# Barriers to and Facilitators of Help-Seeking Among Transgender IPV Survivors

Nicola L. Ford

Master of Counselling, City University of Seattle

**Abstract**

Intimate partner violence (IPV) rates are disconcertingly high in sexual and gender minority relationships. In particular, research has highlighted that transgender individuals are subjected to IPV at higher rates than heterosexual individuals and cisgender sexual minorities (James et al., 2016; Langenderfer-Magruder et al., 2016; Reuter et al., 2015). Unfortunately, IPV has traditionally been understood through a gendered lens in which men are depicted as abusers and women as victims, rendering the problem of transgender IPV invisible (Cannon & Buttell, 2015). Transgender individuals also face greater discriminatory attitudes related to their gender identity, limiting how and where transgender IPV survivors feel safe to seek help (Calton et al., 2016; Furman et al., 2017; Tesch & Bekerian, 2015). The present research provides a comprehensive literature review of transgender IPV and the help-seeking process. Specific attention is paid to barriers and facilitators of help-seeking among transgender IPV survivors. Implications for counselling, recommendations for clinical practice, and directions for future research are discussed.

*Keywords:* transgender, intimate partner violence, counselling

## Barriers to and Facilitators of Help-Seeking Among Transgender IPV Survivors

Intimate partner violence (IPV) against lesbian, gay, bisexual, transgender, queer, two-spirit, and other sexual and gender minorities (LGBTQ2+) is alarmingly prevalent. Studies have highlighted that sexual and gender minorities are much more likely to experience physical (27.6% vs. 18.4%), sexual (20.3% vs. 12.9%), and psychological (21.8% vs. 12.5%) victimization by an intimate partner than their heterosexual peers (Reuter et al., 2015). Transgender individuals in particular face some of the highest rates of IPV victimization. More than half (54%) of transgender individuals have experienced violence at the hands of a romantic partner in their lifetime (James et al., 2016). Transgender individuals experience physical violence from an intimate partner more frequently than the general population (i.e., 35% vs. 30%), and they are more likely to experience injury resulting from the violence (i.e., 24% vs. 18%; James et al., 2016). Transgender individuals may even be at greater risk for IPV victimization than their cisgender LGBTQ2+ peers. Approximately 31% of transgender individuals have experienced dating violence in their lifetime compared to 20.4% of lesbians and gays (Langenderfer-Magruder et al., 2016).

Sexual minorities may be especially susceptible to the damaging effects of IPV given that these individuals already face unique stressors related to having a stigmatized identity. For example, transgender individuals are often met with violence, discrimination, and mistreatment upon disclosing their sexual minority status and consequently experience less social acknowledgement and greater societal rejection, all of which may aggravate the already detrimental effects of IPV victimization (Edwards et al., 2015). In some cases, sexual minority victims may feel the need to conceal their identity to avoid further discrimination (Rood et al., 2017). Discerning what is considered a safe and supportive space can be difficult for transgender

IPV survivors who are hypervigilant about disclosing their transgender history and may impact if and where they feel they can seek help.

Despite the disturbingly high prevalence of IPV among LGBTQ2+ individuals, research has overlooked IPV in the context of sexual minority relationships. The literature on sexual minority IPV is but a fraction of the literature dedicated to understanding heterosexual IPV. Of the research that has explored sexual minorities, more emphasis has been placed on sexual orientation than gender identity, effectively overlooking transgender survivors. For example, many studies mistakenly conflate gender with sexual orientation by relying on items meant to assess sexual orientation, such as, "Have you ever lived with a same-sex partner?" (Calton et al., 2016). IPV prevalence rates and help-seeking data for transgender populations have become difficult to discern because although researchers may be sampling distinct populations, these nuances are lost due to grouping gender identity with sexual orientation (Badenes-Ribera et al., 2016). Also, most research examining transgender victimization has done so in the context of hate crimes or violent acts committed by strangers (Burks et al., 2018). The distinctive dynamics of transgender IPV are overshadowed by the oversaturation of research focusing on heterosexual relationships. Likewise, the overwhelming focus on heterosexual survivors' help-seeking behaviours makes it difficult to discern how transgender identity differentially impacts help-seeking. How and where transgender survivors seek help, how helpful these supports are perceived to be, and what role these supports play in the IPV experience of transgender survivors is not widely understood.

The purpose of this literature review is to examine the help-seeking experience specific to transgender IPV survivors. Guiding research questions included:

1. What are the lived experiences of transgender IPV survivors as they navigate the help-seeking process?
2. How is the help-seeking process for transgender IPV survivors similar to or different from cisgender survivors?
3. What barriers exist in the help-seeking process, and what factors help to facilitate the help-seeking process of transgender survivors?
4. How is the experience of IPV and help-seeking of transgender individuals impacted by having multiple marginalized identities?

Implications for counselling practice, specific recommendations for providing competent care to transgender clients, and future directions for transgender IPV research will also be presented.

## Self-Positioning Statement

On January 5, 2018, Christa Leigh Steele-Knudslien was found stabbed and beaten to death in the home she shared with her husband in Massachusetts (Brammer, 2018). Her husband pled not guilty in court but had previously admitted to police that he had killed her after a heated argument. Christa was a transgender woman. On July 30, 2019, Tracy Williams was found stabbed to death in a Houston parking lot (Dellinger, 2019). She sat unidentified in the morgue for 10 days until a local LGBTQ2+ organization helped identify her body. Police charged her boyfriend with her murder. Tracy was also a transgender woman. Sadly, these are just two examples of the thousands of stories highlighting a growing social crisis: the heightened risk for IPV among transgender individuals.

These are also the stories that impassion me to advocate for change both in my work as a counsellor and a researcher. Although society has come so far, these stories are also a stark reminder that there is still so much work to be done in the fight for justice and equality. In a

society that privileges those who meet stereotypical social expectations of masculinity and femininity, transgender people are made to feel like invisible victims. There are few agencies specific to transgender individuals experiencing violence, and if they decide to seek help, they are often revictimized and retraumatized through systemic discrimination and social disapproval. Transgender individuals are not afforded the same victim status as cisgender heterosexual IPV victims, leaving them with few help-seeking and support options. Stories like those of Christa Leigh Steele-Knudslien and Tracy Williams are a saddening reality of the society we have built—one of oppression, ignorance, and intolerance of anyone different.

The purpose of this research is not to discredit or devalue the work that has been done to challenge patriarchy in society and elucidate men's violence against women. The review that follows intends to highlight the consequences of heteronormative thinking on non-normative relationships and help-seeking for IPV. I recognize that my passion for this research is rooted in social justice and advocacy, which risks leading me to view the literature through an oppression-focused lens. For example, I recognize that if stakeholders do not buy into IPV victimization of transgender individuals as a social issue and do not offer funding for such services, outreach and prevention programs become financially impossible. Without adequate funding, inclusive and comprehensive supports for clients with diverse needs also become difficult. However, this inclination to view transgender IPV through an oppression-focused lens may be shortsighted in that I risk focusing too heavily on where the system is broken and overlook where and how growth is taking place toward inclusivity. It may be shortsighted of me to prematurely label certain experiences as barriers in the help-seeking process, especially given that I have no personal knowledge or understanding of what it means to be transgender. While I might perceive the experience of concealing one's identity as harmful to the mental well-being of transgender

IPV survivors, this may not be a fair or true construction of the transgender help-seeking experience. Concealing one's transgender identity may be an empowering experience by way of affirming one's preferred identity (Rood et al., 2017).

As a White, cisgender, heterosexual woman, I have been assigned inherently more privilege based on my race, gender, and sexual orientation. I cannot fully understand what it feels like to be afraid if others were to discover my gender identity or to experience discrimination and violence for simply being who I am. Transgender persons are intersectional, meaning that their experiences are shaped by other dimensions of their identity, each with varying degrees of privilege (Crenshaw, 1991). The relationship between racism, sexism, and violence impacts individuals of colour in ways that cannot be understood when gender is viewed separately from race (Crenshaw, 1991). Implicit racial or gender biases may lead me to present findings too narrowly, ignoring how intersecting identities—such as age, race, ethnicity, and sexual orientation—are also influential in the IPV experience of transgender survivors.

To mitigate these biases, I plan to embrace an intersectional and reflexive approach to research. Most models of IPV are rooted in feminist philosophy that assumes power and gender are connected; however, power dynamics are more difficult to understand in sexual minority relationships in which either partner may or may not subscribe to traditional gender roles (Goldenberg et al., 2016). Understanding IPV solely in terms of power and control ignores how other identities impact the experience and expression of IPV. In contrast, an intersectional approach acknowledges how gender identity is experienced in tandem with other factors such as sexual orientation, race, and ethnicity to shape the experience of transgender IPV (Subirana-Malaret et al., 2019). Including additional factors such as race, ethnicity, and sexual orientation

will allow for a deeper understanding of the IPV experience of transgender individuals who may belong to multiple marginalized identities.

As a method of bracketing personal biases, I kept a running thought log to critically examine and reflect on assumptions and preconceptions I brought with me to the research. As I worked my way through the research, I wrote down immediate thoughts and then returned to these notes later to explore feelings about the research, question why and where these feelings arose, and challenge them if necessary. This process of memo-ing led to important insights that allowed for a more impartial analysis by recognizing how my biases were enacted and how they may have impacted the outcome (Tufford & Newman, 2012).

## Key Terminology

Sexual orientation and gender identity are often conflated as a result of grouping transgender people under the LGBTQ2+ umbrella; thus, it is worthy of distinction (Anderson, 2020; Calton et al., 2016). *Sexual orientation* refers to a person's romantic attraction to another person (Hidalgo et al., 2013). Transgender individuals can identify as heterosexual, lesbian, gay, bisexual, or queer. For instance, an individual who transitions from female to male and who is attracted only to women may identify as a straight man. In contrast, *gender identity* refers to a person's deeply-felt inherent sense of being male, female, or some other identity, which may or may not match their birth-assigned sex (American Psychological Association [APA], 2015). A person's *birth-assigned sex* is the sex assigned to them at birth based on bodily characteristics, such as chromosomes, hormones, reproductive organs, and secondary sex characteristics (APA, 2015). *Transgender* is an umbrella term encompassing individuals who feel their gender identity differs from their birth-assigned sex or whose gender identity transcends cultural notions of gender (Abramovich & Cleverley, 2018). Those individuals who feel their birth-assigned sex and

gender identity are aligned are referred to as *cisgender* (APA, 2015). *Gender expression* is a term used to refer to the external manifestation of a person's gender identity, such as the expression of gender through a person's name, preferred pronouns, clothing, hair, voice, and other body characteristics (Anderson, 2020). The expression of gender is often used by society as cues of masculinity or femininity.

Not all individuals falling under the transgender umbrella will feel their gender identity fits neatly into a binary gender. Some individuals may prefer terms that describe a gender identity that is neither male nor female, such as genderqueer, gender nonconforming, or non-binary (Abramovich & Cleverley, 2018). Given the scarcity of research that differentiates between transgender, gender nonconforming, genderqueer, and non-binary individuals (Anderson, 2020; Calton et al., 2016), the term transgender is used throughout this review to encompass all individuals who feel their gender identity differs from their birth-assigned sex and/or cultural notions of gender.

