EXEMPLAR TRANS-AFFIRMATIVE THERAPISTS: A CONSENSUAL QUALITATIVE RESEARCH STUDY

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by

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ABSTRACT
EXEMPLAR TRANS-AFFIRMATIVE THERAPISTS: A CONSENSUAL QUALITATIVE RESEARCH STUDY

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The consensus approach for psychotherapy with transgender and nonbinary clients (TNB) has come to be known as trans-affirmative psychotherapy (TAP). TAP is influenced by a collection of guidelines and models (American Counseling Association [ACA], 2010; APA, 2015; Chang et al., 2017; Singh & dickey, 2017) and a small number of empirical studies related to psychotherapy with transgender clients (e.g., Elder, 2016; McCullough et al., 2017, Mizock & Lundquist, 2016, Morris et al., 2020). However, the limited empirical research and guidelines provide minimal direction to clinicians working in-session with TNB clients. This study sought to investigate the perceptions of exemplar clinicians' in providing TAP with TNB clients and to inform future clinical work with this population. Psychotherapy research has previously examined the practices of expert or master therapists (e.g., Jennings & Skolvholt, 1999; Sullivan et al., 2005) and solicited their perspectives to better understand how they work with clients. Understanding the practice of highly skilled therapists can clarify what makes for exceptional practices and so was modeled for this study.

A qualitative approach was taken to understand the rich perspectives and experiences of exemplar clinicians working with TNB clients. A sample of 12 clinicians, as nominated by experts in the TAP field, participated in a single, 60-minute semistructured virtual interview. Participants described motivations and training experiences for working with TNB clients, approaches to providing TAP, how TAP has impacted the participants, and advice for future TAP clinicians. Alongside the overlaps with existing research there were unique findings related to self-disclosure, termination, and training of clinicians. Recommendations for future research are centered on process-based research and research that can better understand the therapy dyad. Limitations and implications of the research are discussed. The study concludes with an exploration of future research directions to address gaps in the literature on TAP.

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I: INTRODUCTION

Transgender and nonbinary (TNB) individuals are those whose gender identity differs from their sex assigned at birth. Located under the transgender, trans, or TNB umbrella, terms used interchangeably in this study are binary (e.g., trans men, trans women) and nonbinary (e.g., genderqueer, genderfluid) transgender identities. Of the available research, findings have indicated transgender individuals are at increased risk for myriad mental health concerns compared to their cisgender peers (James et al., 2016; Meyer et al., 2017). *The Report of the 2015 U.S. Transgender Survey* (USTS), the largest transgender health survey of U.S. transgender adults, compiled data from 2015 and found 40% of transgender respondents had attempted suicide at some point, compared to 4.6% in the general U.S. population (James et al., 2016). Research on transgender mental health has indicated trans individuals appear to be at an increased risk for anxiety (Borgogna et al., 2018; Bouman et al., 2017), depression (Reisner et al., 2016), nonsuicidal self-injury (Lytle et al., 2016), substance use (Valentine & Shipherd, 2018), and eating concerns (Algars et al., 2012; Diemer, 2015) when rates are compared to those of the general population. Though minimal research exists on the transgender population overall (Matsuno & Budge, 2017), nonbinary individuals are at even higher risk for negative mental health outcomes (e.g., anxiety, depression, eating concerns) than their binary transgender counterparts (Budge et al., 2013; Lefevor et al., 2019; Scandurra et al. 2019). For instance, USTS found 49% of nonbinary respondents and 35% of trans men and women reported serious psychological distress, whereas 5% of the overall U.S. population noted this concern (James et al., 2016).

Alongside these high rates of mental health concerns, transgender individuals experience pervasive social discrimination and harassment, which may exacerbate the mental health concerns experienced by the TNB individuals. According to USTS data, TNB respondents reported incidents of verbal harassment (46%), physical attack (24%), or sexual assault (13%; James et al., 2016). In addition, transgender individuals experience significant barriers to employment (Rainey & Imse, 2015) and have reported experiences of discrimination in the workplace (James et al., 2016).

Perhaps in response to these mental health problems and associated stressors of social discrimination, transgender individuals seek therapy at high rates. USTS data indicated a significant percentage (58%) of TNB people reported attending therapy in 2015, and another 25% of transgender survey respondents indicated they intended to seek mental health counseling in the future (James et al., 2016). In comparison, according to Centers for Disease Control and Prevention (CDC), 9.5% of adults in the United States sought therapy or counseling in 2019 (Terlizzi & Zablotsky, 2020), sharply contrasting the help-seeking behaviors expressed by transgender clients. Consequently, though constituting less than 1% of the U.S. population, TNB individuals seek psychotherapy much more often than the general population.

Psychotherapy for TNB Individuals

Despite data indicating trans people are at risk for myriad serious mental health disorders and seek psychotherapy at higher rates than the general population (James et al., 2016; Olfson & Marcus, 2010) little research has explored what psychotherapy approaches, strategies, techniques, or best practices support helpful psychotherapy with this population. Attempts at a meta-analysis of psychotherapy with trans clients have

proven unsuccessful due to the lack of studies meeting inclusion criteria (Budge & Moradi, 2018); for instance, despite attempts at meta-analysis, no studies have included two treatment conditions to compare outcomes, focus on treatments adapted or designed for TNB individuals, or use statistics to calculate effect sizes (Budge & Moradi, 2018). As such, clinicians and researchers have only fragments of evidence rather than conclusive evidence for those attempting to assert what leads to positive therapy outcomes for trans clients or how trans-affirmative therapy is conducted. Only two outcome-based studies have focused on beneficial aspects of therapy for trans clients, specifically affirming therapeutic approaches (Bettergarcia & Israel, 2018; Budge et al., 2020). These preliminary data have suggested, at least in some settings, trans clients derive some positive mental health benefits by participating in psychotherapy that seeks to meet specific needs of trans clients. These findings aligned with others who have called for the inclusion of practices more directly affirming and caring for trans clients (Bess & Stabb, 2009; Bockting et al., 2004; Budge et al., 2020; Elder, 2016; Rachlin, 2002).

Transgender Clients in Psychotherapy

Multiple studies have indicated transgender clients are likely to anticipate being pathologized or encountering unhelpful experiences with therapists (e.g., McCullough et al., 2017; Mizock & Lundquist, 2016). Regarding what contributes to these expectations for transgender clients, a few significant themes have emerged from research. First, before beginning therapy, Hunt (2014) found clients indicated a fear of being judged or misunderstood. Hunt's clients were also concerned they would be stereotyped or misunderstood because of unknowledgeable and nonexpert therapists (Benson, 2013).

Other researchers have also found this anxiety, fear, and feeling of being judged is sometimes influenced by poor experiences with prior therapists (Elder, 2016; McCullough et al., 2017). Researchers have identified some of these poor prior experiences as (a) participants having previous therapists who used incorrect pronouns, or (b) therapists who discouraged clients from disclosing their transgender identity to family or friends (Elder, 2016; McCullough et al., 2017).

Another contributing factor leading to trepidation when transgender clients consider seeking psychotherapy is the diagnostic label of gender dysphoria. Introduced in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychological Association [APA], 2015), gender dysphoria was previously listed in the DSM as gender identity disorder. Despite the declassification as a disorder, diagnostic labels have predominantly been found objectionable by transgender research participants due to the implication that a transgender identity reflects a mental illness or symptom of a disease rather than a normative variation in gender (Bess & Stabb, 2009). This objection reflects similar objections made regarding diagnoses of homosexuality in recent decades (Drescher, 2015); in part due to these objections, homosexuality was ultimately removed from the DSM-II (1973) as a diagnostic category. Despite its declassification as a disorder, the continued use of gender dysphoria in subsequent iterations of the DSM has remained controversial among clinicians and the trans community. The controversy centers around the tension that a gender dysphoria diagnosis is often required to initiate a medical intervention and gender-affirming care for transgender individuals.

Despite the necessity of a gender dysphoria diagnosis in seeking and obtaining medical intervention, the label has continued to contribute to TNB clients feeling pathologized, which has often led to the development of negative attitudes toward psychotherapy (Budge & Moradi, 2018; Mizock & Lundquist, 2016). Relatedly, TNB clients have reported hesitance to enter therapy because some therapists lack knowledge of TNB issues (McCullough et al., 2017) and are unaware of the social, political, and historical concerns of transgender individuals. This lack of knowledge and nonexpert care can also manifest in either overemphasizing the role of gender in clients' presenting problems or, conversely, ignoring gender altogether (Hunt, 2014; McCullough et al., 2017; Mizock & Lundquist, 2016).

Once in therapy, transgender participants have indicated the therapist's lack of knowledge can sometimes manifest in the form of microaggressions. These often-unconscious microaggressions are subtle forms of verbal, nonverbal, or visual discrimination on the therapist's part (Anzani et al., 2019; Nadal et al., 2012). Recent research has found trans clients often experience therapist microaggressions, including instances of being misgendered (i.e., using the wrong pronouns or name when referring to someone). In these instances, microaggressions negatively impacted client–therapist rapport and contributed to negative expectations for future therapy interactions (Morris et al., 2020). As another example, when therapists make nonaffirming statements in mock therapy sessions (e.g., therapists who try to help the client identify with their birth-assigned sex rather than with their stated gender), trans participants rate these therapists lower on trustworthiness, expertise, and likability compared to therapists who made trans or nonbinary affirming statements (Bettergarcia & Israel, 2018). Given a robust

therapeutic relationship is correlated with better psychotherapy outcomes for the general population (Norcross & Wampold, 2011), these lower ratings may portend poorer therapy outcomes for trans clients. Such a possibility, however, has not yet been empirically examined.

Finally, a dynamic sometimes influencing the therapy relationship with TNB clients is the role of gatekeeping. The current model of determining whether a transgender client will be approved for gender-affirming medical interventions such as surgery or hormone therapy (HT) involves a health care professional, often a mental health professional (MHP), evaluating the trans client and writing a letter of support to a physician. In many cases the MHP is a therapist, and this requirement creates a dynamic in which the therapist is a "gatekeeper" determining whether the trans client will be able to access needed medical intervention. Trans clients have reported having an unfavorable reaction to such therapist gatekeeping (Budge & Moradi, 2018; Mizock & Lundquist, 2016), but the impact of gatekeeping on therapy outcomes remains unknown.

In sum, trans clients may experience anxiety entering therapy, often because (a) they feel they may be judged by therapists (Benson, 2013; Hunt, 2014; Snow et al., 2019), and (b) they may also have specific concerns about being diagnostically labeled in antiquated and marginalizing ways (Bess & Stabb, 2009; Mizock & Lundquist, 2016). Furthermore, trans clients may encounter adverse experiences during therapy related to their trans identity, including microaggressions (e.g., misgendering, gatekeeping). Despite instances of poor psychotherapy expectations and encounters, clients are more responsive to therapy when clinicians are affirming and knowledgeable (Bettergarcia & Israel, 2018). Whether these negative experiences are linked to reduced therapy outcomes

(e.g., symptom reduction, early termination) remains empirically unknown; however, given the number of potentially challenging therapeutic encounters for trans clients, researchers have a growing interest in examining therapeutic methods that are expert and trans affirmative (Budge & Moradi, 2018; McCullough et al., 2017; Snow et al., 2019). Researchers seek to identify therapy that intentionally affirms a trans identity, is free of biased therapist attitudes and behaviors, and reduces trans clients' anxiety and hesitancy to pursue or enter treatment. Still, more research is needed to understand what therapist intentions, knowledge, skills, and actions contribute to affirming therapeutic approaches when working with TNB clients.

