, in recent years this theory has been applied to understand the experience of many gender diverse individuals as well.

Minority stress theory accounts for both proximal and distal factors, to include factors that originate from people and institutions that impact queer individuals as well as stressors which arise from internalized stigma for one's queer identity (Frost & Meyer, 2023). Distal factors of minority stress may include things such as discriminatory laws and policies, being a victim of gender or sexuality-based violence, chronic stressors such as living in poverty, and daily experiences of discrimination or microaggressions. Proximal stressors arise from internalized stigma, identity concealment, and anticipated or expected rejection (Frost & Meyer, 2023).

One systematic review found that in gender diverse adults over the age of 25 there is a significant association between suicidal ideation and the desire to transition, but not having done so yet (Vigny- Pau et al., 2021). Gender conversion therapy, internalized transphobia, and gender-based violence were also associated with increased risk for suicidal ideation and suicide attempts. Additionally, higher rates of family rejection and not having access to gender affirming restrooms, adequate housing, identifying as "non-white", having a lower level of education, lower income, and being unemployed were also associated with suicide and suicidality. This review also found that for youth under the age of 25, bullying, victimization, frequent microaggressions by peers, and struggles with body image were also associated with increased risk for suicide. Further, another study applying minority stress theory to analyze suicide risk factors amongst the trans community found that prejudice, discrimination, internalized stigma, and fear of anti-trans stigma from others were all related to depression and suicide (Tebbe & Moradi, 2016). However, access to gender affirming care and utilizing one's chosen name (Vigney Pau et al., 2021) and pronouns (Paley, A., 2020) were found to be protective factors against suicidal ideation.

Environmental Factors

Many environmental or external factors influence the well-being of gender diverse individuals. These factors frequently change based on time and location, and may impact certain "cohorts," or individuals who share similar demographic information, more than others. For example, gender diverse individuals in their mid 20's who live in rural, conservative states may have drastically different experiences compared to gender expansive individuals in their 60's living in very liberal states. One particularly transient external factor is the impact of laws and policies. While these laws not only vary federally, they also drastically differ from state to state which can be a continuous stressor for gender expansive individuals. This may cause increased distress and hypervigilance as they may be constantly aware of frequently changing laws that have a direct impact on their well-being.

According to the Human Rights Campaign, from January to late May, over 220 bills in the United States were proposed targeting gender diverse individuals and 70 bills were enacted. Additionally, per the Trans Legislation Tracker, there are currently 430 active anti-trans bills in the United states at the time of this writing (March 30, 2024). They define anti-trans legislation as legislation that seeks to block trans people from receiving basic healthcare, education, legal recognition, and the right to publicly exist. Awareness of these discriminatory laws and policies have shown increased hopelessness in transgender and gender-nonconforming (TGNC) populations (Tebbe, 2022).

Further, queer youth are more likely to be a victim of gender-based violence compared to their cisgender peers. In a study of 25, 398 youth (ages 13-24), nearly 30% of transgender and non-binary youth reported being physically threatened and/or abused in the past 12 months due to either their sexual orientation or gender identity (Price-Feeney, Green, & Dorrison, 2020).

While the influence of laws and policies on gender-based violence and discrimination is not clear, it is likely that these laws and policies influence the risk of gender-based violence, discrimination, and microaggressions.

Impact of Environmental Facts on Internalized Experience

Internalized transnegativity or internalized transphobia "refers to discomfort with or negative attitudes and beliefs about one's transgender identity that develop as a result of internalizing society's stigma" (Israel et al., 2021). Feelings of shame and decreased mental health have been associated with higher levels of internalized transnegativity (Cascalaheira & Choi, 2023). Those with higher levels of internalized transnegativity may be more likely to conceal this aspect of their identity.

Identity concealment refers to the ways in which individuals who hold stigmatized identities may respond to social rejection through concealment. For those with identities that may be concealable, they must regularly make decisions about whether or not to conceal their identity. It has been documented that identity concealment is often a stressful experience and many queer youth even report not accessing mental healthcare due to fear of being outted by healthcare providers (Pachankis, 2007; Paley, 2020). Identity concealment often includes extra psychological demand including weighing the risks and rewards of sharing their identity with others. This may include wondering whether it is safe to share their identity with others, what will happen if they share their concealable identity with others and/or are "outted" by others, feeling detached from their true sense of self, and the possibility of missing out on forming relationships with others who have similarly concealable identities(Pachankis, 2007). These processes can have a powerful, negative impact on one's daily life and internal experience.

Queer Specific Risk Factors

Another study (Ream, 2019) analyzed data from the National Violent Death reporting system, specifically looking at queer identified individuals between the ages of 12-29. They found that the highest prevalence for prior suicide attempts was for transgender men assigned female at birth. The highest prevalence of suicidal thoughts and psychological diagnoses were amongst bisexual women. Regarding family connections and romantic relationships, lesbians and bisexual women were more likely to have intimate partner problems contribute to their deaths while gay men, bisexual men and women, as well as transgender men were the most likely to have had reported family difficulties prior to death.

Additionally, living in an urban area was associated with lower odds of death by firearm, higher likelihood of prior suicide attempts, and higher rates for both diagnosis and treatment of mental illness (Ream, 2019). While there is considerable data about suicide amongst the queer community, there is less research about inner group differences that may factor into risk within the community. There is growing research regarding suicide amongst transgender individuals, as these rates tend to be significantly higher compared to their cisgender peers. However, limited research has been conducted looking specifically amongst gender non-conforming individuals, or individuals who do not identify within a gender binary.

Need for Gender Informed Care

One study by Goldbech et al. (2019), examined whether there is a need for queer specific crisis services. The study obtained information from those ages 12-25 who received services from a suicide prevention crisis service provider with an emphasis on the needs of queer youth. The study consisted of 657 individuals. Of these individuals, 48% were between the ages of 18 and 24. Additionally, 16.7% identified as transmasculine, 5.5% identified as transfeminine,

13.6% identified as "nonbinary, agender, genderqueer, genderfluid" and another 8.2% identified as another gender identity (other than cisgender).