The World Health Organization (WHO, 2012) defines IPV as "any behaviour within an intimate relationship that causes physical, psychological, or sexual harm to those in the relationship" (p. 1). Scholars have also argued that transgender individuals are particularly susceptible to being victimized on the basis of their gender identity (Garthe et al., 2018; Guadalupe-Diaz & Anthony, 2017; King et al., 2019). For instance, abusers may attempt to discredit a transgender person's identity by making degrading or humiliating comments related to their gender identity, withholding access to gender-affirming surgeries or hormone treatments, targeting body parts associated with their victim's birth-assigned sex, or threatening to reveal their transgender identity to others (Garthe et al., 2018; Guadalupe-Diaz & Anthony, 2017; King et al., 2019). Thus, *intimate partner violence* is used throughout this review to refer to any act of

physical, sexual, or psychological violence within an intimate relationship involving a transgender person, including attempts to belittle, humiliate, threaten, and control a victim on the basis of their gender identity.

## Review of the Literature

Transgender individuals are more likely to suffer physical, sexual, and psychological victimization by a romantic partner than both heterosexual and other sexual minority persons (Langenderfer-Magruder et al., 2016; Reuter et al., 2015). For transgender individuals, the already damaging effects of IPV may be further aggravated by stressors related to having a stigmatized and misunderstood identity, such as a lack of social support and less social acknowledgement (Edwards et al., 2015). Despite high IPV prevalence rates, few studies have examined IPV victimization and help-seeking among transgender populations. The literature review that follows is intended to generate greater insight and awareness of transgender IPV and the help-seeking process. First, an overview of relevant theoretical frameworks is provided. These frameworks are necessary to understand the larger political and social contexts in which transgender individuals experience IPV victimization and navigate the help-seeking process. Next, research pertaining to transgender-specific IPV dynamics and disclosure patterns are discussed to highlight differences between transgender, heterosexual, and other sexual minority groups. Finally, transgender individuals' experiences with domestic violence (DV) agencies, the criminal justice system, and mental health professionals are discussed regarding barriers and facilitating factors in the help-seeking process.

### Search Strategy

Research specific to transgender IPV is scant; thus, multiple searches were conducted using various related terminology. The PsycINFO database was used to search for peer-reviewed

articles published between 2015 and 2021 using the terms "intimate partner violence," "partner violence," and "transgender." Given the limited number of studies focusing solely on transgender populations, the search was then expanded to include related terms such as "abuse," "domestic violence," and "LGBTQ2+." Abstracts were reviewed, and articles not pertaining to IPV were eliminated. Articles describing transgender IPV across diverse racial and ethnic backgrounds were also included as these studies provide important insights regarding culture and the intersectional nature of having multiple marginalized identities.

## Theoretical Context of Transgender IPV

### *Heteronormativity and the Gender Paradigm*

There is an underlying assumption in IPV research that power and control are linked to gender, which has resulted in a dominant narrative of men as abusers and women as victims (Cannon et al., 2015). Reliance on a gender paradigm to understand violence in intimate relationships renders the problem of IPV in non-normative relationships virtually invisible. How can a paradigm that frames men as abusers be used to understand the transgender man who is abused by a woman? While the feminist conceptualization of IPV has been instrumental in exposing the patriarchy that exists in heterosexual relationships and in denouncing men's violence against women, it has also resulted in a gendered construction of IPV that oppresses victims who do not fit the traditional gender binary.

The gender paradigm effectively deprives gender minorities of their victim status because viewing violence as problematic in LGBTQ2+ relationships may be more difficult if one or both partners contradict expected gender norms (Cannon & Buttell, 2015). For example, a study of male same-sex relationships revealed that most respondents believe that men's perceived ability to exert power and control meant they could not experience IPV or that only "weak" men

experienced abuse (Goldenberg et al., 2016). Gender norms dictate that men should be strong. They, therefore, cannot possibly fall victim to abuse, making it difficult for male victims to see violence in same-sex relationships as problematic and define themselves as victims of abuse (Goldenberg et al., 2016). Likewise, a society that espouses a gendered understanding of IPV structurally disadvantages transgender victims by informing gendered policies and protocols within DV agencies, treatment programs, and law enforcement. For example, many DV shelters use a gendered admissions process, which disadvantages transgender survivors because they are either forced to "pass" as female or reject their preferred identity to accept help (Guadalupe-Diaz & Jasinski, 2017).

### *The Intersectional Framework*

The predominant focus on men's use of violence to reinforce patriarchal control in intimate relationships has resulted in a gap in understanding IPV in gender minority relationships. Transgender identity has received arguably less attention than other sexual minority groups because more attention has been paid to sexual orientation than gender identity. Responding effectively to IPV in transgender partnerships requires a comprehensive examination of the unique struggles associated with transgender identity. Rather than relying solely on gender to explain IPV, it has been suggested that IPV may be better understood as a symptom of psychosocial factors and one's cultural context (Subirana-Malaret et al., 2019). From this perspective, gender is viewed not as a cause of IPV but rather one variable among many that shapes the experience of IPV.

Indeed, gender and sexuality may differentially affect help-seeking decisions. For instance, research has highlighted that heterosexual women are more likely to seek help from primary care physicians familiar and known to them while gay men favour help-seeking from

community agencies where there is a greater sense of anonymity and acceptance of sexual identities (Morgan et al., 2016). In this case, gender and sexual orientation appear to impact where and from whom individuals feel comfortable seeking help. An intersectional framework allows for a more nuanced understanding of IPV by acknowledging how different social identities, each with varying degrees of privilege, interact to influence IPV and help-seeking. In other words, the intersectional approach allows researchers to question how one's "manliness" or "womanness" influences help-seeking.

### *Minority Stress Theory*

Sexual and gender minority IPV and subsequent help-seeking decisions are often understood in terms of the minority stress model. Meyer (2003) defined minority stress as the excess stress individuals experience due to having a stigmatized identity. When a person has multiple stigmatized identities, the stigmas and stresses experienced are additive and culminate in adverse mental health consequences (Cyrus, 2017). Transgender individuals may be especially susceptible to the damaging effects of IPV, given their status as a gender minority. For example, gender minorities often anticipate discrimination from others and may internalize negative or stigmatizing beliefs, leading them to conceal their identity to avoid further discrimination (Rood et al., 2017). As such, gender minorities may experience worse outcomes of IPV victimization because they must also grapple with greater prejudice related to their gender minority status, greater social rejection, and increased barriers to help-seeking (Edwards et al., 2015). Thus, stressors associated with minority identities appear to be important factors to consider in understanding the experience of IPV and help-seeking among transgender populations.

## Transgender-Specific Dynamics of IPV

Transgender individuals experience IPV in similar ways to those in cisgender or heterosexual relationships with physical, psychological, and sexual abuse frequently used to demean and control an intimate partner (King et al., 2019). However, transgender individuals also experience IPV in distinct ways related to their transgender identity (Garthe et al., 2018; Guadalupe-Diaz & Anthony, 2017; King et al., 2019). In a study of young transgender women, 22% had a partner who made degrading or embarrassing comments about their gender identity in front of others and 18% were forced to do something that did not agree with their gender identity by a partner (Garthe et al., 2018). In another study, 30.4% of transgender and gender nonconforming participants experienced transgender-related IPV at least once in their lifetime, including having a partner withhold hormone treatment or threaten to reveal their gender identity to others, and being told by a partner that they were not a "real" man or woman (King et al., 2019).

Abusers may target body parts that symbolize cultural expectations of gender (i.e., a victim's chest, hair, or genitals), withhold financial support for gender-affirmative treatments, or threaten to reveal a partner's transgender identity to others (Garthe et al., 2018). Abusers may also attempt to discredit their partner's desired gender expression by drawing attention to insecurities related to their birth-assigned sex (Guadalupe-Diaz & Anthony, 2017). For example, abusers may repeatedly refer to their partner using their birth-assigned name. The adoption of a new name often signifies the construction of a new identity for transgender persons. In forcing their partner to answer to their former name, the abuser effectively prevents their victim from moving forward with their desired sense of self (Guadalupe-Diaz & Anthony, 2017).

Abusers may also exert coercive control over their transgender partner by acting as gatekeepers, controlling access to hormone treatments or physical props that allow them to

present as their desired gender (Guadalupe-Diaz & Anthony, 2017). Clothing, makeup, and hormone treatments are all tools that empower transgender individuals to outwardly present as their desired gender. By controlling access to such tools, an abuser can manipulate their victim to feel stuck between their desired and former identities (Guadalupe-Diaz & Anthony, 2017). In this way, an abuser can control when, how, and to whom their transgender partner presents.

Abusers may also leverage pre-existing discriminatory cultural beliefs as a means of invalidating and demeaning their victims. For instance, many transgender individuals fear the potential repercussions of disclosing their transgender identity and, as such, carefully monitor who knows about their transgender history (Rood et al., 2017). Transgender individuals often face mistreatment and discrimination upon having others learn of their transgender history. Consequently, transgender persons may feel their physical, emotional, and economic well-being is dependent on concealing their transgender identity (Rood et al., 2017). Partners in romantic relationships are often aware of their partner's transgender identity and will threaten to disclose their victim's transgender history as a manipulation and control tactic (Cook-Daniels, 2015). Abusers may also attempt to exploit a transgender partner's self-doubt about how well they live up to social standards of masculinity or femininity (Cook-Daniels, 2015). For example, an abuser may claim their partner is not acting masculine or feminine enough, argue that no one else will express romantic desire for them because they are transgender, ridicule undesired physical traits, or use inappropriate pronouns (Cook-Daniels, 2015).

## Help-Seeking Process of Transgender IPV Survivors

### *Disclosure Patterns*

Transgender individuals experience alarmingly high rates of partner violence (James et al., 2016). Despite the increased risk of violence in romantic relationships, few studies have

explored transgender IPV, which impedes our understanding of transgender IPV survivors' needs in the help-seeking process. Public discourse has storied IPV in the context of heterosexual relationships wherein males are abusers and females are victims, thereby obscuring where and why transgender survivors can seek help, if at all. Transgender survivors are forced to navigate cisgender heteronormativity, heterosexism, and invisibility at several stages of the help-seeking process, making it more difficult for them to seek and receive support than for cisgender heterosexual IPV survivors (Kurdyla et al., 2019). Identifying how and why transgender survivors seek help is an important step to increasing the inclusivity of domestic violence outreach by better tailoring resources to the unique needs of transgender persons.

Research has been mixed about the disclosure rates of transgender IPV survivors (Kurdyla et al., 2019; Langenderfer-Magruder et al., 2016; Sylaska & Edwards, 2015). One study found that 85% of transgender survivors disclosed abuse experiences compared to 67% of cisgender sexual minorities (Kurdyla et al., 2019). In contrast, other research has not found significant differences of abuse disclosure between transgender and cisgender people (Langenderfer-Magruder et al., 2016; Sylaska & Edwards, 2015). Mixed findings about the influence of gender identity on the willingness to disclose abuse may suggest that factors beyond gender expression and sexual orientation also influence the decision to seek help for IPV. For instance, those who chose not to disclose the abuse did so because they believed their situation was not serious, perceived IPV as a private matter, were concerned about others' reactions if they were to disclose being the victim of abuse, or felt they had no one to tell (Kurdyla et al., 2019).