Transgender-Affirmative Psychotherapy

In the last decade, the consensus approach for the psychological care of transgender clients has come to be known as trans-affirmative psychotherapy (TAP). Researchers have sometimes referred to this transtheoretical approach in the literature as transgender-affirming care, approaches, practices, or psychotherapy, with varying but also overlapping definitions (e.g., American Counseling Association [ACA], 2010; APA, 2015; Chang et al., 2017; Singh & dickey, 2017). As of 2023, there is not a collective unifying theory of TAP; rather, TAP appears to be influenced by a collection of guidelines and models that inform thinking about psychotherapy with transgender clients, but which minimally address what TAP looks like in practice or how to implement TAP (Morris et al., 2020).

For instance, in the last 10 years, principles of trans-affirmative care have been outlined in guidelines established by professional organizations, including the APA (2015), APA (2017), and the ACA (2010). The APA's (2015) *Guidelines of*

Psychological Practice With Transgender and Gender Nonconforming People (*Guidelines*) were developed in part after the APA's Task Force on Gender Identity and Gender Variance found less than 30% of psychologists or graduate students reported familiarity with issues TNB people face (e.g., societal discrimination; APA Task Force on Gender Identity and Gender Variance, 2009) or knew about the minority stress model (e.g., Guideline 5). APA's (2015) *Guidelines* were intended to help psychologists who provide care, conduct research, or educate the public about TNB individuals; however, psychotherapy was only mentioned briefly and in combination with assessment or the provision of other tasks of psychological care. Furthermore, the *Guidelines* did not define TAP. There is no current model of TAP, and only a small number of empirical and peer-reviewed studies have explored what keeps trans clients in therapy and leads to helpful psychotherapy (APA, 2015; Bettergarcia & Israel, 2018).

Several definitions of TAP have been described in the literature; these definitions have some overlap, which may help to develop an overarching model of TAP. As an example, the American Psychiatric Association (2017) defined gender-affirming therapy as "a therapeutic stance that focuses on affirming a patient's gender identity and does not try to 'repair' it" (para. 1). In contrast, Singh and dickey (2017) recently defined TAP, noting:

> [TAP is] counseling that is culturally relevant and responsive to transgender or gender nonconforming (TGNC) clients and their multiple social identities, addresses the influence of social inequities on the lives of TGNC clients, enhances TGNC client resilience and coping, advocates to reduce systemic barriers to TGNC mental and physical health, and leverages TGNC client strengths. (p. 4)

Other definitions of TAP have sought to identify counselor characteristics important to the delivery of TAP services; for example, researchers have often defined

TAP as an approach in which the therapist accepts, advocates, or educates others about transgender individuals (ACA, 2010; Carroll & Gilroy, 2002) or validates or affirms (e.g., nonpathologizing) trans people (McCullough et al., 2017). Further, trans-affirmative therapists embrace gender diversity, reject the gender binary (Korell & Lorah, 2007; Spencer et al., 2021), and regard gender variation as normative (APA, 2015). TAP often places an emphasis on being client centered, in part because in previous decades, transgender individuals were often pathologized by the mental health establishment (Spencer et al., 2021). Being client centered, then, makes TAP client driven and helps to buffer against any distrust or suspicion trans clients may have toward their therapist having a pathologizing agenda or having goals not aligned with the client's goals (Carroll & Gilroy, 2002). Relatedly, TAP strives to give the appropriate weight to the role of gender in a client's presenting concern, as research has shown some therapists over or underemphasize the role of gender (Mizock & Lundquist, 2016). Therapists are also encouraged to understand the role of gender minority stress on trans clients and how this stress may impact mental health.

These varied definitions and guidelines have helped to develop limited research on TAP in recent years. Initial research has indicated the importance of (a) a positive therapy relationship (Applegarth & Nutall, 2016; Bess & Stabb, 2009; Elder, 2016); (b) therapist expertise and knowledge of trans clients (e.g., impact of minority stress, transgender medical treatment, appropriate language; Benson, 2013; Bess & Stabb, 2009; Bettergarcia & Israel, 2018; McCullough et al., 2017; Rachlin, 2002); and (c) clinician affirmation of trans clients' stated identity with no intent to change or repair the identity (Benson, 2013; Bettergarcia & Israel, 2018). Trans clients' reports of instances of helpful

counseling have included a positive therapeutic alliance marked by person-centered therapist characteristics like warmth, validation, listening, collaboration, and affirmation (Elder, 2016; Hunt, 2014: McCullough, 2017). Trans clients have also further reported seeking counselors who express respect (Rachlin, 2002), empathy, and care (Bess & Stabb, 2009). For instance, TNB clients have reported therapists who adopt affirming language (e.g., asking about personal pronouns used) helped these clients feel more connected and trusting of their therapists and provided a positive influence on the therapy relationship formation (McCullough et al., 2017).

Statement of the Problem

Preliminary research on affirmative approaches with trans clients is helpful, but understanding of trans-affirmative theory remains limited; thus, more research is needed in this area. Though guidelines developed by experts and professional organizations are beneficial, it is essential to understand how clinicians conduct TAP with clients. Because definitions of TAP remain varied researchers and practitioners alike should work to develop a consensus of what might help clinicians, clients, and the public better understand critical tenets of trans-affirmative theory and how they operationalize in psychotherapy sessions. In addition, current research is limited in scope, as much of the research on affirmative approaches with trans clients has been based on retrospective recall of trans clients' experiences in therapy and with small samples sizes (e.g., Applegarth & Nutall, 2016; Bess & Stabb, 2009; McCullough et al., 2017). Although these perspectives are important, it may also be important to understand what approaches therapists perceive work and do not work in therapy with trans clients. In these circumstances, therapists who have worked extensively with trans clients may have

significant experience and understanding of the unique knowledge, attitudes, and skills that are important to helping trans clients successfully.

This study filled a gap in the current research, as no other study to date has explored the experiences of exemplar therapists or those who are experienced clinically in working with trans clients and who understand the most important elements of applying trans-affirmative theory to their work. Identifying exemplar therapists was especially relevant for this study due to research that suggests TNB clients often have negative interactions with clinicians in therapy (e.g., Morris et al., 2020). Studying the perspectives of exemplar therapists who have these experiences may improve researchers' understanding of the needs of trans clients in therapy and how they implement TAP in their practices. To provide context to this study, the following sections provide a rationale for the study, present research questions, and define and clarify terms central to this study.

Rationale for the Study

This study sought to investigate clinicians' perceptions of their experiences providing what they define as TAP to trans clients. Psychotherapy research has largely reflected a propensity to examine the practices of expert or master therapists (e.g., Jennings & Skolvholt, 1999; Sullivan et al., 2005) and solicit their perspectives to better understand how they work with clients. This type of research has helped therapists understand what makes for exceptional practices as therapists and potentially which therapist actions in therapy contribute to successful outcomes for their clients. For this study, I interviewed therapists who were identified as exemplars in working with trans clients to better understand what aspects of therapy they considered important to

providing trans-affirmative therapy with TNB clients. It seemed reasonable to assume these clinicians' accumulated experiences with trans clients would yield new insights about important aspects of therapy with this client demographic. Additionally, I assumed the clinicians would have insights into aspects of the therapy practices that either supported or challenged their work with clients. Finally, I hoped these experts would help describe the possible behaviors and skills required to establish an affirming therapy relationship with TNB clients and help to bridge the gap between professional organization guidelines and clinical practice.

As noted earlier, TAP remains largely unexplored in empirical literature. Qualitative research is a particularly useful research method for investigating topics that are largely exploratory and enables in-depth insights into topics such as TAP that are not well understood (Morrow, 2007). In particular, consensual qualitative research (CQR; Hill et al., 2005) was chosen as the methodology to examine the uniqueness of individual exemplar trans-affirmative therapists. CQR is an excellent method for investigating complex topics such as the knowledge, skills, and awareness expected of a trans-affirmative psychotherapist (APA, 2015); CQR pays particular attention to participants' experiences while finding potential commonalities across those participants (Hill & Knox, 2021). Results of this study provided insights from trans-affirmative psychotherapists, which illuminated how these clinicians facilitate TAP in sessions with trans clients.

For this CQR study, participants were counselors or psychologists whose postlicensure practices had included work with at least 20 TNB clients and who had been nominated as an exemplar trans-affirming counselor by at least one member of an expert

nomination panel. The panel was comprised of individuals who had presented or published widely on the topic of trans-affirmative work or who were experts in their community on trans-affirming work (i.e., community centers; Bronk, 2012). In addition, participants had to identify themselves as trans-affirmative clinicians.

Research Questions

The questions developed for this study sought to understand the perspectives of exemplar therapists and focused in particular on how exemplar clinicians deliver TAP and what facilitates and challenges these therapists when providing trans-affirming therapy. The primary research questions for this study are included in the following paragraphs.

Research Question 1

How do exemplar trans-affirmative therapists provide trans-affirmative psychotherapy?

Little is known empirically about how clinicians provide TAP throughout the course of treatment, nor what trans clients consider as helpful or unhelpful experiences in therapy (McCullough et al., 2017). As of 2023, researchers have not sufficiently explored how therapists execute TAP with their clients, including aspects of intake, development of a working alliance, or the theories used in their approaches to TAP; rather, many researchers have encouraged future investigations to explore what contributes to positive therapy experiences in general (e.g., the therapy relationship; Bettergarcia & Israel, 2018: Budge & Moradi, 2018). Research Question 1 sought to capture the nuances of TAP by addressing the process of therapy, from intake to termination, aspects of culture, and the therapy relationship.

Research Question 2

What challenges and facilitates exemplar therapists' provision of trans affirmative therapy?

Researchers and clinicians have long identified affirming approaches with trans clients (APA, 2015; Budge & Moradi, 2018; Salpietro, 2019); however, given scant empirical research on the topic of TAP, little is known about which parts of the process either challenge or facilitate the provision of these best approaches. To expand on empirical literature in this area, Research Question 2 sought to understand the unique or perhaps novel aspects of TAP, which have not been previously defined to the extent that they could translate to specific action or practices. Information gathered from this question may help to inform how TAP is practiced through exploration of facilitators and challenges.

Definitions of Terms

Language and definitions in the transgender community are dynamic. Additionally, the definitions used colloquially are often disparate from those used in psychological literature. Providing definitions describes the key terms relevant to this investigation and the literature review that follows, while also acknowledging the terms most current, accurate, and respectful to TNB individuals.

Gender Identity Bias

A relatively new term, Moss-Racusin and Rabasco (2018) defined gender identity bias (GIB) as stereotyping, prejudice, discrimination, and physical aggression or violence administered based on an individual's gender identity. GIB is a general term that replaced

prior explanations of negative reactions to trans individuals, such as transphobia and antitransgender prejudice (Hill & Willoughby, 2005; Tebbe & Moradi, 2012). Researchers have increasingly used GIB as a term to describe the beliefs, attitudes, and behaviors that more broadly describe the negative reactions to transgender individuals (Moss-Racusin & Rabasco, 2018).