Roughly a quarter of the participants said they would not have contacted another helpline if the queer affirming crisis line did not exist and nearly half reported that they were "unsure" of whether they would connect to another helpline if this resource did not exist. When asked why they contacted the queer affirming crisis hotline specifically, over 40% reported that it was because of the ability to speak with an queer affirming provider, and another 14.5% reported that they wanted to speak with a trusted provider. Overall, the study concluded that the primary reason many participants decided to call the chosen provider was because it is queer affirming. Of important note to this paper, transgender and gender nonbinary individuals were more likely to endorse queer affirming care as the driving force for their engagement with treatment.

Another study conducted by Price-Feeney et al (2020) analyzing the mental health of transgender and nonbinary youth, found that amongst a survey of 34,808 individuals between the ages of 13 and 24, 70% reported depressed mood, 39% had considered suicide, and 18% had made a suicide attempt in the past twelve months. Further, transgender and gender non-conforming individuals had higher rates of suicide attempts than their cisgender peers. According to this study, non-binary individuals had the highest rates of being discriminated against for sexual orientation and transgender men had the highest rates of being discriminated against based on gender identity. Transgender men also had the highest rates of depressive mood, considering suicide, and making a suicide attempt compared with other gender identities in this study.

Another study by Horwitz et al (2020) analyzed risk factors for suicide based on sexual orientation and gender identity. Researchers utilized the data collected from wellness screens

of 44,212 degree seeking students in the United States. Among this population, male to female transgender individuals had the highest rates of suicidal ideation and suicide attempts. Although, assigned male at birth (AMAB) genderqueer individuals had the highest rates of depression and reporting two or more risk factors for a suicide attempt.

Implications for Healthcare

This qualitative study (Lykens et al., 2018) analyzed healthcare experiences of individuals who identify as genderqueer or nonbinary. Ten individuals were interviewed about their experiences seeking and accessing healthcare. All participants were adults between the ages of 23 and 33 in the San Francisco Bay Area who had accessed healthcare at least once in the past six months. This study found that participants faced unique challenges even at clinics who specialized in providing gender affirming care. They reported that they often felt misunderstood by providers who approached them from a binary perspective, and often did not receive care sensitive to nonbinary identities.

In response, these participants reported that they often "borrowed" a binary gender label (by identifying as a transgender woman or transgender male) to receive care, modified healthcare they were prescribed, or went without healthcare. Generally, they reported feelings of being frustrated and disrespected as they sought healthcare. They felt that the binary transgender care pressured them to conform to binary medical narratives throughout their healthcare interactions.

A study by Goldberg et al., 2018 analyzed 506 transgender binary and non-binary undergraduate and graduate students' experience in healthcare. The study analyzed "whether binary versus nonbinary status is related to perceived misgendering" and impacts on gender affirming care, whether sex assigned at birth is related to perceived misgendering and gender

affirming treatment, whether race is related to perceived misgendering, and whether student status (undergraduate vs graduate) is related to misgendering and gender affirming treatment. Slightly more than one-third of students described only negative experiences in therapy and slightly less than one third of students described only positive experiences in therapy.

Negative experiences of therapy often involved explicit invalidation of one's gender identity, especially nonbinary gender identities. Further, some therapists failed to use a client's proper pronouns, affirmed name, or over emphasized a client's gender identity as the "root cause" of all their mental health struggles. Other therapists avoided and/or awkwardly approached the discussion of gender, lacked competence about gender diversity, or expected their clients to educate them about their gender identity.

One-sixth of respondents detailed "trans-positive" encounters where they found their therapists to be affirming. These encounters included things such as utilizing one's affirmed names and pronouns as well as having "trans competent" therapists. Additionally, some non-binary participants noted that they appreciated their therapist's knowledge that their gender identity was "not necessarily fixed and might change."

Further, students voiced frustration regarding access to campus medical providers who were able and willing to treat transition and medical related care such as hormones, electrolysis, and gender-affirming medical procedures. Students also expressed frustration, desiring trans-inclusive insurance coverage.

Protective Factors

It is also important to assess one's protective factors when assessing their risk for suicide. Protective factors often include things such as outlook, social support, connectedness, skills (coping, problem-solving, etc.), marriage, positive self- esteem, a sense of competence and effectiveness, cultural values against suicide, fear of dying, and religious beliefs or commitments

(Freedenthal, 2017). Hopefulness and resilience have also been found to be strong predictors in keeping individuals contemplating suicide from making an attempt. Additionally, just as there are static demographic risk factors for suicide, there are demographic protective factors for suicide as well. For example, black women in the United States die by suicide at significantly lower rates than white women. Those who hold religious and/or spiritual beliefs also have lower rates of completing suicide than those who are not.

LGBT Specific Protective Factors

Multiple studies have found that one's positive affect toward their community is a protective factor against suicidal ideation in sexual and gender minoritized groups (Inderbinen et al., 2021). Pride towards one's own gender identity was also found to be a protective factor against suicidal behaviors. Other studies have suggested that resilience is a key protective factor for gender and sexual minorities (Hendricks & Testa, 2012).

Hendricks and Testa suggest that clinicians increase their understanding of trans identities and experiences as well as provide culturally competent assessment and treatment to help reduce the rate of suicide amongst transgender individuals. They recommend assessing prior experiences of discrimination and victimization, expectations of future discrimination and victimization, internalized transphobia, and resilience among transgender and gender diverse individuals.

Further, psychologists and other mental healthcare professionals can further assess the level of connectedness and sense of belongingness one feels to transgender and gender diverse communities. This paper seeks to help further develop guidelines for how to assess for suicidal risk amongst gender diverse individuals as well as steps for intervening with these individuals in a manner that is culturally aware to individuals who are gender diverse.