It has been well established that transgender survivors often turn to informal support for help (Donovan & Barnes, 2019; Kurdyla et al., 2019; McCullough et al., 2017; Sylaska &

Edwards, 2015). According to one study, transgender individuals are more likely to disclose their IPV experiences to friends (80.7%) and family (34.1%) than medical doctors, law enforcement, domestic violence shelters, attorneys, or victim hotlines (Kurdyla et al., 2019). It is not unusual for transgender individuals to have strained relationships with family members after coming out (James et al., 2016), which partly explains the increased willingness to disclose abusive experiences to friends over family members. For instance, most transgender individuals who come out to family experience rejection because of their transgender identity, including being kicked out of the house, cut off from contact with parents, children, or other family members, and experiencing violence from family members (James et al., 2016; Klein & Golub, 2016; Robinson, 2018). In this way, trusting friendships may serve as one's chosen family without a supportive biological family. Prevalence rates also indicate that transgender individuals report IPV less frequently than cisgender victims despite being significantly more likely to experience IPV than cisgender individuals (Kurdyla et al., 2019; Langenderfer-Magruder et al., 2016).

Transgender individuals' preference for seeking help from informal supports may be due to the anticipation of discrimination and past negative experiences with formal supports. For instance, individuals who had never experienced IPV were more likely to perceive support sources as helpful and report a greater willingness to disclose abuse if it were to happen to them in the future (Kurdyla et al., 2019). Nonsurvivors were also more likely to indicate a willingness to confide in family members about abuse if it were to happen compared to transgender IPV survivors (Kurdyla et al., 2019). It may be that negative experiences with law enforcement, domestic violence agencies, the health care system, and family or friends deter victims from seeking help again in the future because they come to anticipate stigma and discrimination in their interactions with these services (McCullough et al., 2017).

### *Stages of Help-Seeking*

Liang et al.'s (2005) help-seeking framework is frequently referenced in IPV research to make sense of the help-seeking process. The help-seeking framework explains that help-seeking occurs in three distinct stages: (a) recognizing that a problem exists, (b) deciding whether to take action and seek help, and (c) selecting where to seek help (Liang et al., 2005). Liang et al. stressed that these stages are not linear but rather occur in the social context in which a person lives. For example, transgender IPV survivors face heteronormativity and invisibility in the help-seeking process, in addition to many of the same stressors as heterosexual survivors. These added stressors may make it more difficult for them to label IPV as a problem, decide to seek help, and know where to seek help.

Defining violence as problematic may be more difficult for transgender IPV victims because society portrays IPV as a cisgender problem. The gendered construction of IPV renders the idea of female perpetrators and male victims inconceivable because it perpetuates stereotypes that violence by women is less severe or that men cannot be victims because they can protect themselves (Cannon & Buttell, 2015). As such, many transgender victims find it difficult to see violence in their relationship as problematic or label themselves as victims when the context of the abuse differs from how IPV is understood by society (Donovan & Barnes, 2019). The invisibility of transgender persons in research and social policy also means that transgender individuals do not have role models to learn what is deemed healthy or problematic in romantic relationships. This lack of representation may add to transgender persons' difficulties defining themselves as victims because abusers may see it as an opportunity to manipulate them by convincing them that controlling or violent behaviours are normal (Donovan & Barnes, 2019).

For transgender individuals contemplating seeking help, discrimination and transphobia likely shape how they believe their disclosure will be received by others (Donovan & Barnes, 2019). Many transgender survivors are concerned that a lack of gender conformity may lead them to be labelled as the perpetrator and limit how accepting they believe formal supports will be (Nadal et al., 2015). In a society that privileges heterosexual and cisgender individuals, transgender individuals may feel that IPV services will not accept their identities or relationships, particularly partnerships that are seen as non-normative (Donovan & Barnes, 2019). The fear of stigmatization and discrimination likely impacts where and from whom transgender IPV victims feel they can seek help.

## Barriers to Help-Seeking

Several studies have also highlighted the stigmatization of transgender persons at the institutional level, which may partly explain transgender IPV survivors' reluctance to seek help from formal supports including domestic violence agencies, the health care system, and the legal system (Calton et al., 2016; Furman et al., 2017; Tesch & Bekerian, 2015). The social construction of IPV as a predominantly heterosexual and cisgender problem means that transgender victims are left out of public policy and programming. Most domestic violence and rape crisis agencies cater to female heterosexual abuse survivors, and domestic violence staff, law enforcement, and mental health professionals often lack knowledge of transgender identities (Elder, 2016; Furman et al., 2017; McCullough et al., 2017; Seelman, 2015; Tesch & Bekerian, 2015). As such, few agencies exist that cater specifically to gender or sexual minorities and those individuals who do not fit within the traditional gender binary are left with few options for safe and inclusive help (Calton et al., 2016; Furman et al., 2017; Tesch & Bekerian, 2015).

### *Domestic Violence Agencies*

Despite their elevated risk of IPV victimization, transgender individuals often encounter barriers to accessing domestic violence programs and shelters. A 2015 study by the National Center for Transgender Equality (NCTE), a U.S. transgender advocacy organization, indicated that of 18,014 transgender respondents, 1% had sought help from DV services the year prior, while 2% of respondents refrained from using DV services because they feared mistreatment (James et al., 2016). Most respondents indicated that they had chosen not to seek help because they believed they would be mistreated or had previous negative experiences, including being harassed and denied equal treatment because they were transgender (James et al., 2016). Indeed, other research has shown that being recognized as transgender is significantly associated with the experience of discrimination in DV centers (Rodriguez et al., 2018). Transgender individuals' risk for mistreatment in DV centers is also often connected to having additional marginalized identities. Those with multiple marginalized identities, such as people of colour and those with disabilities, are at an increased risk for mistreatment related to their transgender identity (Seelman, 2015). One study found that people of colour were 1.9 times more likely than White participants to be denied equal treatment from DV agencies and noncitizens were 2.77 times more likely than U.S. citizens to be mistreated while seeking help from a DV shelter (Seelman, 2015). Moreover, individuals with a disability were 2.14 times more likely to be denied equal by DV agencies (Seelman, 2015).

Transgender individuals are often painfully aware of the biases against them and, as such, may fear that their gender expression will create problems when accessing domestic shelters and programs. Transgender DV shelter clients can also experience transphobic discrimination in the form of staff pushback (munson & Cook-Daniels, 2016). Staff may often be reluctant to accept transgender clients over concerns that female clients will be uncomfortable in the presence of

transgender clients or that a male abuser will infiltrate women's shelters by posing as a transgender victim (munson & Cook-Daniels, 2016). Transgender IPV survivors often avoid seeking help from formal services in response to such stigma and discrimination (Calton et al., 2016; Furman et al., 2017; Tesch & Bekerian, 2015). One study revealed that transgender individuals who do seek help are often rejected from DV services because they outwardly present as "too male" or "too female," creating pressure to abandon one's preferred gender expression to receive help (Guadalupe-Diaz & Jasinski, 2017). As such, many transgender victims feel they have few options for safe refuge and must renounce their biological-at-birth identity to meet the admissibility criteria of DV services.

Another significant barrier to accessing DV programs is a lack of transgender competence among DV agency staff. In 2018, approximately half of DV shelters in Canada indicated that they accepted transgender, gender fluid, or intersex individuals fleeing violence (Maki, 2018). A few years prior, in 2015, 44% of sexual and gender minorities who attempted to seek help from a DV shelter were turned away, with 71% indicating they were turned away because of gender identity-related concerns (National Coalition of Anti-Violence Programs [NCAVP], 2016). Though acceptance rates to DV shelters for transgender individuals fleeing violence have increased, such an increase may not equate to shelters or programs prepared to respond to transgender IPV survivors' needs. Other studies have reinforced the need for increased training and staff with dedicated responsibilities to transgender IPV survivors (Ford et al., 2013; Furman et al., 2017; Tesch & Bekerian, 2015).

Among those staff who had experience working with IPV survivors at DV shelters, a vast majority of staff felt they had not sufficiently practiced LGBTQ2+ inclusivity in their frontline work and required more specialized training to be able to help these populations (Furman et al.,

2017; Tesch & Bekerian, 2015). Similarly, half of the staff across 54 DV agencies in Los Angeles felt only minimally prepared to support transgender clients and 22.6% had not received any training related to sexual or gender minority IPV (Ford et al., 2013). There appears to be a consensus among DV agency staff that their respective employers could be more inclusive by hiring staff with lived experience to increase transgender visibility, adopting clear policies that give transgender persons access to safety, and enforcing harsher repercussions for staff unable to provide equal treatment to transgender clients due to discriminatory beliefs (Furman et al., 2017).

### *Law Enforcement and the Criminal Justice System*

The relationship between law enforcement and the LGBTQ2+ community remains turbulent nearly 51 years after the Stonewall riots, a violent conflict between police and LGBTQ2+ community members that is often associated with sparking the gay rights movement (Calton et al., 2016; Hodge & Sexton, 2020; Nadal et al., 2015; Serpe & Nadal, 2017). An overwhelming proportion of LGBTQ2+ individuals believe that identifying as a sexual or gender minority will determine how they are treated and how their crime will be handled by law enforcement (Hodge & Sexton, 2020). Of the research that has explored transgender individuals' interactions with law enforcement, most studies have shown that transgender individuals are subjected to more discrimination, harassment, and profiling by law enforcement than cisgender persons (Hodge & Sexton, 2020; Serpe & Nadal, 2017). For instance, 57% of transgender individuals who had interacted with police said they were never or only sometimes treated respectfully, and 58% had experienced mistreatment, including misgendering, verbal harassment, and/or physical or sexual assault (James et al., 2016). Among transgender individuals, a lack of trust and fear that police may incorrectly accuse the victim of being the batterer are often cited as

reasons for negative impressions of law enforcement and less willingness to report crimes (Nadal et al., 2015; Serpe & Nadal, 2017).

IPV reporting may be lower among LGBTQ2+ victims in light of their experiences with and anticipation of harassment and discrimination in their interactions with law enforcement (Langenderfer-Magruder et al., 2016). Experiences of transphobia and systemic discrimination might reinforce transgender victims' reluctance to report victimization. In 2015, the NCTE reported that 57% of transgender respondents ($n$ = 18,014) were somewhat or very uncomfortable asking police for help (James et al., 2016). Research has highlighted that transgender individuals are not only less comfortable approaching police to report crimes but are also less willing to seek help from law enforcement over fears that police would wrongfully accuse them as the abuser or blame them for the abuse (Hodge & Sexton, 2020; Nadal et al., 2015; Serpe & Nadal, 2017).