Intersectionality

Intersectionality theory is considered a cornerstone of trans affirmation and represents a more recent contribution to affirmative psychotherapy with gender minorities. In recent years, the APA (2017) included the concept of intersectionality into their multicultural practice guidelines, and intersectionality is applied widely throughout the social sciences. Intersectionality, originating from critical race and law theory, represents the concept of multiple axes of oppression and privilege experienced by an individual. Crenshaw (1991) introduced the term to help describe the lived experiences of Black women who face both sexism and racism (Moradi & Grazanka, 2017). Increasingly, psychology research has employed the intersectionality framework (e.g., Adames et al., 2018; Johnson, 2013) to understand the lived experiences of trans individuals. Intersectionality has been especially salient in understanding the public health crisis of Black transwomen who are at an increased risk for enduring poverty, limiting employment to underground economies, and becoming victims of homicide (Grant et al., 2011). Moradi and Granzka (2017) implored researchers and clinicians of psychology to use the intersectionality framework with integrity, such that the term not become just another word to describe a client's various social locations. Instead,

intersectionality is exclusively representative of multiple, interacting axes of societal oppression and privilege, which may influence mental health outcomes.

Minority Stress

The most comprehensive theory of stress experienced by transgender individuals derived from Meyer's (2003) minority stress theory. Meyer's theory was developed specifically to understand how LGB individuals exposed to social prejudice, discrimination, and other social stressors are vulnerable to mental health concerns more often than their heterosexual peers. Hendricks and Testa (2012) adapted the minority stress model to develop a framework for working with and understanding the unique experiences of TNB individuals. The framework delineates three processes during which individuals experience minority stress: (a) distal (e.g., community discrimination, trans-prejudice), (b) proximal (e.g., internalized transphobia), and (c) anticipated stressors (e.g., confrontation about gender identity).

Exposure to minority stress in their environments may make TNB individuals susceptible to higher levels of substance dependence, mood disorders, posttraumatic stress disorder along with suicidal ideation and attempts than their cisgender peers (Hendricks & Testa, 2012; Meyer, 2003). A recent Williams Institute survey (Haas et al., 2014) found TNB individuals have exponentially higher rates of suicide attempts than their cisgender peers. Further, research has shown violence against TNB people is related to higher substance use among TNB people than cisgender people (Testa et al., 2012).

Sex, Gender, and Gender Identity

Often conflated, sex and gender are not interchangeable, and feminist scholars have sought to differentiate the two (Bem, 1992; Budge & Moradi, 2018). Sex refers to

an individual's biology and anatomy, where most often external anatomy is used to assign sex at birth (e.g., male, female, intersex). Gender, however, refers to the social meaning typically attached to the characteristics of an individual's sex assigned at birth. Gender identity is an individual's felt sense of gender (e.g., gender nonbinary, genderqueer, male or man, female or woman). Increasingly, trans individuals may describe their sex assigned at birth (e.g., assigned female at birth [AFAB]) alongside their gender identity (e.g., transman, transwoman, woman, man, genderqueer).

Sexual Orientation

Often conflated with gender identity or expression, sexual orientation (SO) refers to the attraction and relationship patterns of individuals. SO includes not just the sexual identity of individuals, but their sexual behaviors and attractions, too. SO often relies upon binary conceptions of gender (i.e., men = gay, women = lesbian), which can cause confusion when gender identity is factored into an individual's sexual orientation. Homosexual is an outdated term once used to describe and pathologize same-gender attraction and sexual behavior; use of the term in this paper was limited to discussion of historical usages (APA, 2019).

TNB

Individuals whose felt sense of gender (i.e., gender identity) does not align with their sex assigned at birth are described as transgender (APA, 2015). "Transgender," "trans and nonbinary," and TNB are umbrella terms that succinctly, though perhaps insufficiently, describe the myriad identities considered to fall outside of the gender binary (i.e., man, woman). Some examples, though not exhaustive, include transmen, transwomen, genderqueer, gender nonbinary, gender fluid, and agender. Terms such as

transgendered, transsexual, and hermaphrodite have been deemed derogatory and, therefore, have not been used frequently in psychological literature (APA, 2015; Singh & dickey, 2017). Occasionally, however, individuals may select these terms to self-identify. I use the singular “they” and “their” throughout this study as a gender-neutral alternative to the pronouns “he” or “she” when gender is unknown, as recommended by the APA (2019) style guide.

Due to the evolving nature of language with trans individuals, empirical research has tended to use vastly different terms depending on the era when published. Older research has used binary terms to describe gender identity, including male-to-female (MtF) and female-to-male (FtM; e.g., Bess & Stabb, 2009; Rachlin, 2002). Nonbinary identities have often been absent from research samples but have been increasingly studied and differentiated from binary trans identity (Matsuno & Budge, 2017). Again, although some trans individuals still use MtF or FtM as self-identity terms, this language has been replaced with terms such as transwoman or transman. Similarly, terms such as transfeminine and transmasculine are inclusive terms sometimes used to recognize the socially constructed nature of gender identity and gender expression.

The terms TNB, trans, transgender, and gender diverse were used interchangeably throughout this document when gender specificity was not needed. Similarly, "cisgender" was used throughout the study to refer to those individuals whose gender identity aligns with their sex assigned at birth, either male or female. Intersex individuals are those whose sex assigned at birth is defined by ambiguous secondary sex characteristics, sometimes also noted in the literature as differences of sex development. Although some

intersex individuals may identify as transgender, others do not, and the clinical topics specific to these individuals extended beyond the scope of this work.

Future Implications

In conducting this study, I sought to investigate exemplar clinicians' perceptions of their experiences providing what they defined as TAP to trans clients. In doing so, I aimed to define how TAP is implemented in clinical practice. The research questions were developed to better understand what training or experiences influenced clinician preparation for working with TNB clients. Further, I hoped understanding clinicians' perceptions of the facilitators, challenges, and common components of psychotherapy (e.g., intake, termination) with TNB clients would provide clinical guidance for therapists that is currently missing in the research and guidelines.

Conclusion

The guidelines developed by experts and professional organizations help guide clinical practice; however, more research is needed to understand and build consensus around the critical tenets of TAP and their implementation in clinical practice. Current research is limited to only a handful of peer-reviewed, largely qualitative studies about TNB client experiences in psychotherapy (e.g., Bess & Stabb, 2009; Elder, 2016; McCullough et al., 2017) and only one study exploring therapists' experiences (Salpietro, 2019). This study filled a gap in existing research to explore how exemplar therapists, as nominated by experts in the field, implement TAP in their practice. Chapter 2 presents an overview of the history of the intersection of TNB clients and psychology and a more in-depth review of the literature before describing the results of this study.

CHAPTER II: REVIEW OF THE LITERATURE

> Far too often, medical services for transgender people has [*sic*] depended on constructing transgender phenomena as symptoms of a mental illness or physical malady, partly because 'sickness' is the condition that typically legitimizes medical intervention. (Stryker, 2018, p. 52)

Inherent in Stryker's (2018) quote is a tension underlying fraught interactions between transgender people and medical professionals throughout history—that, for trans clients to have access to some areas of professional care, they must first be labeled with a disorder and often by mental health professionals. In the last 10 years, the relationship between professional intervention and psychological diagnosis has shifted in important and less stigmatizing ways as professional organizations (e.g., American Medical Association, American Counseling Association [ACA], American Psychological Association [APA]) have embraced transgender-affirmative care; however, the legacy of transgender pathology remains.

To understand the need for trans-affirming psychotherapy (TAP), it is first helpful to understand the ways psychiatry and psychology researchers and clinicians have historically viewed transgender identity. The next section examines the history of how psychiatric and psychological organizations have pathologized both nonheterosexual sexual orientation (SO) and nonconforming gender identity, followed by a description of the standards of care developed to provide affirmative care to transgender and nonbinary (TNB) clients.

SO and Gender Diagnoses

Differences in SO and gender identity have been the source of psychological study since the late 18th century and have often been conflated making it useful to

describe their overlap through history. German psychiatrist von Kraft-Ebbing (1886) first described same-sex sexual behavior and attractions as *Psychopathia Sexualis.* von Kraft-Ebbing declared these same-sex sexual attractions as perverse, deviant, and a congenital disorder—emphasizing the disordered nature of homosexuals (Drescher, 2015). Though Psychopathia Sexualis was long ago discredited by researchers, it marked a beginning of a long history of pathologizing homosexuality.

Homosexuality has been of particular interest to the psychology field since Freud. In a now-famous letter written in response to a concerned U.S. mother, Freud (1951) advised:

> Homosexuality is assuredly no advantage, but it is nothing to be ashamed of. No vice, no degradation. It cannot be classified as an illness. We consider it to be a variation of the sexual function produced by a certain arrest of sexual development. (p. 786)

Freud's view on same-sex attraction, as described in the preceding quote, and when viewed in retrospect, might be seen as a tacit endorsement of gay people, especially given the era; however, the sentiment still reflects a pathologizing of nonheterosexual orientation and gender identity (i.e., reference to "arrest of sexual development"). Freud also argued same-sex sexual attraction and bisexuality were observed among high functioning nondiseased individuals, and that homosexuality was normative; yet, he did so while also suggesting homosexuality is the result of arrested psychosexual maturity.

Despite Freud's (1951) perhaps less pathologizing view of nonheterosexual identity, his argument likely contributed to the persistence of an arrested development theory; in the decades following, most psychoanalysts viewed homosexuality as pathological (Drescher, 2015). Given the pervading model of psychiatric treatment until the cognitive revolution was psychoanalysis, psychoanalysts' views of SO and gender

identity were widespread. In fact, it would take until 2012 for the American Psychoanalytic Association to publicly disavow their century-long pathologizing of nonheterosexual sexual orientation.

The pathologizing views of these differences were also encouraged by the science of the time; for instance, 19th-century sexologists described those who did not conform to sex-typical expressions of gender (e.g., feminine men, masculine women) as suffering from the condition of "inversion" (Lev, 2004, p. 69)." These "sexual inverts" were labeled as a "third sex" who sought same-sex relationships, thus conflating SO and gender identities (Lev, 2004, p. 74). Only in recent years have researchers differentiated trans identity and SO, increasing the specificity required to understand the differences and intersection between them (Drescher, 2015).

Differentiating SO and gender has not been helped by psychiatric nosology. For instance, homosexuality has been deemed pathological since the first iteration of the *Diagnostic and Statistical Manual* (DSM) and drew from rigid, often fundamentalist beliefs about gender, including that gender nonconformity was a moral failure and representative of being homosexual (Drescher, 2015). The DSM-I (1952) listed homosexuality as a sociopathic personality disturbance, and in the DSM-II (1968), as sexual deviation (Drescher, 2009). It was not until the 1969 Stonewall Riots of New York City that dissent emerged against these stigmatizing diagnoses. The protests at Stonewall ushered in a wave of activist protesters, many of whom were Black transwomen, along with gay and lesbian people of all races who focused their activism on the social stigma caused by antihomosexual psychiatric theories and conversion practices (Stryker, 2017). Although trans people took an active role in these protests, their concerns were largely

ignored by the psychiatric establishment in favor of addressing concerns related to SO. The oversight of trans people in this movement was due in part to their social isolation and marginalization, as many were sex workers with little sociopolitical power and therefore were not seen as compatible with the concerns of gay individuals wishing to gain mainstream support (Beemyn, 2014).