Personal/Professional Reflections

While there are a vast number of discussions, data, and perspectives on how to best complete risk assessments and inquire about suicide, there remains a need for more culturally informed approaches to completing risk assessment. As has been well-documented there is increased risk for queer individuals to experience suicidal ideation and die by suicide. Further, the rates for transgender individuals experiencing suicidal ideation stand at a much higher prevalence compared to their cisgender peers. However, this still often encourages professionals to assess suicidal risk from a binary perspective. It is my goal to shed light on considerations when assessing for suicide risk with gender diverse individuals who lie outside of the gender binary, such as gender non-conforming, genderqueer, genderfluid, and non-binary individuals.

I have worked with gender diverse individuals in a wide variety of settings including community health, hospitals, the emergency room, and private practice. The most common mistakes I have seen when providers interact with gender diverse individuals is a lack of education working with this population as well as being quick to make assumptions. For example, practitioners may not be familiar with the language for identities that fall beyond a binary perspective such as "genderqueer," "genderfluid," or "non-binary."

Clinicians, especially upon initial meetings, during brief interventions, and in crisis settings should not assume one's gender, experience, or pronouns. We begin building relationships with our patients and clients in our first moment of contact with this person. Whether this be a phone call, greeting someone in the waiting room, or after they have been triaged and are awaiting our care. How we address our clients in these moments can have dire impacts on how they engage in treatment, adhere to treatment, whether they are likely to return

for treatment, and may impact their help seeking behaviors when experiencing a mental health crisis in the future.

It is also important to take accountability and repair when we make a mistake. Mistakes happen and it is normal to be apprehensive about what will happen if we make an error. Rather than avoiding topics of discussing gender all together for fear of making a mistake, we should stay engaged and quickly make an apology for our error if we accidentally misgender someone, use an incorrect name, etc. For example, if we misgender a client when working with them then we may say something such as " She, I'm sorry, they" and continue with our intervention.

It is a disservice to our clients to completely avoid the topic of gender when talking with them. However, it is also a disservice to not acknowledge our mistakes and may impair a client's trust when seeking treatment if we accidentally misgender them and refuse to acknowledge our mistakes. This may have impacts not only on our relationship with them, but also their willingness to seek healthcare in the future. We must repair with clients when we do make a mistake; taking accountability shows we are human and we may also increase rapport with our clients by doing so.

As providers we can often forget the impact of these little things. We must meet our clients with genuine curiosity and approach information obtained from healthcare records with a dose of healthy criticism. Anecdotally, I have heard many clients express frustrations of being mis-gendered, deadnamed (misgendering someone by utilizing a name other than their chosen name), having providers focus too much on their gender when not-relevant, or having providers completely ignore their gender identity

On both systemic levels and the individual provider level we can make simple changes to help prevent these frustrations. On systemic levels we can ensure that our clients have the ability

to report their preferred name and correct pronouns orally and on introductory paperwork. We can make efforts to ensure these are easily identifiable in medical records and are used across the board within our systems, from the front desk, to meeting with case managers, to meeting with physicians. We can also make sure that our environments are welcoming to gender diverse individuals by having resources specific to gender diverse folks, pride flags, and unisex bathrooms.

However, while there are many things systemically that can impact how individuals receive care, for the purposes of this paper I want to focus on what we can do as individual providers and as part of a team. First, we can start off by introducing ourselves with our pronouns. This communicates that we are aware of the importance of pronouns, and it invites our clients to disclose their pronouns if they wish. However, this should also be followed up by asking the name clients prefer to go by and their pronouns. By taking this step upon initially meeting the client we avoid deadnaming them and accidentally misgendering them. We can also ask about their gender identity, ensuring not to assume they identify how they may be perceived or by what is reflected in their medical record.

Providers must also be careful not to pathologize one's gender identity or experience. While we should be informed and aware of how minority stress may impact the mental health of gender diverse individuals, we should not assume that they are or are not in our presence due to distress related to their gender. In this manner, we should still ask and inquire about presenting concerns just as we would with any client or patient. A gender diverse client may be presenting for the same suicidal concerns just as their cisgender peers.

Providers should also have a basic understanding of the legal barriers this population may face in their geographical location. Clients may identify as a different gender or name than is

listed on their legal documents. This may be due to financial barriers, time barriers, or even safety concerns. The patient may utilize a specific name in most settings but not in other settings such as home or work due to safety concerns.

Further, providers should be aware of various insurance barriers to gender affirming care such as gender affirming surgeries and access to hormone replacement therapy. While this may be a large ask for each individual provider to know, providers should at least be aware of resources or other team members they may direct a client to in order to help get these questions answered. Additionally, providers should be aware of local community resources to provide the client with. This may include things such as knowing gender affirming care providers in the area, queer community centers, and support groups for gender diverse individuals.

Risk Assessment

While different settings may utilize different tools to assess risk, many suicide risk screeners share some basic components. The first part being assessment of ideation, intent, plan, means, and behavior. Assessing ideation may include determining if someone is experiencing suicidal thoughts and whether these thoughts are “active” or “passive” in nature. Active suicidal thoughts may be those with plans, intent, means, and behavior. These thoughts include present ideation with a current desire to be dead and/or kill oneself. Passive thoughts consist of thoughts of wanting to be dead without thinking about engaging in a behavior that will lead to one’s death. These thoughts may consist of things such as “things would be better if I didn’t wake up” or “I would not mind if something happened to me and I died.” While both types of thoughts pose a risk for suicidal behavior, active thoughts pose a greater risk and are more likely to be associated with intent, plan, means, and behavior to kill oneself.

If a client answers yes to ideation it is important to assess intent, plan, means, and preparatory behavior. To assess intent, a provider should inquire about if the patient has any desire to act on these thoughts or die by suicide. One screener which is commonly utilized, the Columbia Suicide Severity Rating Scale does this by asking " Have you had these thoughts and some intention of acting on them?" (Bjureberg et al., 2022). It is not uncommon for individuals to endorse suicidal ideation with no intent of ever acting on the ideation.