The perception of culpability of LGBTQ2+ victims by law enforcement frequently appears in the literature as a potential barrier to help-seeking. Many transgender IPV survivors fear that gender nonconformity may lead them to be wrongly labelled as the abuser (Donovan & Barnes, 2019). Indeed, gender and sexual orientation appear to be significant predictors in police perceptions of culpability, threat, and credibility. Among law enforcement, heterosexual men are seen as the most dangerous and threatening, while heterosexual females are least likely to inflict physical harm (Russell, 2018). Similarly, lesbians and heterosexual men are more often blamed for their victimization than cisgender heterosexual victims (Russell, 2018), suggesting that law enforcement may adhere to gender-based stereotypes and use them to guide decisions about criminal responsibility. In another study, police officers were less likely to arrest an abusive partner when one or both partners were a sexual and/or gender minority, regardless of the

victim's willingness to cooperate (Franklin et al., 2019). Law enforcement officers are more likely to arrest abuse perpetrators when the victim has suffered visible injuries (Franklin et al., 2019). The presence of physical injury is often equated with more severe violence, leaving less room for subjectivity in the decision to arrest. However, the reliance on bodily harm in IPV scenarios perpetuates a gendered narrative of IPV in which cisgender heterosexual men are perceived as more threatening and dangerous than other perpetrators, rendering transgender-specific forms of IPV invisible (Franklin et al., 2019).

Adherence to gender-based stereotypes in police officers' decision-making process is problematic as it can skew perceptions of blame and the threat of danger, potentially leading officers to wrongfully label transgender IPV victims as the abuser or leaving victims at risk of further violence. As such, many sexual and gender minorities feel pressured to "pass" or conform to cultural expectations of gender in their interactions with law enforcement (Nadal et al., 2015). For instance, women who self-identify as more masculine, butch, or androgynous report greater hostility and aggression from law enforcement (Nadal et al., 2015). These findings imply that those who conform to traditional heteronormative gender roles and expression may be assigned more privilege than those with an atypical gender expression, thereby eliciting more positive perceptions and responses from law enforcement (Russell, 2018).

### *Mental Health Professionals*

Transgender individuals are at an increased risk of mental health disparities resulting from their gender minority status (Carmel & Erickson-Schroth, 2016; Dawson et al., 2017; Valentine & Shipherd, 2018). A large-scale Canadian survey revealed that transgender respondents were more likely to have contemplated suicide (44.8% compared to 15.6%) and were more likely to have a diagnosed mood or anxiety disorder (61.1% compared to 17.1%) than

cisgender respondents (Jaffray, 2020). As such, transgender individuals may seek mental health help for many of the same reasons as cisgender clients, including depression and anxiety, but may also seek counselling for gender-specific concerns. For example, transgender individuals often seek out therapy to process the decision to come out as transgender to loved ones, to explore decision-making about the gender transition process, and to secure referral letters needed to move forward with gender affirmative procedures (Mizock & Lundquist, 2016). Unfortunately, transgender individuals often encounter several challenges accessing mental health care, including the experience of minority stress, invalidation, microaggressions, and a blatant lack of acknowledgement of one's gender identity (Elder, 2016; McCullough et al., 2017; Mizock & Lundquist, 2016; Morris et al., 2020; Quiñones et al., 2017).

Transgender individuals describe counselling as a fearful time in which they are torn between the desire to engage openly in counselling while simultaneously feeling held back by the fear of judgment and discrimination (Applegarth & Nuttall, 2016). Biases in counselling are often more covert but may cause practitioners to communicate negative messages that demean and degrade transgender clients. For instance, some transgender individuals have cited mental health professionals' exaggerated focus on their gender identity as both unhelpful and hurtful (Mizock & Lundquist, 2016; Morris et al., 2020). The inflated focus by clinicians on gender identity overstates the importance of gender on one's mental health concerns; it may lead mental health professionals to draw misguided conclusions about the causes of a client's mental health concerns (Mizock & Lundquist, 2016).

An exaggerated focus on gender identity also overshadows the influence of other factors and identities. Many transgender individuals are uncomfortable discussing their racial and gender identities with mental health professionals when they are perceived as minimizing the impact of

having multiple marginalized identities (Mizock & Lundquist, 2016). For example, African American transgender males report feeling uncomfortable discussing their anxieties about transitioning from female to male and the cultural bias and violence they now face as African American men (McCullough et al., 2017). As such, transgender clients may feel the need to censor themselves in therapy to avoid judgment and discrimination (Applegarth & Nuttall, 2016; McCullough et al., 2017; Mizock & Lundquist, 2016; Morris et al., 2020).

By contrast, some transgender individuals feel that mental health professionals do not pay enough attention to gender or avoid gender-related topics altogether (McCullough et al., 2017; Mizock & Lundquist, 2016; Morris et al., 2020; Quiñones et al., 2017). In these instances, mental health professionals are seen as attempting to redefine a transgender client's identity to fit a more traditional gender binary, implying there is a right and wrong way to express gender (Mizock & Lundquist, 2016; Quiñones et al., 2017). For example, transgender participants in one study indicated that a mental health professional had purposefully used incorrect pronouns or their birth name, causing them to feel they had to prove their gender and creating more emotional stress and anxiety (McCullough et al., 2017; Morris et al., 2020). Transgender clients have also indicated that a mental health professional had purposefully steered the conversation away from gender identity or avoided the topic altogether (Elder, 2016; McCullough et al., 2017; Quiñones et al., 2017). When gender is minimized or avoided, transgender individuals are left feeling unheard and left to question where the therapist stands in their beliefs about transgender people.

Many transgender individuals also describe experiences in which their gender identity was treated as inherently wrong and a problem that needed to be fixed (McCullough et al., 2017; Mizock & Lundquist, 2016). The concept of gender dysphoria is listed in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*) and refers to the distress felt by those

who experience incongruence between their birth-assigned sex and felt gender expression (American Psychiatric Association, 2013). A diagnosis of gender dysphoria by a mental health professional is often a prerequisite for securing funding for gender affirming treatment and surgeries (Alberta Health Services [AHS], n.d.); however, the diagnostic label alone implies that their gender identity or presentation is somehow pathological (Elder, 2016). Due to gender pathologizing, transgender individuals often struggle with internalized transphobic beliefs—such as those espousing that one must modify their gender to fit the dominant binary—and negative attitudes of mental health professionals and themselves (Mizock & Lundquist, 2016).

Transgender individuals whose birth-assigned sex does not align with their gender identity often seek medical treatments and procedures to achieve a gender expression that best matches their gender identity. Research has highlighted that medically or physically transitioning has important implications for the well-being of transgender individuals. Personal testimonies from 65 transgender adults revealed that 84% believed hormone treatment would better allow their gender expression to align with their gender identity and just over half believed having top (51%) or bottom (59%) surgery was critically important to their well-being (Austin & Goodman, 2018). The World Professional Association for Transgender Health Standards of Care provides guidance for health professionals to assist transgender or gender nonconforming people with safe pathways to achieving fulfillment with their gender identity (Coleman et al., 2012). Outlined in these standards of care is the requirement that transgender people seeking gender-affirming surgery in Canada or the United States must undergo a surgical readiness assessment to ensure they: (a) meet the criteria of gender dysphoria, (b) are unlikely to regret their decision to transition, (c) are aware of the potential risks and side effects, (d) are the age of majority and have the capacity to make an informed decision, (e) have major medical or mental health under

control, and, in some cases, (f) have been living in a gender role aligned with their gender identity for at least 12 months (Coleman et al., 2012).

Many transgender individuals have described the requirement to see a mental health clinician prior to undergoing gender-affirmative surgeries as gatekeeping and a major barrier to care (Brown et al., 2020; Frohard-Dourlent et al., 2020; Mizock & Lundquist, 2016; Morris et al., 2020). This perceived gatekeeping role may also frame mental health professionals as a barrier because it increases the power differential between therapist and client. For instance, some transgender individuals described the surgical readiness assessment process as stressful, nerve-wracking, and panic-inducing given the clinician's ability to deny referrals for gender-affirming surgeries (Brown et al., 2020; Frohard-Dourlent et al., 2020; Mizock & Lundquist, 2016; Morris et al., 2020). This power imbalance elicits a degree of "coercive cooperation" in which many transgender persons feel pressured to follow a certain script and embellish or omit certain aspects of their experience in case the clinician uses it to label them "unfit" (Frohard-Dourlent et al., 2020). Many transgender individuals also describe the process as discriminatory, transphobic, and infantilizing (Brown et al., 2020; Frohard-Dourlent et al., 2020; Mizock & Lundquist, 2016; Morris et al., 2020). Critics have argued that scrutinizing a transgender person's confidence in their gender identity or decision to transition raises questions about their autonomy and personal agency (Bouman et al., 2014; Frohard-Dourlent et al., 2020; Murphy, 2016). By putting the decision-making power in the hands of a mental health care professional, it is implied that transgender people do not have the capacity to make informed decisions about themselves (Frohard-Dourlent et al., 2020).

Proponents of the surgerical readiness assessment process argue that because such procedures are generally irreversible, mental health clinicians are providing a duty of care by

safeguarding the individual from the potential harms of post-surgical regret (Frohard-Dourlent et al., 2020; Murphy, 2016). Therapists will often discuss with clients pursuing gender-affirming surgery the risks and benefits of such procedures, their surgical aftercare plan, and their support network (Frohard-Dourlent et al., 2020). Therapists may also discuss with these clients the possible effects of switching gender roles on family dynamics and workplace status as well as the residual effects of stigma associated with transitioning genders (Murphy, 2016). Counselling may also help clarify motives for body changes and help clients identify what is most important to them: adopting a specific gender role, possessing specific body traits, or something else altogether (Murphy, 2016). Such discussions are important and may help elucidate traits and capacities a client has that may facilitate their success in the gender transition process (Frohard-Dourlent et al., 2020; Murphy, 2016). Indeed, some transgender individuals who had undergone surgical readiness assessments and counselling described the experience as affirming when they were able to engage in an open discussion rather than feeling interrogated by the therapist and left their appointments feeling more prepared for surgery (Frohard-Dourlent et al., 2020).

## Facilitating Help-Seeking

### *Affirmative Practice*

A substantial amount of research has emphasized the importance of an affirmative approach to facilitate help-seeking among gender minorities (Applegarth & Nuttall, 2016; Craig & Austin, 2016; Elder, 2016; Kahn et al., 2018; McCullough et al., 2017; Quiñones et al., 2017). Affirmative practice explores and validates sexual and gender minority identities and recognizes the impact of heterosexism, homophobia, and transphobia on the well-being of these individuals (Kahn et al., 2018). The goal of affirmative approaches is to help LGBTQ2+ individuals dispute feelings of difference from stigma and marginalization. Transgender individuals have indicated

feeling most supported when helping professionals adopted a "trans-affirmative" approach by validating and normalizing their experience and creating a nonjudgmental space to seek help and process emotions, whether or not these feelings were related to gender identity (Quiñones et al., 2017). For example, transgender individuals report that it was most helpful when mental health professionals were nonjudgmental and used proper names and pronouns (Elder, 2016). Other transgender individuals highlight that a nonjudgmental approach allowed them to rethink labels and encouraged them to question what these categories meant, ultimately allowing them to become more aligned with their inner self (Applegarth & Nuttall, 2016). Indeed, affirmative practice has been associated with a significant reduction in mental health symptoms (Craig & Austin, 2016).