Despite barriers, these lesbian, gay, and bisexual (LGB) activists engaged in years of protest until homosexuality as a disorder was removed from the DSM in 1973. The removal was announced at the APA's annual meeting (Drescher, 2015), during which a prominent APA psychiatrist came out as gay himself (Stryker, 2017). The removal, however, was highly controversial, especially among psychoanalytic members who continued to believe homosexuality was a mental illness. After the announcement, Dr. Spitzer was quoted in *The New York Times* (1973) as saying, "It doesn't say homosexuality is normal. It only says that it doesn't meet the criteria for an illness or a disorder" (p. 5). Though Spitzer was in favor of removing SO from the DSM, his opinion on the matter reflected the pervasive sense that homosexuality was not normal.

Like Freud and Spitzer, the DSM committee refused to explain same-sex attraction as fully healthy and normal. APA's 1973 ruling, however, was a step toward depathologizing homosexuality. Subsequent iterations of the DSM still allowed for LGB identity to be pathological; for example, future versions of the DSM included SO-related disorders, including ego-dystonic homosexuality (DSM-III) and sexuality disturbance not otherwise specified (DSM-III-R). These diagnoses remained in some form until APA formally removed them from the DSM-5 in 2013 (Drescher, 2015).

During the era spanning the introduction of the DSM (1952) and the early 1970s, trans people were similarly viewed as nonnormative. Green et al. (1966) conducted a clinician survey where respondents endorsed overwhelmingly negative attitudes toward transgender individuals. Results showed 81% of psychiatrists felt transgender individuals were "severely neurotic" or psychotic, and therefore experienced psychopathology (Green et al., 1966). Despite these negative attitudes, some pioneering medical doctors worked with trans individuals to accommodate medical (e.g., surgery) and social transitions (e.g., changing names, clothing) despite the overwhelming belief that transgender identity was pathological.

In fact, gender clinics were established on the coasts of the United States, including Johns Hopkins and University of California, Los Angeles, to provide care to trans clients (Stryker, 2017). Though these clinics were a resource for treatment-seeking clients, trans clients often reported cruel treatment, including forced experimentation in other settings (Stryker, 2017). Treatment during this era included attempts to change a client's desire for gender transition (e.g., reparative therapy or conversion therapy). Clinicians often used psychodynamic or behavior modification therapies to reinforce behavior and adherence to norms typical of their sex assigned at birth (Bockting, 2008). However, in the persistence of gender identity incongruence, gender-affirming surgeries were often initiated for these clients.

Perhaps to address the increase in gender-affirming surgeries, the DSM-III (APA, 1980) introduced gender identity disorder (GID). Though previous iterations of the DSM had included *transvestism* as a sexual deviation—arguably the DSM's rudimentary attempt to address trans identity—GID more directly addressed gender identity rather

than sexual deviance. In some ways, the GID diagnosis was seen as a solution to the growing number of clients identifying as transgender and seeking transition-related medical intervention (e.g., hormone therapy, gender affirmation surgery; Drescher, 2015). Once diagnosed with GID, clients then gained access to treatments. Because gender identity and SO were not yet accepted as distinct concepts, psychologists argued the GID was nothing more than an alternate way of pathologizing sexual orientation (Drescher, 2009).

The *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (DSM-5-TR) is the most current version as of 2023 and lists gender dysphoria in place of GID. Individuals diagnosed with gender dysphoria experience persistent distress as a result of their birth-assigned sex being incongruent from their felt sense of gender and the gender by which they identify. The 2022 World Health Organization's (WHO) International Classification of Diseases (ICD) 11 lists transgender identity as gender incongruence, no longer falling under the category of mental health and instead moving to the sexual health chapter (Beek et al., 2016). Despite these continued changes, many trans individuals have viewed the psychological establishment and associated diagnostic classifications with skepticism due to the role classifications have played in accessing hormone therapy or other interventions (Bess & Stabb, 2009; Carroll & Gilroy, 2002). The inclusion of any gender-related issues within the DSM/ICD remains controversial, and the tension between psychological diagnosis and access to healthcare has persisted even as modern medicine has established gender-affirming standards of care, as discussed in the following section.

Standards of Care: Then and Now

In the 1970s, being transgender was often not differentiated from homosexuality and was treated as such with reparative methods. These methods typically included a combination of behavior therapy, older models of psychoanalytic theory, and religion, and intended to help these individuals fully identify by their sex assigned at birth (Drescher, 2015). It was not until 1979 that Dr. Benjamin and the Harry Benjamin of the International Gender Dysphoria Association (later the World Professional Association on Transgender Health [WPATH]) established the Benjamin Standards of Care. These standards of care were established to guide clinicians in their work with trans clients seeking medical transition. The following is a brief review of the standards of care and mental health professionals' involvement in the care of transgender people.

Harry Benjamin rose to considerable fame for his work with transgender clients during the 1950s, 1960s, and 1970s, including his work with the famous transwoman, Christine Jorgenson. Benjamin has sometimes been called "The Father of Transsexualism" (Schaefer & Wheeler, 1995) and was author of a groundbreaking book, *The Transsexual Phenomenon*. The first standards of care for trans clients outlined their psychiatric, psychological, medical, and surgical management needs, placing an emphasis on medical treatment rather than the behavioral or reparative methods of the past.

The Harry Benjamin standards of care became the WPATH standards of care in 2007 when the organization officially changed its name. The WPATH standards of care have been significantly revised since the first version, and each recent iteration has addressed implications for counselors and psychologists working with trans clients. In early versions, transgender individuals had to meet specific WPATH standards of care

requirements before medical intervention (e.g., social transition). Particularly important among these requirements was the expectation that trans individuals live *full-time* in their authentic gender (Meyer et al., 2001). This requirement was typically met by trans individuals changing their names, gender expression (e.g., clothes, hair) for at least 1 year. Mental health professionals were often asked to provide proof of this full-time social transition (e.g., living in the world as their felt gender) and the standards of care were a means of guiding the letter-writing process (i.e., therapist letter describing client readiness for transition-related treatments). The most recent version, the WPATH Standards of Care 8 (Coleman et al., 2022), no longer requires proof of social transition and explicitly recommends mental health professionals not provide reparative or conversion therapy. Changes to these standards of care addressed critiques that expecting trans clients to transition in a particular way (e.g., social transition first) violates client autonomy (Hale, 2007).

Recognizing trans clients' diverse needs, the most recent WPATH Standards of Care 8 (Coleman et al., 2022) emphasized flexible clinical guidelines for mental health professionals working with trans clients. For instance, clients may wish to pursue certain aspects of gender-affirming medical and/or surgical treatments (GAMSTs; e.g., surgery, hormone therapy), but may not wish to pursue other aspects (e.g., hormone therapy but not surgery), or may have unique preferences for the order in which they pursue various interventions. As such, mental health professionals working with trans clients are expected to conduct an early assessment of the client's goals for treatment and determine if and when clients are interested in GAMSTs. Based on this assessment, these professionals can then provide referral letters for these services as needed.

The WPATH Standards of Care 8 (Coleman et al., 2022) indicated the role of mental health providers is multifaceted when providing a referral for GAMSTs (i.e., referral letter for hormone therapy or gender-affirming surgery). Initially, the provider must conduct a psychosocial assessment; assess for gender incongruence in the client; provide information regarding options for gender identity and expression and possible medical interventions; and then assess, diagnose, and discuss treatment options for coexisting mental health concerns. Next, provided the client wishes to pursue GAMSTs, the provider can help clients become psychologically prepared (e.g., make an informed decision regarding interventions with clear and realistic expectations for the result of the intervention). Finally, with informed consent obtained, a mental health professional can provide a referral letter stating (a) the client's identifying characteristics; (b) results of psychosocial assessment and any diagnoses; (c) duration of referring health provider's relationship with client, including type of evaluation and therapy or counseling to date; (d) statement that informed consent has been obtained by the client; and (e) a statement that referring health professional is available for coordination of care (Coleman et al., 2022). These referral letters are then provided to treating provider and act as evidence of the client's informed consent.

WPATH offers guidance on this informed consent process, but clinicians typically do not obtain any specialized training in conducting the informed consent process. Only in the last 5 years has professional training emerged to address the process of referral and informed consent (Keo-Meier & Kei-Meier, 2019). One obvious consequence of this lack of specific training is that clinicians may be approached to provide these assessments in psychotherapy but may not be aware of the WPATH

Standards of Care or have any training in trans-affirming practices. Additionally, researchers have documented that some therapists believe time in psychotherapy is a requisite for hormone therapy or surgery (Singh & dickey, 2017). According to the standards of care, treatment recommendations for gender dysphoria—in addition to medical interventions—include psychotherapy; however, psychotherapy is not required. Psychotherapy is instead seen as an option, among many, to address identity and gender expression, manage minority stress effects, and build resilience (Coleman et al., 2022). When asked to provide referral for GAMSTs mental health providers may believe this request will have an impact in ongoing psychotherapy. This belief is supported by research indicating some trans clients find the assessment and referral process as a barrier to the therapy relationship in psychotherapy (Mizock & Lundquist, 2016).

In summary, the treatment of transgender mental health concerns has changed substantially throughout history, as evidenced in the creation and evolution of the WPATH Standards of Care 8 guidelines (Coleman et al., 2022). Created as a reaction to the pathologizing, reparative methods of previous generations, the WPATH Standards of Care 8 represent a more affirmative treatment approach and acknowledge there is not one correct way to transition; rather the standards of care prioritized client autonomy to direct how, when, and if they pursue a gender-affirming intervention (Coleman et al., 2022). Similarly, research on TAP has emerged as a response to the history previously outlined. The next section presents a review of existing literature as it relates to affirming approaches to psychotherapy with transgender people.

Empirical Research on TAP

In many ways a reaction to the history of bias and discrimination in transgender healthcare, trans-affirming psychotherapy (TAP) psychotherapy is intended to be client centered and focused on client autonomy and self-determination (Chang et al., 2017). Though TAP has been defined in varied ways by several clinicians and researchers, generally TAP is considered to be an approach constructed of multiple theories that are "respectful, aware, and supportive of trans identities . . . as these clients have . . . either been ignored or tacked on in ways that do not necessarily meet their therapeutic needs" (Korrell & Lorah, 2007, p. 271). Trans-affirmative practice is not a one-size-fits-all approach and clinicians must consider how to affirm each client based on their presenting cultural intersections within the sociopolitical context (Chang et al., 2017). As of 2023, trans-affirmative psychotherapy has not been precisely defined; this lack of an operational definition has limited researchers' abilities to conduct randomized controlled trials and other outcome studies. Minimal research has investigated approaches to clinical work with TNB client leaving clinicians to be guided by the APA's (2015) *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (*Guidelines*), clinician authored books (Chang et al., 2017; Singh & dickey, 2017) and a small collection of empirical research. Though the current research has been diffuse, several themes emerged that are discussed in the following sections supported by recommendations from the *Guidelines*: a) client reasons for attending therapy and barriers to treatment (e.g., Bettergarcia & Israel, 2018; Mizock & Lundquist, 2016; Rachlin, 2002), (b) therapist identity and demographics (Bess & Stabb, 2009; Elder, 2016; Hunt, 2014, McCullough, 2017), (c) therapist attitudes and experience (Kanamori

& Cornelius-White, 2017; Salpietro et al., 2019; Whitman & Han, 2016), (d) counseling skills and the therapy relationship (Applegarth & Nutall, 2016; Benson, 2013), and (e) negative therapy experiences (Bess & Stabb, 2009, Mizock & Lundquist, 2016).