Further, when assessing for a plan, questions such as "Have you been thinking of how you might do this?" and "Have you started to work out or worked out how you might do this?" These questions help identify how thoroughly a client has thought out their suicidal ideation. For example, some clients may have responses such as "cutting my wrists and overdosing." While others may have more specificity such as "I plan to kill myself on Tuesday when my roommate is gone for work by overdosing on my anti-depressants and cutting my wrists."

While a more specified plan implies a greater risk of the client completing suicide, this is only one factor to assess when determining their level of risk. Further, one's prior suicidal behaviors should also be assessed as prior suicide attempts is one of the greatest predictors of future suicide attempts. Other behaviors that may be of concern include an increase in risk-taking behaviors and intentionally putting oneself in harm's way. If an individual has a sudden change in regard for risk taking behaviors and increased impulsivity compared to their typical demeanor, these are additional factors that should be considered as signs of risk when completing a risk assessment.

Finally, lethality of means and whether the individual has access to a firearm or other lethal means should also be assessed. The healthcare provider should inquire about means to kill oneself, lethality of means, and access to means. This commonly includes inquiring about one's

access to firearms and medications. However, it can also include assessing for things such as access to knives, chemicals, and any other means an individual has identified as materials they could utilize to die by suicide. Completion of suicide via firearm is the most common means for cisgender men and often the most lethal means for those making an attempt impulsively.

If an individual has identified means in which they would kill themselves it is important to discuss what they can do to limit access to these means such as giving medications to a loved one, utilizing safes to store means, or even temporarily handing over firearms to loved ones or someone they trust. In addition to assessing for a client's direct risk for suicide, a thorough suicide assessment also includes assessing for both additional risk factors and protective factors.

Risk Factor Considerations

When assessing risk with gender diverse individuals experiencing suicidal ideation we should still consider risk factors that we assess with all other clients such as access to means and prior attempts. However, we should also consider things that may influence one's distal or proximal minority stress factors. We should not assume one's family connections or social support. Our clients may not have connections with social or familial support, often due to coming out or expression of their identity. Further, we should be careful of how we are defining "family" and acknowledge that the chosen family may be a crucial part of our client's support system.

Queer individuals also face additional factors that may make it even more difficult to discuss suicide such as internalized transphobia, negative reactions from others, societal stigmas about queer people, negative perceptions and/or healthcare experiences from healthcare professionals (Dunlap, 2022). All of this in addition to the general stigma and shame that may exist when talking about suicide generally.

Protective Factors

Protective factors are often assessed with questions similar to “What keeps you from killing yourself?”. Individuals often report responsibilities to family, loved one, or pets as crucial protective factors. Other factors may include things such as spirituality, engagement at school and/or work, and positive relationships with mental health providers. Internal protective factors may include things such as reasons for living, ability to cope with stress, knowledge/use of coping skills, and fear of death or the actual act of killing oneself. Those protective factors that can further be fostered such as relationships, responsibilities, and engagements in society should be noted and further fostered. However, it is important to note that this is not an exhaustive list and protective factors may be extremely individualistic. For example, some gender diverse clients whom I have worked with have reported continuing to support their community, engaging in efforts for advocacy and change, and “existing out of spite” as reasons for living.

Protective Factor Considerations

As mentioned earlier, a key part of risk assessment is not only identifying suicidal ideation and potential threat to oneself, but also identifying protective factors and one’s reasons for living. For gender diverse individuals assessing for gender euphoria may help to alleviate aspects of gender dysphoria. Important factors to assess may include one’s access to supportive family and friends, whether one’s workplace is affirming of their gender identity, and connection to the queer community. Even when individuals may not have queer friends and family, it may be important to inquire about supportive online spaces. Additionally, awareness and connection to queer community events and spaces may be important.

External Factors

Another factor which must be considered when assessing risk for suicidal ideation and intervening amongst gender diverse individuals is considering the impact of external factors. While most professionals trained to assess suicidal risk are taught to also assess some aspects of relationships and various protective factors, this is especially pertinent when working with gender diverse individuals. These things may include spending time around rejecting and/or abusive individuals, policies and laws impacting one's well-being, feeling disconnected and/or rejected from the queer community, social media, queer stigma, and spending time in unhealthy environments (Dunlap, 2022).

Considerations for Intervention

The first step of intervening with suicidal clients is within the relationship. This is why utilizing the proper name, pronouns, and having a non-judgmental stance are crucial when intervening with gender diverse individuals who may be experiencing suicidal ideation. Part of an effective intervention with these clients (or any other clients) may be validating their identity and lived experiences. Additional pieces to intervening with these clients in a short-term setting may include different ways to foster hope such as: identifying their reasons for living, identifying protective factors, increasing their knowledge of queer resources, decreasing shame, decreasing stigma, and increasing their level of connectedness with the queer community. Further, safety planning is an effective tool which can be adapted when working with gender diverse clients who are suicidal.

Identifying Reasons for Living

Helping a client identify reasons for living may be as simple as asking just that, "What are your reasons for living?" Other approaches to this may be reflecting on "What keeps you from killing yourself?" "What motivates you to get up in the morning?," and "What are you

passionate about in life?". Once reasons for living have been identified validation, encouragement, and motivational interviewing may be possible strategies to implement and create behavioral activation move closer to those reasons for living. However, it is important to consider that not all clients may be able to identify a reason for living, even with additional exploration from a supportive therapist or healthcare provider. In these instances, it may be even more crucial to draw on protective factors.

Increasing Knowledge of Queer Resources

One should quickly assess their patient's familiarity and connectedness with various queer resources. It is always important to first ask the client of their knowledge of resources, in case they may already be aware of and utilize the resources you are able to provide. This may be as simple as informing them of queer affirming crisis lines such as the Trevor Project's crisis line or The Trans Lifeline. Other potential options may include referring them to local queer spaces in your area and/or informing them of any queer specialty healthcare clinics.