### *Intersectional Approach*

Transgender individuals often feel that helping professionals lack awareness of intersectional identities, overlooking or blatantly ignoring how other aspects of identity may be contributing to presenting concerns (McCullough et al., 2017; Mizock & Lundquist, 2016; Morris et al., 2020). As such, research has stressed the importance of addressing the lived experience of those individuals with multiple marginalized identities (Chang & Singh, 2016; Elder, 2016). A person of colour who transitions from female to male may gain more privilege by identifying as a man but may simultaneously face additional minority stressors related to stereotypical beliefs about men of colour. For instance, this individual may experience the cumulative stress of racial bias toward men of colour and transphobic discrimination. Research suggests that it may be helpful for professionals to explore how gaining or losing privilege due to having multiple identities impacts the experience and expression of various mental health concerns for multiply marginalized individuals (Chang & Singh, 2016). Some transgender

individuals indicate that it is unhelpful and even harmful when a mental health professional overstates the importance of gender identity on presenting concerns (Mizock & Lundquist, 2016). From this perspective, it may be more helpful to question the role that a person's multiple identities play by asking whether and how gendered experiences relate to different aspects of themselves (Chang & Singh, 2016). For some clients, gender identity may be especially salient, while others may feel their gender is not as important as other aspects of their identity, such as race or ethnicity.

### *Education and Training*

For some transgender individuals, it is imperative to find a helping professional whose sexual orientation, gender identity, or race/ethnicity aligns with one's own (McCullough et al., 2017). It is generally assumed that those who have experienced similar struggles related to marginalized identities are more equipped to understand and empathize (McCullough et al., 2017). Unfortunately, research has noted few openly transgender individuals within DV agencies, law enforcement, and mental health professions (Furman et al., 2017; Hodge & Sexton, 2020; McCullough et al., 2017). Many transgender individuals describe negative and stigmatizing experiences due to uneducated and incompetent service providers as key factors in their reluctance to seek help (Calton et al., 2016; Elder, 2016; McCullough et al., 2017; Mizock & Lundquist, 2016; Morris et al., 2020). If transgender individuals decide to seek help, they must often bear the burden of educating helping professionals about gender identity (Mizock & Lundquist, 2016).

In response to a lack of educated and competent support sources, research has stressed the importance of training and education to improve the relationship between transgender individuals and formal support services as well as increase their willingness to seek help (Craig

et al., 2015; Elder, 2016; Hodge & Sexton, 2020). Community-based educational interventions have shown promising results for increasing health professionals and DV service workers motivation to intervene to support gender minorities. Those who participated in educational training indicated that the training had equipped them with new knowledge and skills and increased their sense of self-efficacy, thereby increasing personal and professional competence in working with gender minorities (Craig et al., 2015). For example, 79.5% of training participants indicated that they intended to make at least one change to improve the lives of gender minorities (Craig et al., 2015).

Other agencies have leveraged the use of training and education to advocate for change at the institutional level to reduce systemic barriers and discrimination. In the United States, the Community Response Service (CRS) is responsible for helping communities prevent and appropriately respond to hate crimes or discrimination based on race, gender identity, sexual orientation, and religion, among other marginalized identities (Chalberg & Collins-McMurry, 2016). The CRS is responsible for facilitating collaboration between key stakeholders—such as local law enforcement and LGBTQ2+ organizations—through mediation, consulting, and training in response to allegations of discrimination (Chalberg & Collins-McMurry, 2016). For example, an assault against a transgender student at a university in Jacksonville, Florida in 2014 prompted tension between local law enforcement and LGBTQ2+ students because the students alleged the school and law enforcement failed to handle the case appropriately. A local LGBTQ2+ organization arranged for a CRS-facilitated mediation with key stakeholders, including the university's LGBTQ2+ center and campus law enforcement, resulting in targeted outcomes to end systemic discrimination against transgender students, including training and guidelines for campus police (Chalberg & Collins-McMurry, 2016). In this way, education and

training break down systemic barriers and improve the relationship between transgender persons and formal support services.

**Summary of Findings**

The present review has highlighted that transgender individuals are disproportionately impacted by IPV and face greater stigmatization and discrimination in the help-seeking process than cisgender survivors. Transgender individuals are often not comfortable disclosing abuse and are more likely to encounter barriers in the help-seeking process related to their gender identity (Edwards et al., 2015; Langenderfer-Magruder et al., 2016). Gendered admissibility criteria for DV services and transphobic attitudes among DV staff leave transgender IPV survivors with few inclusive and accepting resources for safe refuge (Guadalupe-Diaz & Jasinski, 2017; munson & Cook-Daniels, 2016). Moreover, transgender IPV survivors face more discriminatory attitudes from law enforcement and are more unwilling to report abuse to police than cisgender individuals (Hodge & Sexton, 2020; Nadal et al., 2015; Serpe & Nadal, 2017). In addition to the damaging effects of IPV, transgender survivors also suffer worse mental health outcomes related to their minority status. They may be more likely to seek help from mental health supports than cisgender persons (Jaffray, 2020). Unfortunately, transgender individuals also contend with discrimination and stigmatization from mental health professionals, although in more covert forms. For instance, mental health professionals often communicate transphobic attitudes in the form of microaggressions, such as overemphasizing or understating the importance of one's gender identity (McCullough et al., 2017; Mizock & Lundquist, 2016).

The present review has also highlighted factors that facilitate the help-seeking process for transgender IPV survivors. For instance, transgender IPV survivors report feeling more supported when practitioners use an affirmative approach that normalizes their gender identity

and recognize the impact of minority stress (Applegarth & Nuttall, 2016; Craig & Austin, 2016; Elder, 2016; Kahn et al., 2018; McCullough et al., 2017; Quiñones et al., 2017). Research has also stressed that mental health practitioners can better support transgender individuals by adopting an intersectional approach (Chang & Singh, 2016; Elder, 2016). Recognizing how a transgender person may gain or lose privilege resulting from having multiple identities can help mental health professionals better understand transgender clients' mental health concerns (Chang & Singh, 2016). The present review has also underscored the importance of specialized training and education. Training and education may help improve practitioner preparedness to work with gender minorities, ameliorate the relationship between transgender individuals and formal support services, and increase transgender survivors' willingness to seek help (Craig et al., 2015; Elder, 2016; Hodge & Sexton, 2020).

## Implications for Counselling

The following sections provide an in-depth discussion of counselling implications, recommendations for therapeutic practice, and directions for future research. First, a discussion of mental health outcomes among transgender IPV survivors is provided. Awareness of the mental health implications experienced by transgender clients is necessary to understand why these individuals may seek help from mental health supports and help inform treatment planning. Next, the components of affirmative practice and intersectional sensitivity are discussed. Specific recommendations pertaining to clinical skills, treatment approaches, and education, training, and supervision are also provided. Finally, suggestions are made for areas warranting further research.

### Mental Health Implications

Transgender individuals experience many of the same life stressors as the general population, resulting in a wide range of reasons for seeking help from a mental health professional. In the context of IPV, transgender victims may seek counselling for many of the same reasons as cisgender IPV victims, such as seeking refuge and safety, help in navigating the process of leaving an abusive relationship, or dealing with the psychological trauma of abuse. In addition to IPV-related stressors, transgender people are also subjected to disturbingly high rates of discrimination, violence, and rejection based on their gender identity (Edwards et al., 2015). In a society that espouses a strict gender binary, transgender individuals often have a heightened awareness of the extent to which their physical presentation is or is not congruent with social expectations of gender. Transgender individuals will often go to great lengths to avoid being stigmatized and discriminated against, including hiding their identity (Rood et al., 2017). While identity concealment may serve as a protective coping strategy in the short term, it is associated with numerous adverse mental health consequences in the long term, including depression, anxiety, and low self-esteem (Hatzenbuehler & Pachankis, 2016; Rood et al., 2017).

In addition to the mental health ramifications of social stigma, transgender individuals may also experience several personal and interpersonal challenges that they may bring forth in counselling. For example, uncertainty about transitioning, when and how to disclose one's transgender identity to a romantic partner, fears of being "outed" as a transgender person, and difficulties accessing gender confirmation treatments are gender-specific stressors that may show up in counselling transgender clients. As suggested by minority stress theory, transgender individuals are more likely to experience negative mental health outcomes due to the added stressors tied to their gender identity (Chodzen et al., 2019). Transgender individuals may anticipate unfair treatment from others, learn to believe the negative messages they hear about

their gender identity, and conceal their identity, all of which contribute to adverse mental health outcomes, such as depression and anxiety (Chodzen et al., 2019).

The increased risk for adverse mental health outcomes among transgender individuals has significant implications for counselling psychology. Transgender clients may feel distrustful of mental health clinicians due to past negative experiences with discrimination, and, as such, clinicians need to be prepared to counter these oppressive experiences (McCullough et al., 2017; Mizock & Lundquist, 2016; Morris et al., 2020). Clinicians must also recognize how their attitudes about gender impact the quality of care they provide to transgender clients and examine personal biases to avoid perpetuating cisnormative notions of gender in psychotherapy, which may further burden the mental health of transgender clients (APA, 2015). Conversely, mental health clinicians must be careful not to inflate the importance of gender. Gender may not always be the most salient aspect of a transgender person's life or presenting issues. Overstating the importance of gender may dehumanize or minimize transgender clients and interfere with the clinician's ability to address other important aspects of one's mental health (Hatzenbuehler & Pachankis, 2016; Mizock & Lundquist, 2016).

**Trans-Affirmative Practice**

One of the primary vehicles by which mental health clinicians can counter the oppressive and marginalizing experiences of transgender clients is by adopting a trans-affirmative approach (Alessi et al., 2019; Edwards et al., 2015; Victor & Nel, 2016). Inherent in the definition of the word "affirm" is the notion that something is believed to be valid (Merriam-Webster, n.d.). In this way, transaffirmative practice can be understood as the clinician's empathic support and acceptance of one's gender identity as true. Gender-affirmative practice views variations in gender not as pathological but as fluid and ever-evolving (Hidalgo et al., 2013). Mental health

clinicians who practice affirmatively view gender expression as a normal aspect of identity development, acknowledge the role of minority stress in mental health outcomes, and recognize biases that may negatively impact treatment with transgender clients (APA, 2015). Affirmative practice aims to create a safe and nonjudgmental space for transgender individuals to seek help and challenge feelings of difference from stigma and marginalization, regardless of whether presenting issues are related to gender identity.

### *Attitudes and Beliefs About Gender*

Monitoring one's attitudes toward transgender clients is a key component of affirmative practice (Alessi et al., 2015, 2019). Transgender clients, especially those who have experienced IPV, may challenge clinicians' understanding of gender and victimhood. Victims who do not fit society's gendered narrative of abuse are robbed of their victim status because it is more difficult to recognize abuse and promote help-seeking (Cannon & Buttell, 2015). Moreover, not all those whose gender identity differs from their birth-assigned sex will feel they identify with the transgender label. Some individuals may be less likely to identify as transgender and more likely to adopt labels such as androgynous, genderqueer, or two-spirit, and use nonconforming pronouns such as "they" or "them." The unique identities that people choose to define themselves may challenge clinicians' deeply held beliefs and attitudes about gender, as well as who can be considered a victim. As such, affirmative practice requires that clinicians stretch their understanding of gender beyond a male-female dichotomy to allow for a range of gender identities viewed as normative and healthy (Alessi et al., 2015; APA, 2015). Clinicians who model an acceptance of ambiguity and a nonjudgmental stance toward gender identity can help to counter the stigma and discrimination experienced by many transgender clients and foster a safe and supportive environment to explore gender.