Client Reasons for Attending Therapy and Barriers to Treatment

The APA (2015) *Guidelines* stated when working with TNB clients, "Psychologists strive to understand how mental health concerns may or may not be related to a TNB person's gender identity and the psychological effects of minority stress." (p. 845). In other words, what brings clients to therapy is not always because of their gender concerns or gender identity. For instance, trans clients may attend therapy for relationship concerns, work issues, mood disorders, or overall growth (Rachlin, 2002). Trans clients might also seek treatment for psychological distress in relation to gender identity concerns, all of which may be impacted by the barriers associated with minority stress (Benson, 2013).

Researchers have confirmed trans clients identify a range of reasons for attending therapy (Bettergarcia & Israel, 2018; Rachlin, 2002), including mood and anxiety (Elder, 2016), suicidal ideation (Hunt, 2014), relationships, and prejudice and stigma-influence hardships (e.g., minority stress; Benson, 2013). As such, TNB individuals regularly seek and attend therapy for a diversity of concerns that are not always related to their gender or gender identity. That said, trans clients also seek treatment for gender-specific concerns (Bettergarcia & Israel, 2018). For some clients, psychotherapy is the means to obtain necessary letters (i.e., evaluation of a client's readiness for hormone therapy or gender-affirming surgery; Bettergarcia & Israel, 2018; Hunt, 2014). Historically, those seeking such procedures were required to attend psychotherapy for several sessions

(Ettner, 1999). Referrals from a qualified mental health professional remain needed for gender-affirming medical and/or surgical treatments (GAMSTs), however, there is no mandated time needed to be completed in psychotherapy before these referrals are provided (WPATH, 2022). Based on survey data, it appears few TNB individuals endorse starting psychotherapy solely to obtain a referral for surgery (Bettergarcia & Israel, 2018; Hunt, 2013; Rachlin, 2002).

Minority Stress

From a trans-affirming theoretical perspective, trans clients may experience mental health concerns and seek psychotherapy because of stress resultant from social inequities and systematic barriers (e.g., barriers to employment, transphobia; Singh & dickey, 2017). Examples of this source of distress might be unsupportive families, difficulty obtaining work, or unsupportive and discriminatory work environments. Benson's (2013) qualitative investigation found participants experienced stressors in their environment, such as prejudice and stigma-influenced emotional hardship. The anticipated fear of transphobia led one participant to say:

> Transgendered [sic] individuals are going to come to a therapist and most of their issues have nothing to do, specifically, with being transgendered [sic]. It has to do because they've had to hide, they've had to lie, and they've felt all of this guilt and shame, unfortunately usually for years! (Benson, 2013, p. 27)

Evident from the prior quote, and perhaps the literature at large, is that environmental stressors (e.g., bias, discrimination) impact why trans clients seek psychotherapy, perhaps more so than gender-related issues. Qualitative research has suggested trans people experience microaggressions (e.g., subtle, daily forms of verbal, behavioral, environmental indignities) from family, peers, and society at large (Nadal et al., 2012). Exposure to violence and victimization may influence the development of

mental health diagnoses in trans people and proximal stigmatization, such as internalized transphobia, may contribute to psychological distress as well (James et al., 2016). As such, minority stress and societal bias concerns are an important consideration when counseling TNB clients (Budge et al., 2020).

Bias and Gatekeeping

Alongside societal bias, historical bias and institutional bias are other important clinician consideration suggested by experts of TAP. In particular, to have knowledge about the intersection of psychology and trans identity through history, along with current barriers to care for these clients; for instance, competent clinicians maintain the knowledge that gender and sexual minorities throughout history were often pathologized and that gender nonconformity was labeled as "neurotic," "psychotic," and evidence of psychopathology (Drescher, 2015). With this knowledge, clinicians are expected to understand how this history may influence client reticence to engage in treatment.

Trans clients experience barriers at institutional and systemic levels influencing their engagement in healthcare; for example, nearly a quarter of the trans respondents from the 2015 USTS (N = 27,715; James et al., 2016) indicated avoiding general healthcare due to fear of being mistreated based on their gender identity. Of those who did seek care, one third reported negative experiences with the provider (e.g., having to educate the provider, verbal harassment, refusal to refer for services). Other barriers to treatment include unfriendly environments found throughout the healthcare system. McCann and Sharek (2016) described examples of overt discrimination in healthcare, including providers who refused to use client name and gender or who overemphasized trans identity despite unrelated presenting concerns. These barriers may influence general

healthcare; preliminary evidence has also suggested barriers have a similar influence upon trans clients' engagement in mental health care or psychotherapy (Seelman et al., 2017)

In recent survey data, 77% of transgender individuals said they wanted to seek therapy in the future (James et al., 2016), however, TNB clients have expressed obstacles to entering psychotherapy. Noted obstacles include affordability (Benson, 2013; Hunt 2014), fear of being judged or misunderstood (Hunt, 2014), and poor experiences with prior therapists (Elder, 2016). Gatekeeping may also prevent trans clients from entering therapy. Gatekeeping was defined as "focusing the psychotherapist's role on controlling access to gender-affirming medical resources" (Mizock & Lundquist, 2016, p. 152). Participants in Mizock and Lundquist's (2016) grounded theory investigation, for example, described gatekeeping as contributing to harmful and nonaffirmative psychotherapy. As a result of gatekeeping by therapists, participants described being reluctant to express the full range of their trans experiences or withheld information about their mental illness for fear of being pathologized or for fear the counselor would withhold the referral for medical intervention (Mizock & Lundquist, 2016).

In summary, the data about barriers to trans people seeking general healthcare suggest counselors need to be aware of TNB clients' barriers to seeking counseling and that what brings them to therapy may not be related to their gender. There is heterogeneity of presenting concerns and counselors should not assume trans individuals are attending therapy only to address their gender identity. As such, therapists should avoid either inflating or avoiding the role of gender in a client's presenting concerns (Mizock & Lundquist, 2016). Further, the barriers noted in the research such as

affordability, fear of being pathologized, or poor prior therapy experiences are potential areas of concern and suggest therapists must be aware of the history of transgender healthcare and gatekeeping.

Therapist Identities and Demographics

When trans clients consider the personal identity of a counselor they may want to see for therapy, some have specific preferences regarding characteristics of their counselor. There is evidence TNB clients select clinicians based on their affiliation with the LGBT community (Bess & Stabb, 2009; McCullough et al., 2017) and their gender identity (Hunt, 2014). Some evidence indicates racial and ethnic identity are also relevant to provider selection among trans clients of color (McCullough et al., 2017).

It is not uncommon for trans clients to seek out a provider who identifies as LGBT, with the expectation these providers would better understand the lived experience of queer and trans clients (Bess & Stabb, 2009). Using a qualitative approach, McCullough et al. (2017) found that all their trans client participants (n = 13) considered demographic identity characteristics (e.g., transgender identity, gender, race, ethnicity) as relevant to their selection criteria for a therapist. Regarding LGB identity specifically, McCullough et al. noted LGB therapists are sometimes seen as "cultural insiders," which means they may understand the lived experience of trans clients because they themselves are sexual minorities and better understand transgender issues as a result.

Similarly, study participants have identified preferences for clinicians based on the counselors' gender (Hunt, 2014). Bess and Stabb (2009) found specifically cisgender female therapists, irrespective of the trans client's gender identity (i.e., both transmasculine and transfeminine participants preferred cisgender female therapists) were

preferred. Preference for therapist identity appeared to be largely related McCullough's (2017) concept of "cultural insider" though in this case, the perception that women or queer therapists might understand the concerns of trans clients because they have experienced discrimination, similar sociocultural concerns, or the process of coming out (Bess & Stabb, 2009; Elder, 2016).

Beyond how knowledgeable a counselor is about trans concerns, trans clients—particularly trans clients of color—have reported considering the race and ethnicity of a counselor when selecting a provider. For instance, McCullough et al. (2017) reported one of the most important issues in selecting a counselor, indicating:

> Not as much the queer identity but having a person of color was really important for me. . . . And at the time when I was choosing the therapist, a lot of the issues that I wanted to discuss were like issues that affected a person of color. (p. 428)

One of the 16 principles outlined in the *Guidelines* included an emphasis on intersectionality in large part because for those individuals whose intersecting identities place them at the center of multiple marginalized identities (i.e., Black and TNB), their mental health outcomes appear worse than their White TNB peers (Mathy, 2002). In a qualitative study of resilience among trans people of color following a traumatic event, researchers found that participants emphasized the need to connect with other people of color, particularly activist communities that connected them to transaffirming resources (e.g., healthcare; Singh & McKleroy, 2011). Racial and ethnic identity factors then may be especially important to trans people of color who are seeking connection to other POC.

There appears to be good reason for seeking a therapist with a shared identity. For instance, findings from education, public health, and medicine have suggested client–

provider concordances in gender and race sometimes improve health outcomes for patients (Greenwood et al., 2018). However, there are no such similar data of client-provider concordances in TAP and research on trans clients' preferences for certain counselor identities has yielded mixed results. In fact, participants noted an important nuance, noting trust, empathy, and care mattered most in their perception of therapy, suggesting general psychotherapy skills and therapist attitudes may be just as influential in client positive perceptions of psychotherapy (McCullough, 2017). One participant in McCullough et al.'s (2017) study stated, "I thought it would be better to have an LGBT counselor, but getting deeper into my transition, a lot of gays and lesbians don't understand what it means to be trans in the community" (p. 428). However, if these "insiders" are not supportive of or fail to understand trans clients in some way, McCullough et al. noted participants seemed especially hurt because the providers were assumed to be knowledgeable about trans issues. In these instances, trans clients may prefer a knowledgeable and trans-informed cisgender and heterosexual counselor rather than an LGB-identified counselor (McCullough et al., 2017). Though a counselor's identity (e.g., gender, sexual orientation) may imply a shared lived experience with potential clients, these identities do not necessarily indicate that counselors are trans affirming or knowledgeable.

In summary, though trans participants in these studies endorsed some preferences for counselors regarding race, gender, and sexual orientation, no obvious consensus regarding such preferences emerged. To date, no researchers have directly assessed the affirmative characteristics of counselors and how they relate to or predict trans clients' preferences for a clinician. At least for some trans clients, the identity of the therapist was

less important than a therapist attitude, experiences, and skills which are discussed in the following section (McCullough et al., 2017).