Increasing Connectedness with Queer Community

It would also be important to assess one's level of connectedness with the queer community. For some individuals they may be well connected and have no interest in further increasing their connection with the community. Other individuals may have no connection and may not be interested in developing a connection for many reasons. Others may have previously attempted to connect with queer individuals, attend queer events, and go to queer spaces, but have had negative experiences. It is important not to be forceful in the approach to encourage clients to engage with their community, but rather be explorative and "leave the door open" as something to further discuss if the client is interested.

If an individual is interested in enhancing or increasing their level of connection with the queer community, it may be important to explore ways in which the individual is willing and ready to do this. Is the individual open to attending in-person meetings and going to in person spaces, or would they prefer online spaces? Are they open to exploring any spaces catered to individuals within the broader community or do they want something more specific to their identities?

It is also important to consider how one’s intersecting identities may impact their willingness/ability to be present in certain spaces. This is crucial to consider as just because one space or community is accepting of one aspect of an individual’s identity, they may not be accepting of other parts of their identity. Once these questions have been clarified then various resources both in-person and online may be offered to the client. Even in locations where physical queer spaces cannot be accessed, awareness and involvement in online communities may decrease one's feelings of loneliness and enhance their feelings of connectedness with the queer community.

Decreasing Shame, Stigma, and Internalized Negative Experiences

Decreasing shame and stigma one is having in relation to their gender identity may begin with speaking to them with curiosity and taking a non-judgmental stance. Providers can do this by being curious about the patient’s experience and having a general knowledge about working with transgender and gender diverse patients prior to doing so. While these topics are best discussed when following the client’s lead, it may be also beneficial to “softly” inquire about these experiences when working with queer folks. Questions could be broad such as “Are you comfortable with who you are?” or “If you could change anything about yourself what would it

be?" Broad, open-ended questions may give us insight to our patient's internalized experience as it pertains to gender identity, mental health concerns, and suicidality.

Additionally, we can decrease shame and negative internalized experiences by challenging a client's beliefs. We may explore what beliefs they hold about themselves, where they have received messaging about themselves and/or an identity they hold, and gently challenge these beliefs. For example, if a non-binary patient is experiencing feelings of shame or internalized transnegativity because they do not present "androgynous enough." It may be beneficial to explore these thoughts, discuss possible alternatives to these thoughts, and provide gender-affirming resources as necessary.

Safety-Planning

Once risk and protective factors have been assessed another crucial step for intervention can be safety-planning. Perhaps the most used safety plan is the Stanley-Brown safety plan (Stanley & Brown, 2008). This plan encourages healthcare providers to collaboratively identify ways in which the client can keep themselves safe during times of crisis. Client's are asked to identify warning signs they might be experiencing a crisis, things they can do to take their mind off of the desire to hurt and/or kill themselves, people who can provide a distraction, places that may provide a distraction, individuals in their life they can ask for help, professional resources they can go to to seek help, as well as ways in which they can keep their environment safe.

Throughout this process, it is important to utilize the client's correct name and pronouns. If a copy of the safety plan is uploaded to the client's electronic healthcare record their correct name and pronouns should also be reflected on this version of the safety plan. Additionally, when discussing warning signs the client is experiencing a crisis it may be important to also

discuss the precipitation of these events or what “triggers” clients. Gender diverse folks may be more likely to be triggered by news, policies, and unsupportive families than other clients.

Next, things the client can do and people they can contact to provide a distraction to themselves are further explored. It is essential to identify which people may be safe for the client and providers should not be invalidating of the relationships the client reports. When inquiring about supportive individuals in the client’s life, gender neutral language should be utilized such as using terms like “partner” and “children” rather than “husband/wife”, “boyfriend/girlfriend”, or “son/daughter.” It is crucial to be open to the idea of chosen family and providers should not assume that the individual’s biological family is supportive.

If the client is struggling to name individuals then perhaps exploring friendships and chosen family would be beneficial. Additionally, gender diverse folks may be more likely to report significant online relationships if they have had difficulty connecting with their local community. Finally, queer friendly crisis resources should be included on the safety plan in addition to other local and national resources. Two such resources are the Trevor Hotline (1-866-488-7386) and Trans Lifeline (877-565-8860), these two crisis lines provide support specifically to queer individuals.

Conclusion

While providing gender-affirming care and conducting risk assessments are both nuanced topics, it is my hope that this paper has provided the reader with further guidance on how to do so in the future. When working in mental health there is rarely a “right” or “wrong” and treatment is often guided using a combination of best practices and our own unique clinical judgement. Attached are four appendices: 1) an infographic for providers on providing gender affirming care, 2) guidelines for interviewing gender diverse folks about suicidality which is

intended to be used as a guide of things to consider when assessing suicidal ideation with this patient population,3) general guidelines to utilize when working with gender expansive clients, 4) a glossary of terminology to reference various gender terminology and identity, and 5) a safety planning template for use when working with gender diverse individuals.

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PROVIDERS NAVIGATING HEALTHCARE: GENDER AFFIRMING CONSIDERATIONS

It is important as a clinician or healthcare provider to be aware of ways to eliminate health disparities, increase health equity, and help clients get the most out of their time with you. Gender is one way in which healthcare providers must be conscious of the way they provide care and the way they can help eliminate health disparities. It is important for providers to consider the healthcare needs of gender diverse clients such as those who are transgender or non-binary. Healthcare providers must be aware of their own assumptions around gender and sex and be familiar with how these words are utilized in their professional setting. For example, one mistake commonly made is referring to someone being a man or women as their sex-this is not their biological sex, it is their gender. When working with individuals who identify as transgender or non-binary making a mistake in terminology can have quite distressing impacts. Other things that one may be conscientious of when working with gender diverse clients are their preferred name and pronouns. Unfortunately, in the world of health, practicality and formalities don't always align: make sure that if a client's medical record does not align with the name they go by or their pronouns, you address them by their preference in order to help minimize or reduce client distress. It is always good practice to start off by introducing yourself with your name, pronouns, and what relation to the client you will have in providing them healthcare services. This helps build rapport with clients and may increase their comfort level in disclosing any gender-related health concerns they may have. Additionally, it may help build rapport with clients by having some sort of gender inclusive symbols (ex: trans pride flag, pamphlets on local resources, books about gender diversity and healthcare) incorporated into your professional space. Aside from direct concerns about providing gender affirming care, one should also be aware of some of the things that the gender diverse community is at a higher risk for, such as: homelessness, incarceration, suicidal ideation, being the victim of violence and sexual assault, lack of support system, etc. These risks have immense impact on a client's overall well-being and conscientious providers are aware of these risks and resources to help with them.