### *Recognizing Stigma as a Barrier to Care*

Affirmative practice involves more than just monitoring one's attitudes and biases about gender. Affirmative practice also requires that clinicians recognize the inherent privilege assigned to those who meet cisnormative and heteronormative social expectations (APA, 2015). The present review has highlighted the stigmatization, discrimination, and marginalization that transgender IPV survivors face when accessing DV services, health care, and other social services. Awareness of the effects of transphobic discrimination can help mental health professionals recognize how stigma acts as a barrier to fair and competent care and encourage them to advocate for transgender clients and provide gender-affirmative treatment. Transgender clients may present with various needs, such as wanting help navigating public spaces and services, dealing with the psychological trauma of transphobic discrimination, and developing self-advocacy strategies. Whether it be talk therapy or assisting clients in accessing gender confirmation treatments, mental health professionals play a critical role in empowering and validating transgender clients and increasing positive mental health outcomes. Affirmative clinicians can also facilitate help-seeking by educating themselves about cisgender privilege in social policy and locating resources that are both gender-affirming and accessible for clients (APA, 2015).

### Intersectional Sensitivity

The present review also highlights that transgender individuals often feel that mental health clinicians overlook intersecting identities and overstate the importance of gender (McCullough et al., 2017; Mizock & Lundquist, 2016; Morris et al., 2020). These findings underscore the necessity that practitioners have an awareness of and sensitivity to the lived experience of those with multiple intersecting identities (APA, 2015; Chang & Singh, 2016;

Elder, 2016). Intersectionality elucidates the interconnected inequalities that a person may experience because of their gender, sexuality, race, class, and culture and challenges the notion that all transgender individuals will experience IPV in the same way (Cardenas, 2020). In other words, the intersectional approach stresses that a person's multiple identities, each with varying degrees of privilege, interact with numerous societal systems of oppression to create differing experiences. Some identities may be inherently more privileged by society while others may elicit more stigma and discrimination, drastically changing how each will experience IPV and the help-seeking process.

In practice, mental health professionals must recognize how the multiple and intersecting identities of transgender individuals influence distress, coping, and resilience (APA, 2015; Chang & Singh, 2016). Those from diverse backgrounds may be more vulnerable to IPV due to added oppression tied to their status as an ethnic or racial minority (Whitfield et al., 2021). The stigmatization of mental health struggles in one's country of origin and subsequent experiences of shame may further inhibit help-seeking among those with multiple marginalized identities (Kahn et al., 2018). For example, immigrants may have fled countries where mental illness is heavily stigmatized and where being a sexual or gender minority is pathologized and considered deviant. The shame associated with one's gender identity and mental health struggles may be internalized as shame, making it much more difficult for them to seek help. Those from diverse backgrounds may also face additional barriers in their interactions with social systems and resources. Some individuals from ethnic minority backgrounds may be reluctant to report IPV to the police due to past negative experiences with law enforcement in their country of origin or fear of anti-immigration sentiments (Mahapatra & DiNitto, 2013). English proficiency and lack of accessibility and availability of culturally appropriate services may also deter those from

diverse backgrounds from utilizing IPV services (Lelaurain et al., 2017). Even when mental health professionals match a client in terms of language and culture, these clinicians are often not adequately prepared to deal with issues of sexual or gender diversity (Kahn et al., 2018). Specific cultural beliefs may also influence IPV survivors' decision to seek and utilize IPV services to escape abuse. For instance, collectivist cultures generally prioritize group harmony over personal well-being. As such, IPV survivors with strong collectivist values or beliefs may feel conflicted when deciding to leave an abusive relationship and seek out IPV services if they feel their role is to preserve harmony in the family unit (Hu et al., 2020; Kim & Hogge, 2015). The intersection of multiple identities within transgender peoples' lives is complex and may hinder or facilitate help-seeking behaviours.

Conceptualizing IPV through an intersectional lens empowers mental health clinicians to recognize and address the complex relationship between multiple forms of oppression and mental health (Lewis et al., 2017). Clinicians who adopt an intersectional perspective can better help transgender clients understand and integrate their multiple identities that may be disproportionately privileged or oppressed. The intersectional approach may also illuminate power systems that marginalize transgender people and place some transgender individuals in privileged positions compared to others. Further, clinicians can highlight and strengthen transgender clients' resiliency as they learn to manage multiple stigmatized identities and face systemic discrimination. Even when the client's gender identity is the focus of counselling, mental health clinicians must recognize that a person's experience of gender is also shaped by other important aspects of identity, such as race, ethnicity, sexual orientation, religion, and culture (APA, 2015). A comprehensive and nuanced understanding of transgender IPV needs to encompass societal and systemic contributions, such as the oppression and marginalization of

various identities. As such, the intersectional approach elucidates the broader context in which IPV occurs and allows for a more nuanced and complex construction of IPV among transgender survivors. Psychologists should also be aware of the inherent privilege associated with their own intersecting identities (APA, 2015). The cisgender and heterosexual clinician will have drastically more privilege and different experiences than a transgender person of colour. Psychologists who are aware of their own racial or cultural influence may be more poised to provide culturally sensitive care to clients of diverse backgrounds (Chang & Singh, 2016).

**Gatekeeper Role and Advocacy**

The present review also underscores the potentially harmful power imbalance that arises when mental health clinicians adopt a gatekeeper role in counselling transgender clients. The requirement that a person must see a mental health professional to verify they are unlikely to regret the decision to transition situates clinicians in a position of power relative to transgender clients (Brown et al., 2020; Mizock & Lundquist, 2016; Morris et al., 2020). This power differential creates a barrier to establishing a collaborative working alliance with transgender clients and has the potential to further contribute to oppressive experiences with transphobia and systemic discrimination (Brown et al., 2020; Budge, 2015; Gridley et al., 2016; Mizock & Lundquist, 2016). The gatekeeper role held by many mental health practitioners implies that transgender clients are incompetent and incapable of making informed decisions about their gender identity. Consequently, many transgender clients may feel pressured to secure the therapist's approval by outwardly presenting in socially expected ways (Brown et al., 2020; Mizock & Lundquist, 2016). On the other hand, the requirement to see a mental health professional prior to undergoing gender-affirming procedures can be an affirming experience and

help draw out traits and strengths that may increase transgender clients' preparedness while decreasing the likelihood of post-transition regret (Frohard-Dourlent et al., 2020; Murphy, 2016).

The negative consequences of adopting a gatekeeper role in counselling highlight the importance of instead acting as a "gateway" for transgender clients. Gateway behaviours—such as affirming a client's preferred gender and supporting clients in their ability to make decisions for themselves—can contribute to more positive experiences with health care and assist transgender clients in navigating what many consider a flawed and oppressive system (Brown et al., 2020; Ross et al., 2016; Singh & Burnes, 2010). Therapists can counter oppressive experiences with gatekeeping by creating an affirmative environment in which the client is considered the expert of their own experience rather than pressuring clients to prove their gender (Brown et al., 2020). Mental health clinicians should also explicitly state their willingness to help in whatever ways necessary so that clients' fears about potential discrimination and rejection do not become barriers in treatment. Some mental health professionals have even proposed moving toward an informed consent model of care with transgender clients. The informed consent care model requires that practitioners discuss the risks of gender-affirming treatments so that clients can make an informed decision regarding their health, but does not require additional assessments, a diagnosis of gender dysphoria, or letters of referral from a therapist (Cavanaugh et al., 2016). Using this type of model can restore a degree of power to transgender clients by removing obstacles in the transition process and communicating respect for transgender peoples' autonomy and competency to make decisions.

Transphobic discrimination and adherence to a strict gender binary negatively impact transgender people in nearly all facets of their lives, including their families, schools, health care and legal systems, workplaces, and communities. Transaffirmative practitioners can use their

position of power to recognize the impact of cisgenderism and heteronormativism on the well-being of transgender persons and advocate for change at social and institutional levels (Austin & Craig, 2015). Cisgender and heterosexual privilege can be used to challenge the oppression of transgender people in the same way that male or White privilege can be leveraged to fight against the oppression of women or people of colour (Singh & dickey, 2016). Transgender individuals are expected to speak up about the injustices they experience and are overwhelmingly burdened with the responsibility of educating others (Mizock & Lundquist, 2016). In their position of power, clinicians are well-positioned to address the many ways that transgender people are disadvantaged by institutional barriers. For instance, clinicians working in various care or institutional settings—such as DV agencies, prisons, the health care system, or substance abuse treatment programs—can serve as liaisons and advocate for the needs of transgender individuals within these settings (APA, 2015).

At the local, state, or national level, psychologists may advocate for the support of transgender persons in gaining access to affirmative health care, human rights in sex-segregated facilities, or policy change regarding gender-affirming identity documentation (APA, 2015). For instance, many transgender people are still not protected from gender identity discrimination. These individuals lack employment security and housing protection because there is nothing to prevent them from being fired or losing housing based on their felt gender identity (James et al., 2016). For many IPV survivors, a lack of human rights in sex-segregated spaces means that they are rejected from traditional DV agencies because of their gender identity or turned away for not having documentation to prove their gender (Guadalupe-Diaz & Jasinski, 2017). Mental health clinicians can use their power to inform public policy that will reduce systemic barriers for transgender people and promote greater social acceptance of transgender identities. When mental

health practitioners recognize barriers and advocate for transgender clients, these clients may be better able to navigate obstacles in a cisgender and heteronormative system with greater support and confidence (McCullough et al., 2017).

## Fundamental Next Steps for Research

Research exploring sexual and gender minority IPV has disregarded transgender identities by grouping these individuals under the larger LGBTQ2+ umbrella. Grouping transgender persons with other identities is problematic given that transgender individuals experience IPV at a disproportionately higher rate (Langenderfer-Magruder et al., 2016) and in unique ways compared to other sexual minorities (Garthe et al., 2018; Guadalupe-Diaz & Anthony, 2017; King et al., 2019). Research has often defined IPV as physical violence, psychological aggression, and/or sexual violence. However, IPV may be experienced and expressed quite differently for transgender individuals than in heterosexual relationships or those involving other sexual minorities. For instance, abusers may withhold financial support for gender confirmation treatments or refer to their victim using their birth-assigned name, effectively preventing their victim from presenting as their desired self (Garthe et al., 2018; Guadalupe-Diaz & Anthony, 2017). The decision to seek help for IPV is contingent on a victim recognizing that a problem exists (Liang et al., 2005). Transgender IPV victims may find it difficult to see violence in the relationship as problematic, label themselves as victims, disclose experiences of abuse, or seek help if their experience differs from how society defines IPV (Donovan & Barnes, 2019). As such, future research should focus on transgender identities separate from other sexual minority groups and broaden operational definitions of IPV to include gender identity-specific abuse tactics.