Therapist Attitudes and Experiences

Historically, attitudes toward trans clients have been negative (Franzini & Casinelli, 1986; Green et al., 1966). Fortunately, these attitudes have improved significantly and clinicians increasingly display a comfortability and willingness to work with trans clients (Kanamori & Cornelius-White, 2017; Salpietro et al., 2019; Whitman & Han, 2016). Though attitudes have improved, it appears some individuals are less biased and more interested in working with TNB clients than others. In addition, it appears that clinicians are poorly trained for working with TNB and rarely asked to explore their biases toward trans clients in any of their graduate coursework (Whitman & Han, 2016).

For instance, cisgender women have self-reported lower gender identity bias (i.e., negative reactions to gender nonconformity) when compared to cisgender men (Nisley, 2011; Norton & Herek, 2013; Tee & Hegarty, 2006; Willoboughy et al., 2010). Additionally, in at least one survey of mental health clinicians, sexual minority individuals reported lower gender identity bias in comparison to heterosexual counselors (Kanamori & Corenlius-White, 2017).

In addition to these positive attitudes, there appears to be growing interest in working with trans clients among mental health practitioners. Whitman and Han (2016) found 93.7% of their sample (n = 53) of mental health providers were generally interested in providing service to trans client as measured by the sample's responses to vignettes of TNB clients. Interestingly, only 5.7% endorsed a high level of interest providing service to a genderqueer (i.e., nonbinary) client. These respondents cited fear of using incorrect

pronouns as one reason for their low-interest rating. It would appear the clinicians' self-presentational concerns (e.g., not using correct pronouns or making a mistake) seemed to partially influence reticence to work with nonbinary clients. Perhaps contributing to these self-presentational concerns are the clinicians' preparation to work with TNB clients. In this same study, of the entire sample, only 5.7% had received any TNB-specific training. Despite interest in providing services for trans clients, counselors are questionably prepared to do so given the lack of education. In addition, a small percentage of this sample endorsed transphobic responses to vignettes (Whitman & Han, 2016). As such, these findings highlighted the importance of integrating education about trans identity and particularly nonbinary identities for those in graduate preparation programs.

Overall, although it seems cisgender women and sexual minority individuals endorse fewer negative attitudes toward transgender clients, there appears to be some indication that fewer clinicians have interest in working with nonbinary clients (Whitman & Han, 2016). Clinicians' attitudes, competency, and emotional reactions appear to influence interest in working with trans clients and specifically nonbinary clients, which may influence negative therapy experiences for trans clients; research on negative therapy experiences and the counseling skills of the therapist follow.

Counseling Skills and the Therapy Relationship

Research on trans clients in therapy has yielded several characteristics or skills of counselors that contribute to helpful therapy. Evidence from studies of both TNB clients and therapists have suggested that (a) the therapy relationship and (b) approach of the counselor are important factors in an affirmative therapy experience. For instance, clients have reported favorable experiences with counselors who expressed respect (Rachlin,

2002), empathy, and care (Bess & Stabb, 2009). Clients have also described how they view validation, normalization, and celebration of gender identity exploration as positive therapist practices that signify safety to clients (Benson, 2013).

Counselors have described the importance of using person-centered skills to build a foundation of trust, safety, and connection. One counselor in Salpietro et al.'s (2019) qualitative, transcendental phenomenological study of cisgender counselors' experiences working with trans clients described how person-centered skills contributed to the therapy:

> Just coming in without preconceived notions and trying to really reflect back as closely as possible what someone is saying, what their feelings are, because I think the more people feel heard and understood as they are uniquely, the more they feel connected to the therapist. (p. 209)

From the counselors' perspectives, their use of person-centered skills allowed their clients to feel heard, and subsequently, more connected to the counselors (Salpietro et al., 2019). Whether examining client or counselor perspectives, these person-centered skills appeared important to establishing and improving the therapy relationship.

Alongside person-centered skills, qualitative research on both trans clients and counselors has suggested developing a strong therapy relationship is important (e.g., Elder, 2016; McCullough et al., 2017; Salpietro et al., 2019). From the perspective of clients, support and empathy from their counselor were indications of a strong therapy relationship (Bess & Stabb, 2009). Echoing similar findings, McCullough et al. (2017) found their TNB participant clients described a strong therapeutic alliance demonstrated by clinician empathy, trust, and collaboration. The cisgender counselors from Salpietro's et al. (2019) study indicated a strong therapeutic alliance is important for working with trans clients and suggested, in the presence of a strong therapeutic alliance, clients feel

increased safety, and this safety potentially contributes to clients' abilities to grow. Overall, these findings may in part be explained by what Castonguay et al. (2010) described in their content analysis of helpful therapy events as "alliance strengthening" (p. 332) wherein a client feels understood, supported, encouraged, reassured, more invested in the tasks of therapy, and closer to the therapist. Similarly, perhaps participants in the aforementioned qualitative studies experienced this alliance strengthening when their therapists used these general counseling skills.

Though the strength of the therapy alliance is important, it is not without complexity. For instance, Applegarth and Nutall's (2016) interpretive phenomenological analysis qualitative study, which sought to understand the lived experience of transgender people in talking therapies, described how the therapy relationship, whether supportive or negative, sometimes evokes ambivalent emotions. Applegarth and Nutall noted a theme titled "a fearful time" wherein clients wanted to engage in therapy, but their fear created a perceived barrier between themselves and the therapist. Their participants reported highest fear at the outset of therapy and noted this fear would reemerge occasionally due to either the therapist or the material discussed in session. One client described how the intimacy of the therapeutic encounter created feelings of exposure and vulnerability, and another client indicated they felt supported by their therapist; yet, they also felt annoyed they needed the affirmation (Applegarth & Nutall, 2016).

Research has consistently indicated clear and unambiguous verbal affirmation of gender diversity is a specific counseling intervention and an integral component of trans-affirming therapy (e.g., Benson, 2013; Morris et al., 2020). Using feminist phenomenology-informed interviews with self-identified transgender people, Benson

(2013) found clients experience affirmation and a sense of safety when counselors or agencies explicitly state they are trans or LGB affirmative. Participants noted affirmation includes explicit verbal validation or celebration of their gender identity (Benson, 2013). Clients also felt these affirmations or celebration of gender diversity were indications of sufficient counselor knowledge and readiness to work with trans clients (Benson, 2013). Similarly, adoption of affirming language (e.g., correct gender pronouns) used by the TNB community contributed to therapeutic alignment among McCullough et al.'s (2017) participants, defined as counselor "behaviors and traits that increased participants' feelings of connection and trust" (p. 428). In the presence of more alignment, participants felt increased interpersonal comfort and were more forthcoming about their concerns in the session. These verbal declarations then were perceived by clients as indicative of counselor knowledge and as influencing the trust they felt in session (Benson, 2013; Elder, 2016; McCullough et al., 2017).

To quantitatively test the influence of affirmation, Bettergarcia and Israel (2018) used an analogue research design with short video vignettes of counselors reacting to session disclosures of trans identity exploration. Bettergarcia and Israel separated their large sample of trans-identified individuals into three conditions (i.e., transition affirming, nonbinary affirming, or nonaffiming) to view videos of actors depicting a therapist and a client. The transition affirming and nonbinary affirming conditions considered affirming included counselors depicting openness to explore gender fluidity, openness to nonbinary identities, and awareness that not all trans clients will seek medical interventions (e.g., hormones, surgery). In contrast, the nonaffirming condition depicted counselors who described trans identity as a phase and suggested clients could

become more aligned with their birth-assigned sex if they attempted to identify with it more (i.e., reparative therapy interventions). Participants rated affirming therapists as more expert than those in the nonaffirming condition, and they rated the therapeutic alliance higher when counselors were more affirming than nonaffirming (Bettergarcia & Israel, 2018). These findings indicated affirming approaches may lead to perceptions of counselor expertise and positive therapeutic alliances. Further, affirming therapists were rated as more trustworthy and likeable.

Bettergarcia and Israel's (2018) study was the first to quantitively assess a trans-affirmative intervention and their study provided preliminary evidence about the relationship between affirmation and the therapeutic alliance. Further, Bettergarcia and Israel's study explored how affirmation and alliance may contribute to negative or positive experiences in therapy or impact the therapeutic relationship.

These collective findings suggested, in the presence of general person-centered counseling skills, validation, and explicit affirmation (Benson, 2013; Elder, 2016), clients feel safe; this sense of safety seems to influence the therapy relationship in positive ways. However, these primarily qualitative studies emerged largely from the perspective of trans clients, where only one study examined the perspective of counselors (Salpietro et al., 2019). Future research would benefit from exploring counselors' views of trans-affirming therapy, particularly the perspectives of highly skilled clinicians. These experts may be able to identify some of the challenges and nuance in conducting trans-affirming psychotherapy, as was evident in the studies described in the prior section on the therapy relationship. Further, because explicit affirmation appears to influence positive therapy

experiences for trans clients, an exploration of the specific methods counselors use to express their affirmation to clients would be beneficial.

Negative Therapy Experiences

The practice of trans-affirmative therapy seeks primarily to prevent harm to trans clients (e.g., Carroll & Gilroy, 2002; Korell & Lorah, 2007; Lev, 2004). However, what might constitute harmful therapy has not been explored extensively in the research, perhaps in part because clients ultimately terminate with counselors whom they consider unhelpful or harmful. Characteristics of unhelpful and potentially harmful therapy materialize in a few different ways. These experiences seem to fall on a spectrum from mild to more severe, though researchers have not fully described the impacts of these events or their severity. In some cases, the therapist acts in deliberate hostile and harmful ways (Elder, 2016; Morris et al., 2020; Rachlin, 2002), whereas in other instances, counselors engage in microaggressions or transnegative approaches to counseling (e.g., Elder, 2016; McCullough et al., 2017).

Microaggressions, which have been found to widely impact trans individuals in everyday life (Chang & Chung, 2015), also appear to follow trans clients into the therapy room (McCullough et al., 2017; Nadal et al., 2016). Microaggressions are defined as subtle forms of intentional or unintentional discrimination, which include derogatory messages communicated to individuals belonging to historically marginalized groups (Sue et al., 2007). Nadal et al.'s (2012) qualitative study found trans individuals experience covert and overt microaggressions in systemic, familial, and interpersonal domains. Trans participants (n = 9) described encountering microaggressions that conveyed a range of subtle forms of discrimination, from physical threat and denial of

societal transphobia to the assumption of trans identity as abnormal and pathological (Nadal et al., 2012).

Researchers have only begun to understand how microaggressions manifest in psychotherapy. These microaggressions sometimes manifest as invalidation of TNB identities, such as through avoidance of gender in therapy (McCullough et al., 2017; Mizock & Lundquist, 2016), misgendering (i.e., using the wrong pronouns; McCullough et al., 2017; Morris et al., 2020), or denying the existence of transgender identities (Morris et al., 2020). Therapist invalidation is also sometimes related to an insensitivity about intersectional identities wherein the therapist refuses to see the importance of holding multiple marginalized identities, such as a Black AFAB transman who now faces all the racism to which Black men are subjected (McCullough et al., 2017).