2017 TRANSGENDER AWARENESS MONTH NOVEMBER

TRANSGENDER is an umbrella term for a diverse group of people—such as male-to-female (MTF) and female-to-male (FTM) trans people, genderqueer individuals, and many others—whose gender identity or expression differs from societal expectations of how they should look, act, or identify based on the sex they were assigned at birth.[1]

33% of transgender people delayed seeking preventative care because of mistreatment within the healthcare system.[4]

Limited financial resources also keep transgender people out of care. In Massachusetts, nearly 20% of transgender people did not see a doctor because they could not afford to.[2]

Without regular preventative care and treatment transgender people are at risk for **advanced and costly diagnoses** such as late-stage cancer, HIV and other chronic illnesses.[4]

Language within the community is constantly *evolving*

More than 500 unique gender identities were shared in the *2015 U.S. Transgender Survey (USTS)* by participants.[2]

1 in 5 transgender people has been turned away by a health care provider.[3]

Transgender and gender non-conforming individuals were **3x more likely** to have to travel more than 50 miles for transgender competent care.[2]

Anti-transgender laws, employment discrimination, and workplace harassment prevents transgender people from earning livable wages and accessing benefits like health insurance.

UNEMPLOYMENT RATE (TRANSGENDER PEOPLE)[4] 14%

UNEMPLOYMENT RATE (GENERAL POPULATION)[4] 7%

x2

However, participants faced **financial and legal barriers** when attempting to update their identification:

49% Don't have an ID with their preferred name.[2]

67% Don't have an ID with their preferred gender.[2]

Discrimination and violence beyond healthcare & employment

ONLINE + MOBILE

Transgender and gender non-conforming survivors were **2.8x more likely** to have to experienced hate violence online or on the phone compared to cisgender survivors.[5]

IN RELATIONSHIPS

Transgender and gender non-conforming survivors were **3.3x more likely** to have to experienced intimate partner violence compared to cisgender survivors.[5]

DEATH

130 transgender and gender non-conforming individuals were murdered between 2010-2017.[6]

of the murder victims were **black transgender women**.[6]

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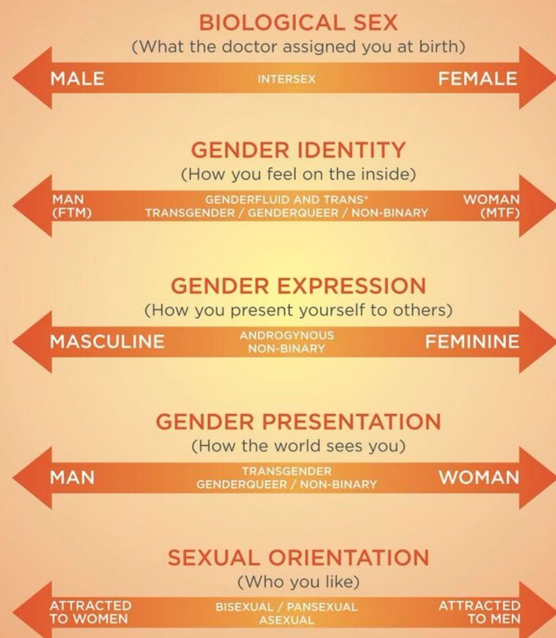
FENWAY HEALTH fenwayhealth.org @fenwayhealth COMM-81

Considerations for Intervening with Gender Diverse Individuals Experiencing Suicidality

- Acknowledge your own biases. While these guidelines are aimed for working specifically with the gender diverse population, it is important not to assume and/or emphasize one's gender identity as the root cause of their distress.



- Introduce yourself with your pronouns and ask about their preferred pronouns and name.
- Be aware of the concept of "chosen family" when discussing protective and risk factors. Family roles may look different for this community and their biological family may be a source of emotional distress. It is important to emphasize the client's current social support system.
  - It may be especially important with this community to identify which individuals in their life are supportive of them and which individuals are not. For example, they may have people in their life who are supportive of them in aspects other than their gender identity and individuals who are supportive of their gender identity, but not other aspects in their life.
- Assess for connection to the LGBTQ+ community. Research has shown that those who feel more connected to their community are less likely to experience suicidal ideation (Freedenthall, 2017).
  - Those involved with the LGBTQ+ community may be more likely to feel a sense of pride towards their gender identity and/or sexual orientation which has been found to be a protective factor against suicidal behaviors.
- Be aware of societal laws and policies that may impact and/or cause distress to gender diverse individuals. Fluctuating policies that impact the LGBTQ+ community could directly impact one's sense of hopefulness as well as sense of self-worth.
  - Policies may further impact one's sense of transnegativity or internalized "transphobia." This would likely have a negative impact on one's mental well-being and may put them more at risk for feelings of low self-worth, hopelessness, and experiencing suicidal ideation.
- Assess for things such as anticipation of future discrimination and expectations of future victimization.

- Validation of prior experiences and anticipatory fears may further help these client's feel heard in moments of distress. The provider may consider working with the client to help identify how they may cope when fears of future discrimination and victimization are increased. This may include things such as exploring distress tolerance techniques, social supports, and community supports.