The grouping of transgender individuals with other sexual minority subgroups is also problematic because gender identity and sexual orientation become conflated. Sexual orientation and gender identity are two distinct constructs, but the two are often confused in research and practice. Sexual orientation is understood as a person's sexual and/or emotional attraction to another person, whereas gender identity is a person's felt, inherent sense of gender (APA, 2015). The conflation of gender identity and sexual orientation may be especially problematic for those questioning their gender as it may create pressure to identify as lesbian, gay, or bisexual (APA, 2015). Research has also traditionally conceptualized anti-LGBTQ2+ discrimination and victimization as maltreatment based on one's sexual orientation (Anderson, 2020). For instance, dislike of an effeminate man may be a negative reaction to his perceived sexual orientation as a gay man rather than his expression of gender. In this way, gender expression is treated as a signifier of sexual orientation. Future research should pay special attention to the entwined nature of gender expression and sexual orientation and account for the role of gender expression in the experience of IPV victimization.

The term "transgender" has also been widely used in research as an umbrella term to encompass various gender-nonconforming identities; however, not all gender variant people identify with the transgender label. The term "gender nonconforming" is often used to describe those who feel their identities do not fit neatly into a gender binary and whose gender expression differs from social expectations (Anderson, 2020). Transgender individuals, and in particular those whose gender expression is aligned with social expectations or conceals their transgender identity, may experience greater freedom from the emotional burden of having to justify one's identity or face constant discrimination (Anderson, 2020; Henry et al., 2021; Levitt, 2019; Puckett et al., 2016). Those individuals whose gender expression transgresses social expectations

are not afforded the same "passing privilege." Evidence suggests that gender nonconformity is associated with heightened expectations and experiences of discrimination and a greater likelihood of violent victimization (Anderson, 2020; Henry et al., 2021; Levitt, 2019; Puckett et al., 2016). The degree to which "passing privilege" influences IPV and subsequent help-seeking patterns among transgender and gender nonconforming individuals warrant further investigation. For instance, some transgender survivors may feel pressured to "pass" to be accepted into DV shelters (Guadalupe-Diaz & Jasinski, 2017). In contrast, passing privilege associated with gender conformity may be linked to a decreased fear of discrimination and a greater likelihood of seeking help (Kurdyla et al., 2019).

Future research may also benefit from a more nuanced understanding of the role that other identity-related factors play in IPV victimization and help-seeking patterns, such as one's ethnic, racial, and cultural background or age. Individuals from diverse backgrounds may be more susceptible to IPV victimization and more reluctant to seek help due to cultural expectations and oppressive experiences tied to their multiple marginalized identities (Whitfield et al., 2021). For instance, research has explored very little about the needs of sexual and gender minorities who flee persecution in their countries of origin (Kahn et al., 2018). For these individuals, the traumatic effects of IPV may be intensified by the difficulties associated with immigration, such as securing housing, learning a new language, and establishing financial stability (Alessi, 2016; Alessi et al., 2017). These individuals likely face discrimination from the dominant cultural group and those from the same cultural group, leaving them with few outlets for help-seeking and support (Alessi, 2016).

Age may also exacerbate the experience of IPV and impede help-seeking in similar ways. In addition to gender identity-related stressors, older transgender individuals may also contend

with age-related concerns such as declining health, lack of social support, changes in career or education, and end-of-life issues (Elder, 2016). Those belonging to older generations may have also experienced greater prejudice and discrimination as a result of transitioning or coming out when it was still viewed as deviant and pathological. In contrast, younger people may reap the benefits of the gay liberation movement started by the generations before them. For instance, younger individuals may experience greater ease and freedom about sexuality and gender identity due to changing social attitudes toward sexual and gender minorities (Elder, 2016). Future research highlighting generational and racial, ethnic, or cultural differences may allow for a more comprehensive and refined understanding of the impact of minority stress on mental health concerns.

Research exploring LGBTQ2+ IPV has predominantly taken a reactive stance by focusing on intervention efforts for survivors in the help-seeking process. Fewer studies have sought to examine LGBTQ2+ perpetrators of abuse and proactive interventions to address and minimize IPV in sexual and gender minority relationships. Batterer intervention programs (BIPs) are generally considered the preferred treatment for IPV perpetrators; however, few studies have explored the acceptability and feasibility of such programs with sexual or gender minority perpetrators (Cannon, 2019). LGBTQ2+ identified batterers might have specific needs that differ from the heterosexual perpetrator population (Cannon, 2019). For instance, bidirectional violence is common in sexual and gender minority relationships, and internalized homophobia, stigma, and discrimination are related to IPV perpetration (Longobardi & Badenes-Ribera, 2017). Moreover, the effectiveness of BIPs for transgender IPV perpetrators may be contingent on the degree to which it addresses issues related to the experience of minority stress, such as transphobia, discrimination, and oppression (Cannon, 2019). Future research exploring BIPs

specific to the needs, concerns, and challenges transgender individuals face may increase outreach efforts for both perpetrators and survivors.

## Recommendations for Practice

### Therapeutic Relationship and Clinical Skills

When it comes to promoting change, the therapist's specific theoretical orientation is thought to be less relevant than the therapist's ability to cultivate and maintain a strong therapeutic relationship (Alessi et al., 2019). The therapeutic relationship is argued to be one of the key underlying mechanisms of affirmative practice. That is, a stronger therapeutic relationship may make it easier for transgender clients to bond with their therapist and express their authentic selves, especially in the context of IPV in which survivors may anticipate blame from others (Alessi et al., 2019; Applegarth & Nuttall, 2016; Salpietro et al., 2019). Given that many transgender survivors have encountered prejudice and discrimination in their interactions with public services, it is critical that they feel accepted and supported in therapy. As such, therapists should focus on the therapeutic relationship to ensure they create an environment that allows clients to feel heard and understood (Alessi et al., 2019; Applegarth & Nuttall, 2016; Salpietro et al., 2019). A strong therapeutic relationship may also increase the likelihood that transgender clients feel they have somewhere to turn for help should new problems arise in the future.

General counselling competencies and skills—such as empathy, active listening, asking questions, clarifying, and openness—are perceived as helpful to clients and in cultivating and maintaining a strong therapeutic alliance (Alessi et al., 2019; Applegarth & Nuttall, 2016; Quiñones et al., 2017). Counselling skills such as active listening can allow transgender IPV survivors to feel that their concerns are validated, which is essential when helping clients also

manage the effects of minority stress and oppression related to having multiple marginalized identities (munson & Cook-Daniels, 2016). Practitioners may lean toward problem-solving or offering solutions when what the client desires is to be heard and understood. Hearing a survivor's story and communicating back understanding and acceptance may be therapeutic in itself (munson & Cook-Daniels, 2016). In this way, therapists do not need specific solutions to effectively work with transgender clients but rather core clinical skills and a strong therapeutic relationship.

Therapists should also know and be willing to discuss information specific to gender minority culture in addition to using core person-centred counselling skills (Quiñones et al., 2017). Transgender people are often forced to educate others about transgender culture and identities, so clients may appreciate when therapists read and gain information before or during their work together (Mizock & Lundquist, 2016; Quiñones et al., 2017). Information gathering by conveying genuine curiosity and asking thoughtful questions can also facilitate relationship building by providing an interpersonal context in which information about gender minority culture can be sought and shared between the therapist and client. Many transgender individuals also experience minority stress through the lack of recognition of their gender identity (Mizock & Lundquist, 2016). Clients may feel unsure about how a therapist views non-cisnormative or non-heteronormative identities and relationships if they are silent on such issues and may try to determine whether they can safely discuss transgender issues in counselling (Alessi et al., 2019). Given the power differential in the therapeutic relationship with transgender clients, therapists are responsible for bringing up topics that may be difficult for clients to broach and be prepared to self-disclose about one's own gender identity or sexual orientation (Alessi et al., 2019). Indeed, transgender clients have noted that being paired with a sexual or gender minority

therapist is less important than having a therapist who is empathic, trustworthy, and caring (McCullough et al., 2017).

## Treatment Approaches

### *Trauma-Informed Care*

The present review has also highlighted that transgender individuals experience a significant amount of trauma throughout their lives, particularly interpersonal victimization related to their minority status (Scheer & Poteat, 2021). In addition to the traumatic effects of IPV, transgender IPV survivors also experience psychological trauma from lifelong experiences of anti-transgender prejudice and internalized stigma (Cyrus, 2017; Gamarel et al., 2020; Rood et al., 2016; Walch et al., 2016). The trauma associated with IPV victimization can have immobilizing effects, such as social withdrawal and dissociation (Pantalone et al., 2017). Trauma-informed care (TIC) is intended to move survivors toward safety and recovery by building on their strengths and resiliency, facilitating social connections, and fostering empowerment to help survivors of abuse regain a sense of control over their lives (Scheer & Poteat, 2021). Chronic experiences with discrimination may further contribute to the immobilizing effects of IPV trauma, such as greater shame, loneliness, poor emotion regulation, and lower agency. The negative effects of chronic discrimination may be particularly traumatizing for transgender IPV survivors who may already struggle with feeling isolated, unheard, and helpless in a highly stigmatizing society (Scheer & Poteat, 2021). As such, TIC may help counteract the immobilizing effects of both interpersonal trauma and psychological trauma arising from chronic exposure to minority stress. By incorporating a TIC framework in treatment with transgender IPV survivors, mental health clinicians can help survivors increase

their resilience in the face of negative experiences and help mobilize them toward recovery by promoting social connection and empowerment (Pantalone et al., 2017; Scheer & Poteat, 2021).

### *Affirmative Cognitive-Behavioural Therapy*

TIC may strengthen the sense of empowerment and social connection of transgender IPV survivors; however, cognitive behavioural therapy (CBT) may be better suited to address negative core beliefs contributing to feelings of shame related to gender identity (Scheer & Poteat, 2021). Victims of abuse often learn distorted thinking from the negative messages they hear from their abusers and society as a whole (munson & Cook-Daniels, 2016). Affirmative practice involves deprogramming feelings of difference arising from experiences of discrimination and marginalization. Cognitive behavioural interventions adapted to affirmative practice can validate transgender IPV survivors' experiences of trauma and discrimination and deprogram feelings of blame and shame by critically evaluating the helpfulness of harmful beliefs (Craig & Austin, 2016). AFFIRM, a cognitive behavioural intervention focused on improving coping and reducing depression by modifying distorted thoughts, has been adapted to acknowledge and validate the unique struggles of sexual and gender minorities by focusing on how they have learned to cope with identity-specific stressors (Craig & Austin, 2016). As transgender IPV survivors also experience persistent stigma and discrimination, attending to cognitions and coping associated with minority stress can significantly impact subsequent emotions and behaviours, including decreased feelings of depression and more adaptive ways of thinking about negative situations (Craig & Austin, 2016). These findings illustrate the importance and benefit of using CBT-based approaches that affirm transgender identities, pay attention to minority stressors, target maladaptive responses to these unique stressors, and build skills to cope proactively.