Most recently, Morris et al. (2020) found in their phenomenological investigation of transgender participants (n = 91) in therapy that therapists lacked competency to work with TNB clients and engaged in gatekeeping. Morris et al.'s participants described instances of being denied services, therapists enforcing outdated World Professional Association of Transgender Health standards, or therapists prematurely terminating therapy based on the client's gender identity. In a similar study, and the first of its kind, Mizock and Lundquist's (2016) findings highlighted a spectrum of experiences in therapy, from unhelpful to overtly harmful events. Not unlike those perspectives found by Morris et al. (2020), TNB clients in Mizock and Lundquist's study described gender inflation, or the tendency for the clinician to inflate the role of gender identity while overlooking other important aspects of the TNB client's life. As an example from the findings, one participant said, "If I'm going to somebody for anxiety, all they want to talk

about is how it must be because I'm trans, and how that must be the cause of all my problems, that's very frustrating" (Mizock & Lundquist, 2016, p. 151). Mizock and Lundquist noted this type of gender inflation can lead clients to feeling as though their therapy needs are not being met, and subsequently, believing the clinician is unhelpful for progress in therapy. Mizock and Lundquist (2016) also described "education burdening" (p. 150) wherein clients feel burdened by the need to educate their clinicians about working with TNB clients; further, these clinicians were perceived to have insufficient knowledge to proceed in providing psychotherapy to trans clients. Clients described how this burden of educating the clinician changes the nature of therapy because they are taken out of their role as clients to be educators (Mizock & Lundquist, 2016).

In general, concerns related to education burdening or misgendering result in potentially negative therapy experiences for TNB clients, however, overt forms of bias have also been documented in research. Examples of therapist overt bias include therapists who sought to conduct therapy as if gender is something to be fixed (Elder, 2016) or who pathologized gender with the belief that trans identity is pathological (Mizock & Lundquist, 2016). In some instances, it appears the therapist's actions reflected overt and intentional discrimination. Researchers have recorded instances of open hostility toward clients' gender identities (Bess & Stabb, 2009) and therapists who were "belittling, challenging, or judgmental" (Rachlin, 2002, p. 17). It also appears TNB clients are sometimes exposed to sexualization and exoticization; Morris et al.'s (2020) participants described clinicians asking about surgical and medical history, their genitalia, and sexual preferences, and even making sexual advances toward them.

In the case of overt and biased therapist behaviors, these instances are seemingly conscious, unethical therapist behaviors. For instance, according to the APA (2017) ethics code, therapists must practice within the boundaries of their practice. However, when engaging interventions such as conversion efforts, clinicians do so in violation of best practices outlined in the WPATH (2022) Standards of Care and are thereby engaging in unethical practice (Morris et al., 2020). In terms of microaggressions, and unlike these conscious unethical behaviors, it is not clear to what degree therapists are aware of them or how they are managed or discussed in therapy. Future research could address how often therapists' behaviors reflect conscious, intentional actions by the therapist.

In summary, existing research has identified a range of negative and unhelpful therapy experiences among trans clients (Bess & Stabb, 2009, Mizock & Lundquist, 2016; McCullough, 2017; Morris et al., 2020). These experiences fall on a spectrum microaggressions to overt bias and hostility. The research is unclear to what degree these experiences influence the continuation of therapy or exacerbations of TNB client mental health. However, evidence points to the potential for ethical violations resultant from discriminatory or overtly hostile therapist actions (Morris et al., 2020).

Limitations

The existing research has considerable limitations. The first of these limitations are methodological. The retrospective qualitative methodology used by most of these studies raises concerns about the effect of recall bias and social desirability, which may limit the accuracy of participants' memories of psychotherapy (Althubaiti, 2016). For instance, retrospective recall of Elder's (2016) older adult TNB participants implied they

may have been recounting therapy experiences from decades past, when therapists were more overtly biased (Green, 1966).

Further, when surveys are used, as was the case with Bettergarcia and Israel's (2018) study, the researchers used Amazon Mechanical Turk (MTurk), a human intelligence task generator that provides participants financial incentives to complete tasks, such as taking a survey. One criticism of MTurk is it is prone to self-selection bias (Hauser et al., 2019). In other words, MTurk respondents may be more likely to complete the tasks in which they have an interest, potentially biasing the sample. Ultimately, such response bias may affect the validity of findings (Hauser et al., 2019). Bettergarcia and Israel's sample may have included proportionally more individuals who had therapy (e.g., elected to participate because they had therapy).

Concerns of selection bias may explain why in Bettergarcia and Israel's (2018) sample, the percentage of trans clients who endorse therapy attendance was 20% higher than in the USTS survey. For instance, 80% (n = 325) of participants from Bettergarcia and Israel's (2018) sample had seen a therapist. In contrast, survey data from the 2015 USTS (n = 27,715) found 77% of transgender respondents reported wanting therapy, although only 58% of this subsample had received any therapy (James et al., 2016).

A related selection bias concern of many of samples were small with disproportionately White and educated sample of convenience. The USTS made meaningful efforts to capture a diverse and more representative sample of the trans population (e.g., outreach to LGB and trans organizations), although its survey distribution was online and thus a sample of convenience (James et al., 2016). Therefore, both the USTS and MTurk samples may have been more commonly accessed by

individuals who have greater access to technology resources (e.g., the internet) and who trust researchers, leaving the number of potential respondents with limited technological access and low socioeconomic privilege potentially absent from study samples.

Until recently, most samples have favored capturing data related to binary trans identity (e.g., transmen, transwomen) and have excluded nonbinary identities. The impact of a limited range of gender identities is that research has likely failed to measure the experiences of nonbinary clients and counselor attitudes toward these identities. This oversight reflects a potentially critical error in that nonbinary clients and trans people of color are often at greater risk for poor mental health outcomes than their binary trans peers and may face greater barriers to care (Matsuno & Budge, 2017; Whitman & Han, 2016).

Future Directions

In its current state, TAP has not been precisely defined; this lack of an operational definition has limited researchers' abilities to conduct randomized controlled trials and other outcome studies and left clinicians with little understanding about how TAP is implemented in practice. One method to formulate critical tenets important to TAP is to gather perspectives from expert clinicians on what constitutes TAP. Even as the theoretical and empirical body of knowledge on TAP incrementally grows, clinicians who engage in psychotherapy with trans clients are considered by their peers and the trans community to be experts in their fields. These expert clinicians have hard-earned insights about how to arrive at successful therapy outcomes with trans clients, though they have been practicing in the absence of professional consensus.

Expert insight would be particularly useful due to the multiple roles (e.g., advocate, psychotherapist) of trans-affirmative therapists. Additionally, understanding expert delivery of TAP may help to further refine the definition of TAP through their informed perspective. Just as the existing body of knowledge can be seen through the lens of therapist knowledge, awareness, and skills, areas for future research fall in the same domains.

Hearing directly from expert clinicians will provide necessary data to arrive at consensus about what constitutes TAP. Trans affirmation has begun to be operationalized in the framework of necessary knowledge, awareness, and skills; data from expert clinicians are necessary to move this framework from the general and theoretical to the specific and solidly defined. This specificity is a necessary precursor to future research. Furthermore, expert insight provides a lens for understanding how to assess the quality of current graduate training on TAP and what, if any, improvements are needed. The insights of expert clinicians will help complete a necessary foundational layer of trans-affirmative theory, without which future empirical research will lack focus.

Chapter Summary

The preceding research review was based on scant number of peer-reviewed studies—a combination of quantitative, qualitative, and mixed methods. Research to date has provided clinicians and researchers with information about the following domains: (a) client reasons for attending therapy (Bettergarcia & Israel, 2018; Rachlin, 2002), (b) therapist identity and demographics (Bess & Stabb, 2009; Elder, 2016; Hunt, 2014, McCullough, 2017), (c) barriers to treatment and gatekeeping (Mizock & Lundquist, 2016), (d) therapist attitudes and experience (Kanamori & Cornelius-White, 2017;

Salpietro et al., 2019; Whitman & Han, 2016), (e) counseling skills and the therapy relationship (Applegarth & Nutall, 2016; Benson, 2013), and (f) negative therapy experiences (Bess & Stabb, 2009, McCullough et al., 2017; Morris et al., 2020; Mizock & Lundquist, 2016).

This existing body of research has several significant limitations. Many studies used samples of convenience when selecting participants. Several subpopulations were underrepresented in these studies, including racial and ethnic minorities, individuals with limited formal education, individuals without access to the internet, and individuals with nonbinary transgender identities (James et al., 2016). Given the homogeneity of the samples, the results are not necessarily representative of the wider TNB population. Furthermore, over half of studies were qualitative in nature and involved small sample sizes, which limits generalizability to the general population. Of the quantitative studies, the sample sizes were also small, limiting generalizability. Most existing studies gathered qualitative data from TNB clients only; therapist responses were not collected (Morris et al., 2020).

Given that psychotherapy researchers are still working to comprehensively define the components of TNB affirmative therapy, it is necessary to gather data from therapists to determine if the *Guidelines* and conceptual literature reflect what is happening in-session with clients. Of the few studies that did solicit responses from therapists (Salpietro et al., 2019), the therapists self-reported their attitudes, providing data that were vulnerable to distortion to appear in socially desirable ways. This nascent body of research into affirmative therapy with TNB clients provides a helpful launching point for future research. To operationally define TNB affirmative therapy and evaluate the

effectiveness of said therapy, future research is needed on therapists' knowledge, awareness, and skills.

CHAPTER III: METHOD

Given the limited research on trans-affirmative psychotherapy (TAP), a qualitative method was selected for this study, specifically consensual qualitative research (CQR; Hill, 2012), to understand what defines the components of TAP and how it is implemented in clinical practice. To study these areas, the intended population for this study was exemplar trans-affirmative psychotherapists. This selection method was adapted from developmental research (e.g., Bronk, 2012), wherein a sample is selected intentionally to consist of individuals who exemplify the construct or experiences of interest in a highly developed manner. Existing literature has supported an emerging emphasis on the importance of expertise among trans-affirmative therapists; as such, using the exemplar method may help further define the components of TAP. The following sections describe the study's participants, research team, and data collection procedures, and conclude with the procedures for data analysis.

Participants

The dissertation researcher established a panel of experts to nominate exemplar clinician participants, first by reviewing relevant literature and then identifying experts. Experts were classified as individuals who had published in professional journals, presented on counseling trans clients, or were definitive sources of trans-affirmative care in their communities (e.g., LGBT community centers). The dissertation researcher first established an initial list of 48 experts and asked them to nominate exemplar clinicians, defined as individuals the experts believed were highly skilled at trans-affirmative counseling and whom they would recommend to a trans individual seeking counseling

services. If these experts were themselves clinicians, they were allowed to self-nominate and be eligible for participation in the study. Of the initial expert contacts, two replied declining to provide nominations, 39 did not respond, and seven replied providing nominations. Of the seven who responded, two were from LGBT community centers and the remaining five were individuals who had published widely related to TAP. The dissertation researcher received a total of 49 nominated possible participants from a snowball sampling method wherein nominated exemplar clinicians could also nominate other exemplars.