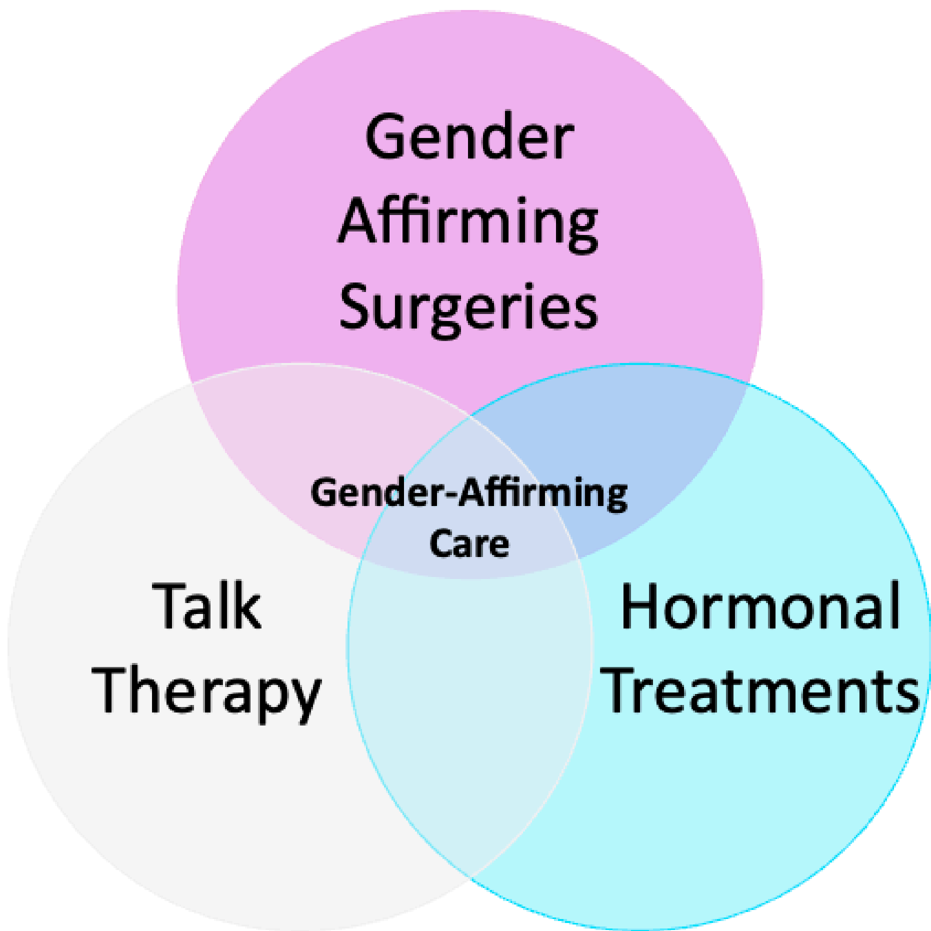
- Be aware of LGBTQ+ community resources and gender diverse friendly crisis resources.
  - Trevor Project Hotline is an LGBTQ+ crisis line that is open 24/7. The phone number is 1-866-488-7386. They can also be communicated with via text at 678678 or chat online at www.thetrevorproject.org
  - TransLifeLine is a crisis line run by and for transgender/gender diverse individuals. Their phone number is 877-565-8860. However, it is important to note that they are not a 24/7 hotline their line is available Monday-Friday 10 AM-6 PM pacific time, 11 AM-7 PM mountain time, 12 PM- 8 PM central time, and 1 PM to 9 PM eastern time.
- Have a safety template created that is gender diverse friendly and incorporates both national and local crisis resources at the bottom of the template.

Working with Gender Diverse Clients : The Basics

- Understand how the terms sex and gender are used in your workplace and know that they are two separate things.
- Understand that gender is not binary, and clients may identify outside of being a man or woman.
- Staff should identify a patient's pronouns and preferred name at intake
  - For example, the staff member doing intake could say "What pronouns do you use?" "Is your legal name the name you would like to go by, or do you utilize another name?"
  - This should be done for all clients DO NOT ASSUME a client's pronouns or that the legal name in their medical records are correct
  - It may also help build rapport with clients by introducing yourself using your pronouns. For example: Hi, my name is--- I will be your--- or treating you for---- my pronouns are----.

	Subject	Object	Possessive	Pronunciation	Example
Gender Binary	She	Her	Hers	As it looks	She is speaking.
	He	Him	His	As it looks	He is speaking.
Gender Neutral	They (Sing.)	Them	Theirs	As it looks	They are speaking.
	Ze	Hir	Hirs	Zhee, Here, Heres	Ze is speaking.
	Ze	Zir	Zirs	Zhee, Zhere, Zheres	Ze is speaking
	Xe	Xem	Xyr	Zhee, Zhym, Zhyre	Xe is speaking.

- Use gender neutral language
  - When asking about a client's relationship status or romantic involvement use the word "partner" instead of boyfriend/girlfriend or wife/husband.
  - When inquiring about parental status or relationships with children use the words "children" or "kids" instead of "daughter" or "son". Further, the words "parent" or "guardian" are gender neutral terms that could be utilized to ask about parental status.
- Electronic Medical Records
  - Healthcare providers should have a way to change or indicate a patient preferred name and pronouns on their electronic medical record.
  - If legal name is different from preferred name them consider having a way to place this an attention-grabbing manner in a client's charts/records so that other staff members do not call out the incorrect name or pronouns when interacting with the client
  - When working in a setting that utilizes wristbands to identify patients ensure preferred name is listed and if sex is listed have an option available to leave it blank or enlist a gender-neutral marker.
  - Have a consensus among staff what a blank or gender-neutral marker could mean when working with clients.
  - Make sure that any letters or paperwork sent to the client also utilizes the preferred name
- Understand legal barriers
  - Clients may identify as another name or different sex than assigned on their legal documents. It would be best to have a general understanding of what the legal process is in your state to have a better understanding of the client's barriers or why the client's identification may not always be consistent across records.



- Understand insurance policies
  - Some insurance policies cover gender affirmative care such as therapy, gender affirmative surgeries, and hormone replacement therapy and others do not. Know how to find requirements and process for getting gender-affirmative care covered under different insurance plans.
- Be aware of community resources
  - Know of other gender affirming healthcare providers in the area that you may consult with or refer your clients to if necessary.
  - Be familiar with community resources you can direct your client to for additional support such as: community centers and support groups.
  - Additionally, be familiar with resources for family and friends of the client that may support their gender identity and/or their transition.
  - Provide info to LGBTQ+ suicide prevention hotlines and other support organizations

Glossary of Terminology [1]

AFAB or "Assigned Feminine at Birth" – The sex used to describe a female child at birth based on their external anatomy.