**Education, Training, and Supervision**

This review has also highlighted that negative and stigmatizing experiences arising from a lack of education and training in transgender issues are often a critical factor in transgender IPV survivors' reluctance to seek help from formal services, including mental health professionals (Calton et al., 2016; Elder, 2016; McCullough et al., 2017; Mizock & Lundquist, 2016; Morris et al., 2020). When transgender individuals seek help, they are often burdened with educating counsellors and other providers about transgender identities and issues (Mizock & Lundquist, 2016). Indeed, most clinicians indicate a lack of appropriate training in graduate programs and a lack of professional development opportunities (Salpietro et al., 2019). Clinicians who lack training and resources to provide culturally competent mental health care are generally more uncomfortable and reluctant to work with transgender clients (Whitman & Han, 2017). Moreover, a lack of trauma training also puts inexperienced clinicians at a greater risk of experiencing secondary trauma, vicarious trauma, and compassion fatigue due to their work with IPV survivors (Tarshis & Baird, 2019).

Education and training are critical strategies to address the lack of transaffirmative competency among mental health care providers and improve care for transgender IPV survivors. Mental health clinicians who participate in community-based educational programs organized by advocacy groups experience greater knowledge of transgender mental health concerns, greater perceived clinical skills and self-efficacy, and fewer negative attitudes about transgender identities (Craig et al., 2015; Kanamori & Cornelius-White, 2017; Lelutiu-Weinberger & Pachankis, 2017). Learning through community involvement, such as community-based educational programs, also increases mental health provider visibility in gender minority communities and positions clinicians as allies. When mental health providers visibly show

support in the community, clients can feel more deeply understood and supported (McCullough et al., 2017). Positioning oneself as a professional ally through education-based interventions and training is key to improving inclusive and competent care and reducing stigmatizing and discriminatory experiences among transgender survivors.

Clinical supervision and consultation are also crucial for development and learning because it allows clinicians to explore emotional reactions and receive feedback that encourages them to reflect on complex cases (Salpietro et al., 2019; Tarshis & Baird, 2019). Supervision and consultation also increase the likelihood of diffusing expertise in LGBTQ2+ specific across various systems of care. For instance, a clinician working specifically with transgender clients in a DV setting may provide knowledge and skills to those without personal and professional experience with transgender IPV. Indeed, consultation is strongly associated with culturally-sensitive counselling skills, over and above one's awareness of and attitudes toward transgender individuals (Moe et al., 2018). Specific to the IPV context, supervision and consultation also provide mental health providers with the opportunity and strategies to deal with the adverse effects of prolonged exposure to clients' traumatic experiences, such as secondary trauma, vicarious trauma, and compassion fatigue (Tarshis & Baird, 2019). Together, supervision and consultation are pertinent to helping mental health providers increase their awareness of transgender-specific issues and competency for working with transgender populations. Competency is a key factor in service utilization for transgender individuals; thus, supervision and consultation may also promote help-seeking by way of increasing clinician competency (Calton et al., 2016; Elder, 2016; Furman et al., 2017; McCullough et al., 2017; Mizock & Lundquist, 2016; Morris et al., 2020).

## Reflexive Self-Statement

Within the conversation about transgender rights has emerged a debate about whether the gender binary should be abandoned, a view that I blindly accepted. As I have moved through the research, I have started to question whether the gender binary can or should ever be abandoned. Although research has emphasized that people use a range of identities to define themselves, I wonder whether we, as a society, can ever escape the almost instinctual reliance on the gender binary. More than ever before, there is greater acceptance of a multitude of gender identities. Despite this greater acceptance, society continues to treat people based on their perceived gender, no matter how hard a person tries to convince others that they are something other than male or female. The oppression-focused filter through which I viewed the gender binary also blinded me to the potential value the gender binary may have for some individuals. While the gender binary may not be as useful for understanding other gender nonconforming identities, it may indeed be practical for those who identify as transgender. Someone deemed biologically male at birth but identifies as female is not rejecting the binary but rather conforming to it. The oppression-focused stance I initially adopted made the idea that some people might find solace and freedom in a gender binary inconceivable but also signalled a need to challenge such all-or-nothing thinking. Perhaps gender is more appropriately viewed as a spectrum, with binary genders at either extreme and people being free to choose where they fall at any point.

Another question that I have not been able to shake as I have moved through the research is whether labels are helpful or hindering. Since the inception of language, human beings have relied on labels to make sense of the complexity that is being human. From an evolutionary perspective, I can understand how labels were probably a good thing. Labelling something as "dangerous" or "safe" has undoubtedly played a role in how the human species has survived and continues to thrive. Labels have incredible power to influence, but I can also see how this power

can be limiting. In many ways, the research that I explored has highlighted the benefits and usefulness of particular labels, such as transgender, bisexual, lesbian, and gay. Consider the growing number of LGBTQ2+ advocacy organizations emerging across the world. These agencies are a testament to how gender and sexuality labels have been instrumental in raising public awareness of gender identity-related issues and bringing these issues to the domain of public policy and programs. The term LGBTQ2+ is widely accepted across the world and provides society with a common language for talking about human rights related to one's gender identity and can unite people to pursue these rights. Moreover, labels can also make a complex and diverse concept like gender identity easier to understand and embrace. For some people, adopting the transgender label can create a greater sense of authenticity, belonging, social acceptance, and even increase sexual self-esteem (Levitt, 2019). The label allows transgender people to be seen and valued as their authentic selves.

Labels also risk being too simplistic and restrictive. Labels aim to capture the entirety of a person in just a few words, but people are more than just how their gender is expressed or what sex to which they are attracted. The risk with labels is that they convey something as being absolute. Once a person has adopted a label, it is assumed it cannot be changed. When people feel they cannot change because of a label they have either been assigned or adopted themselves, they become cemented to assume that they must look or act a certain way. How can we, as a society, expect things to change if we are always forcing people to fit in a box or if we are still talking and thinking through predefined labels? How do labels leave room for things to be different? I recognize that research on transgender identities is important for recognizing and addressing the pervasive social problem of gender-based violence, but one of the most important points I have learned through this process is that transgender individuals should be treated as

"normal" people first. Gender identity and sexual orientation are just additional aspects of a person's background—just like other aspects that make up a person's identity, such as race, ethnicity, religion, employment, interests, and so many more. These people are also fathers, mothers, sons, daughters, teachers, doctors, politicians, and so much more. Paying attention to issues of gender diversity is a delicate balance between being careful not to overstate or undervalue the role that person's gender plays in their experience and their problems.

## Conclusion

IPV scholarship has largely overlooked transgender identities despite evidence suggesting that transgender individuals are much more likely to experience interpersonal victimization than their heterosexual and sexual minority counterparts (Langenderfer-Magruder et al., 2016; Reuter et al., 2015). Research has overwhelmingly focused on IPV in heterosexual relationships and on heterosexual survivors' help-seeking patterns. As such, little is known about how IPV is expressed and experienced in transgender relationships and how being transgender impacts help-seeking. Moreover, help-seeking is dependent on a victim recognizing that a problem exists, deciding whether to take action and seek help, and deciding where to seek help (Liang et al., 2005). Gendered conceptualizations of IPV overshadow the distinctive dynamics of transgender IPV effectively robbing transgender survivors of their victim status. For instance, identity-specific aspects of transgender IPV—such as an abuser withholding financial support for gender confirmation treatments—are not included in typical conceptualizations of IPV (Garthe et al., 2018; Guadalupe-Diaz & Anthony, 2017; King et al., 2019). As such, it may be arguably more difficult for transgender victims to recognize violence as problematic, see themselves as a victim of abuse, and seek help because their gender expression contradicts social expectations of gender (Goldenberg et al., 2016).

The decision to seek help is made more complex by the experience of minority stress among transgender individuals. Transgender individuals may come to anticipate prejudice and discrimination from others, begin to believe stigmatizing social stereotypes, and may conceal their identity, all of which may deter help-seeking (Chodzen et al., 2019; Donovan & Barnes, 2019). For instance, many transgender survivors are concerned that failing to conform to social expectations of gender may lead them to be blamed for the abuse and limit how helpful they feel formal services will be (Nadal et al., 2015). Given the gendered nature of most IPV agencies and programs, transgender individuals may feel that IPV services will be less be accepting of their gender identity or non-heteronormative relationships (Donovan & Barnes, 2019). These fears are likely exacerbated for those with multiple marginalized identities. Transgender individuals from diverse racial, ethnic, and cultural backgrounds may be more reluctant to seek help due to experiences of marginalization from the dominant culture and negative stereotypes from their cultural background (Kahn et al., 2018; Whitfield et al., 2021). The fear of being met with prejudice and discrimination likely impacts where transgender victims feel they can seek help and how helpful these supports are assumed to be.

The focus on heterosexual relationships in IPV literature has also resulted in gendered policies and programs that inform law enforcement protocols and treatment options for IPV survivors. For instance, many DV shelters use a gendered admissions process that forces transgender IPV survivors to "pass" as the required gender to receive help (Guadalupe-Diaz & Jasinski, 2017). Staff are often hesitant to accept transgender clients over concerns that their gender identity will make others uncomfortable (munson & Cook-Daniels, 2016) or are unprepared to work inclusively with transgender survivors (Furman et al., 2017; Tesch & Bekerian, 2015). Similarly, transgender individuals are met with more discrimination,

harassment, and gender profiling in their interactions with law enforcement than cisgender individuals and are less willing to report crimes (Hodge & Sexton, 2020; Nadal et al., 2015; Serpe & Nadal, 2017).

In addition to the traumatic effects of IPV, transgender survivors may be at an increased risk for mental health concerns resulting from their gender minority status. Transgender people are more likely to meet the criteria for a mental health disorder and experience higher levels of suicidal ideation due to living with a stigmatized identity (Coulter et al., 2017; Dawson et al., 2017; Jaffray, 2020; Valentine & Shipherd, 2018). As such, transgender individuals may be more likely to seek help from a mental health professional. Unfortunately, counselling is often a fearful time in which transgender individuals feel conflicted between being open and honest and facing discrimination (Applegarth & Nuttall, 2016). Mental health practitioners may inadvertently treat a client's transgender identity as something to be fixed, ignore issues related to gender identity, overemphasize the importance of gender, or burden the client with having to educate them about transgender identities and issues (Mizock & Lundquist, 2016).

In light of the present review, mental health professionals should aim to reduce transphobic behaviours that reinforce negative stereotypes and patterns of discrimination against transgender individuals and recognize that IPV is not unique to heterosexual relationships. Moreover, mental health clinicians can work to oppose the oppressive experiences of transgender clients by treating nonnormative identities not as pathological but rather a normal part of personal development (Alessi et al., 2015, 2019; Hidalgo et al., 2013; Victor & Nel, 2016). Clinicians should also pay special attention to the therapeutic relationship in their work with transgender IPV survivors. A stronger therapeutic relationship may facilitate the bond between client and therapist and move survivors toward recovery (Alessi et al., 2019; Applegarth &

Nuttall, 2016; Salpietro et al., 2019). It is also crucial that IPV services adopt policies and protocols to improving inclusivity, accessibility, and outreach for transgender IPV survivors. Such a move may reduce the number of discriminatory experiences transgender IPV survivors face in the help-seeking process.

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