AMAB or "Assigned Masculine at Birth" – The sex used to describe a male child at birth based on their external anatomy.

Cisgender- A term used to describe someone whose gender identity consistently aligns with the gender identity assumed with their sex assigned at birth.

Coming Out- The process by which queer and trans folks recognize, accept, typically appreciate, and often celebrate their sexual identity, sexuality, or gender identity/expression, either to themselves or others.

Dead-Name/Dead-Named- The previously given name of a person who has decided to change their name in order to better align with their gender identity. As a verb, to deadname someone means to misgender someone by using a name they no longer use. This can be intentional or unintentional.

Gender- A social construct. This term is often understood as a binary, however, historically and presently, gender is expansive and dynamic. Gender is framed by a society's understanding of masculinity and femininity as related to roles, behaviors, expectations, activities, identities, and attributes. The key elements of an individual's gender are gender identity, gender attribution, and gender expression.

GenderFluid- An individual who does not identify with a single, fixed gender. These individuals have a fluid, or unfixed, gender identity.

Gender Diverse[2] – An umbrella term used to describe gender identities that demonstrate a diversity of expression beyond the binary framework.

Gender Expansive- A person with a wider, more flexible range of gender identity and/or expression than typically associated with the binary gender system. Often used as an umbrella term for those who fall outside of the gender binary.

Gender Identity - A person's individual understanding of their own gender and the language they use to describe this understanding. This can also be considered one's innate and personal experience of gender.

GenderQueer – Those who reject static notions of static gender and embrace fluidity in gender identity. These individuals may see themselves as both masculine a feminine, neither masculine or feminine, or somewhere in between.

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[1] Definitions included in the Glossary of Terminology are taken directly and/or adapt from Michigan State University and the Human Rights Campaign. Direct links to these websites can be found in the references section of this paper.

[2] Definition taken directly from the Agender Agenda. A link to this website can be found in the reference section of this paper.

Gender Binary- A socially constructed system in which gender is classified into two distinct and opposite categories such as “male or female,” “masculine and feminine,” “man or woman.” These categories are narrowly defined and disconnected from one another. They are strictly enforced through narrowed gender roles and gender expectations.

Gender Nonconforming – A term that describes a person whose behavior or appearance does not conform to societal and cultural expectations of what is appropriate for their gender. This term is usually more related to gender expression or gender attribution than gender identity. It is usually used as a descriptor. Although rare, some people do use this term as a gender identity term.

Sex - the designation that refers to a person’s biological, morphological, hormonal, and genetic composition. One’s sex is typically assigned at birth and classified as either male or female.

Sex Assigned At Birth- The sex, male, female, or intersex used to describe a child at birth based on their external anatomy.

Transgender/Trans- A gender identity term for an individual whose gender identity does not match or is at some distance from the gender identity assumed based upon the sex they were assigned at birth. For some folks, transgender and/or trans are considered to be umbrella terms.

Non-Binary - A gender identity term for a person who identifies outside of the gender binary. Nonbinary is also conceptualized as an array of genders at some distance form the gender binary. Nonbinary is sometimes written as “non-binary.” A common abbreviation for nonbinary is enby.

Transfeminine/Transfemme- An adjective describing a transgender person assigned male at birth with a primarily feminine-spectrum gender identity. This term is inclusive of both binary and nonbinary transgender people.

Transmasculine/ Transmasc- An adjective describing a transgender person assigned female at birth with a primarily masculine-spectrum gender identity. This term is inclusive of both binary and nonbinary transgender people.

Trans Man/ Trans Woman – A man who was assigned female (or intersex) at birth and identifies as a trans man; A woman who was assigned male (or intersex) at birth and identifies as a trans woman.

Transitioning- The process in which a trans or nonbinary person begins to live as their gender identity. It may include changing one’s name, taking hormones, having surgery, and/or altering legal documents. Transitioning means very different things to different people. There is no right way to transition and each trans person has their own path.

Outing/Being Outted- The act of disclosing, intentionally or unintentionally, a person’s identity to others without their permission. Outing someone can have serious consequences on their safety, employment, family situation, etc.

Transphobia/Transnegativity- Fear, hatred, and intolerance of transgender, nonbinary, genderqueer, and gender nonconforming people, or those who break, blur, or transgress assigned gender roles and the gender binary.

Stanley Brown Safety Plan

Adapted for working with transgender and gender diverse populations

Chosen Name: Pronouns:

Step 1) Identify Warning Signs & Triggers *(This can include mood, thoughts, or physiological and somatic feelings. Societal influences and policies should also be explored as possible triggers.)*

- X

Step 2) Internal Coping Strategies- Things I can do to take my mind off problems without contacting another person

- X

Step 3) People and places that provide a distraction (*This may include non-biological chosen family, queer friendly spaces, and online spaces as well.)*

- Name
- Name
- Place

Step 4) People whom I can ask for help during a crisis *(Once again it is important not to assume gender of one's partner, family members, etc.; non-biological chosen family is important to include here also.)*

- X

Step 5) Professionals or Agencies I can contact during a crisis

- Clinic/Agency Name
- Local Emergency Department
- Trevor Project Hotline- 1-866-488-7386 via phone; 678678 via text; via chat at www.thetrevorproject.org
- Trans Lifeline- 877-565-8860. Available Monday-Friday 10 AM-6 PM pacific time, 11 AM-7 PM mountain time, 12 PM- 8 PM central time, and 1 PM to 9 PM eastern time.
- Suicide Prevention Lifeline 1-800-273-TALK (8255) or 988

Step 6) Things I can do to make my environment safer (Plans for Lethal Safety)

- X
- X

Step 7) Identify reasons for living

- X
- X