Ultimately, 12 participants were recruited for this study, and each participant was a counselor or psychologist (a) whose postlicensure practice included work with at least 20 transgender and nonbinary (TNB) clients; (b) who was licensed; and (c) who graduated from an American Psychological Association (APA)-accredited clinical psychology graduate program, an APA-accredited counseling psychology graduate program, or a Council for Accreditation of Counseling and Related Educational Programs (CACREP)-accredited counseling program, a Council on Social Work Education (CWSE)-accredited social work program, or a Commission on Accreditation of Marriage and Family Therapy Education (COAMFTE)-accredited marriage and family therapy program. All participants identified as White, nine self-identified as trans or nonbinary, and three participants indicated they were cisgender women. Participants ranged in age from 29–45 (M = 34.3*; SD* = 4.98). Of the participants, four were from clinical or counseling psychology graduate programs, four from marriage and family therapy programs, two from social work master's programs, and two from marriage and family therapy master's programs.

Research Team

The research team consisted of three White graduate students of counseling psychology, including me as the dissertation researcher. The dissertation researcher is nonbinary and queer, and the other two researchers are cisgender women, one lesbian and one heterosexual. All graduate student researchers had previously been a contributing member of three CQR research studies. The dissertation researcher conducted all participant interviews and oversaw the domaining and writing of core ideas. Transcription was completed by an external transcriber. As is typical of CQR (Hill & Knox, 2021), the study included the use of an auditor. The auditor had published several CQR studies and methods chapters on conducting CQR research and was a White, European American, cisgender man.

To help train the team in CQR data analysis procedures, the dissertation researcher first encouraged team members to review *Consensual Qualitative Research: A Practical Resource for Investigating Social Science Phenomena* (Hill, 2012; Hill et al., 2012) and *Essentials of Consensual Qualitative Research* (Hill & Knox, 2021) for guidance on each step of the CQR process. Next, the team reviewed the study's interview protocol and discussed the questions. Then, using an example interview transcript, the dissertation researcher prepared the team members for each step of data analysis. There are three central steps in CQR data analysis: domains (i.e., topics used to cluster data), core ideas (i.e., summaries of the data in fewer words and with greater clarity), and cross analysis (i.e., developing categories that describe the common themes from the core ideas with domains across cases; Hill & Knox, 2021). At the outset of each stage, the team reviewed the goals and outcomes of that stage; for instance, before an independent review

of the cases, the team worked on creating a few domains together using a sample transcript. Similarly, during the core ideas stage, the team practiced creating clear summaries of the data together before moving on to an independent review. Finally, during the cross-analysis phase, the team practiced writing category titles, placing core ideas into created categories, and coming to consensus on these categories.

As is standard practice in qualitative research, and CQR specifically, the research team met to discuss their biases prior to beginning data analysis (Hill & Knox, 2021). The dissertation researcher provided prompts to the team and asked each member to reflect on their own gender, their biases and assumptions about TNB individuals, and their own understanding of TAP. Further, team members were asked to reflect on their own training and clinical experiences and their readiness to work with trans clients. Team members were encouraged to consider their biases and expectations and to learn about themselves throughout the research process, and to bracket these biases during data analysis.

Team members had varying levels of experience working with TNB clients in either psychotherapeutic or assessment capacities during their counseling psychology training. The dissertation researcher has worked counseling transgender Veterans and college students, and these experiences are central to their interest in this research. One researcher worked in an assessment capacity for a youth gender health clinic working with TNB youth and their families, while the other researcher worked within the prison system to determine competency for gender affirming care for trans prisoners. In light of our varied experiences, we all expressed enthusiasm about the topic, in particular what knowledge could be generated to better support TNB clients to obtain affirmative care.

As a psychologist-in-training, one experience related to affirmative care has been central to the dissertation researcher's motivation to do this research. During graduate school, the dissertation researcher had gender-affirming surgery. To obtain letters of support for this surgery, the dissertation researcher worked with their current psychotherapist and another outside therapist to receive letters to access gender-affirming surgery. Though they ultimately got the letters required for surgery, the dissertation faced some of the challenges commonly described by trans research participants. For instance, the dissertation researcher had to educate my psychotherapist on transgender issues and pay to meet with another provider to obtain these two letters.

Although the experience was overall positive, it undoubtedly shaped how the dissertation researcher thought of their role as a researcher and psychotherapist providing trans-affirming care to current and future clients. Relevant to this study, the dissertation researcher's personal experience helped shape the questions asked in the protocol, and all researchers agreed that we had expectations for the responses of the exemplary trans-affirmative therapists. One such expectation was many participants would be queer or trans themselves and their gender identities and sexual orientations (SOs) would be motivators for their becoming trans-affirming clinicians. We all agreed that we were excited to learn from the research participants, deepen our knowledge about a topic with minimal research, and stay open to further self-reflection about how our experiences may influence our response to the participant data.

Measures

Two primary measures were used in this study to gather information from participants: a demographic form and an interview protocol. Gathered through Qualtrics

survey software, participants completed the demographic form, which included their contact information and availability for an interview. In addition, prior to the interview, participants were given a copy of the interview protocol. An explanation of each measure follows.

Demographic Form

Participant demographic data were gathered and completed using Qualtrics survey software. Open-ended questions were used to gather information about participants' gender and various social identities (i.e., race, ethnicity, sexual/affectional orientation), age, degree, theoretical orientation, and clinical training experiences (see Appendix A). To understand training for addressing TAP both through formal clinical training and supervision participants were provided a Likert-type scale to rate features of their clinical training experiences. Additionally, participants were asked to provide availability for interviews and an email address to receive results upon completion of study.

Interview Protocol

The interview protocol was developed for this study (see Appendix B). The introductory question was designed to broadly explore why participants became trans-affirmative therapists. Additionally, the protocol explored participants' experiences with clinical training and theory related to trans clients. Next, participants were queried about a specific clinical case regarding their work with a trans client. These questions addressed the course of psychotherapy with each participant's client, including specific considerations for intake, working alliance, termination, and any barriers and facilitators encountered in therapy. Next, participants were asked to reflect on how being a trans-

affirmative therapist had affected them personally and what advice they may have for trainee clinicians. Closing questions gave participants an opportunity to reflect on the interview process and reasons for choosing to participate in this study.

Procedures for Collecting Data

The process for collecting data from study participants began with vetting the interview protocol through two pilot interviews. Once the protocol was finalized, study participants were recruited. Those who met criteria were contacted to schedule their interview. Specific details of these processes are outlined in the following sections.

Piloting the Protocol

Prior to data collection, the dissertation researcher conducted pilot interviews with two clinicians. Though efforts were made to identify clinicians with experience working with trans clients, pilot interview participants were not exemplar clinicians so as not to eliminate possible participants. A limited number of clinicians who met this study's participant criteria were available to participate; therefore, the pilot protocol was used for participants who were not fully eligible, maintaining eligible participants' abilities to participate in the full study. These pilot interviews were used to obtain feedback about the protocol, including the clarity and flow of questions. Feedback from these pilot interviews were used to clarify questions as needed. Additionally, the pilot interviews gave the dissertation researcher an opportunity to gain confidence in use of the protocol and navigation of the interview process.

Consent Form

The consent form began by briefly describing the topic of the study and the process of interviews (see Appendix C). Next, a central component of the consent form

involved a description of the risks and benefits of participation, confidentiality, and the process for maintaining and managing confidential information. Participants were also provided the contact information for the dissertation advisor, in case they had any concerns resulting from the study.

Recruiting Participants

The dissertation researcher developed a list of nominators based on their reputation as scholars on trans psychotherapy or knowledge of clinical practice of trans-affirmative therapy. These individuals were identified using relevant research as those who (a) published widely on TAP, or (b) were identified as individuals who worked with TNB individuals extensively in community settings and had extensive knowledge about trans-affirmative community resources (e.g., college counseling centers, LGBTQ resources centers). The selected nominators were provided a recruitment letter (see Appendix D) with a definition of trans-affirmative therapy based on supporting literature and were asked to nominate clinicians who exemplified such work for participation in this study. Nominators were asked to provide contact information for the identified exemplar clinicians. Using this nomination strategy, nominated participants were given an opportunity to participate, as well as nominate other suitable participants through a snowball sampling method.

Contacting Participants

Potential participants, as identified by the nomination panel, were sent a participant recruitment letter via email (see Appendix E). This letter provided information about the study, including a description of the nomination process, eligibility criteria, and a link to the Qualtrics platform. In Qualtrics, participants found the following: (a)

description of the study and eligibility criteria, (b) consent form (see Appendix C), (c) demographic form (i.e., questions regarding participant training, accreditation, race, ethnicity; see Appendix A), (d) an option to nominate other potential participants, and (e) a compensation designation form (see Appendix F). Once the consent and demographic forms were completed, the researcher contacted participants to schedule an interview.

Interviews and Transcription

The primary dissertation researcher completed all interviews with participants. Each interview consisted of the following: a review of the informed consent and confidentiality, an opportunity for participants to ask questions about the process, and an interview using the questions outlined in the protocol (see Appendix C). Although the protocol was developed to be standardized for each interview, probes were used to clarify responses or to help participants elaborate their answers.

Interviews were digitally audio recorded, and then transcribed verbatim by an external transcriber. The transcribers filtered the use of minimal encouragers (e.g., um, ah), along with information pertaining to confidential material (e.g., locations, names) and excluded filtered information from transcripts. To protect confidentiality, each participant was assigned a code number in lieu of their name.

Procedures for Analyzing Data

Data analysis was completed following the CQR methodology outlined by Hill (2012), Hill and Knox (2021), and Hill et al. (1997, 2005). The process followed steps to (a) domain the data and write core ideas for each case, (b) complete cross analysis of the data across cases, and (c) have the data audited. An integral part of the data analysis

process is gathering consensus from the team at all points of the process and following an audit. The following sections outline the data analysis used in this study in greater detail.

This study closely followed the method described by Hill (2012) and Hill et al. (1997, 2005). CQR is an approach to qualitative research that places a particular emphasis on consensus among research team members in the analysis of the collected data. Though only one of several integral components, the consensus process is a primary feature of this research method. For instance, though CQR was derived in part from other qualitative methods (e.g., grounded theory), CQR places an emphasis on multiple judges to address the concerns that other qualitative methodologies tend to rely on a single judge in the analysis of data. CQR acknowledges the complexity in any data set and uses the consensus process among research team members to best capture the essence of the data. This process is seen as a triangulation of data, where consensus and multiple perspectives enhance the trustworthiness of the data.

As outlined in Hill (2012) and Hill et al. (1997, 2005), other key components of CQR include the following: (a) CQR is inductive rather than deductive, allowing results to emerge from data without imposing theoretical constructs on the data; (b) CQR uses open-ended questions to stimulate participants' reflection and to elicit rich responses; (c) words (e.g., stories, narrative) are used rather than numbers; (d) the context of the entire case is included to understand each element (e) a small number of cases are studied in depth; (f) there is an emphasis on ethics, trustworthiness, and the role of culture; and finally (g) the method requires researchers to repeatedly return to raw data to verify the researchers' conclusions.

In the data analysis phase of CQR, collected data were analyzed using three steps: development of domains, development of core ideas, and cross analysis. In this study, the dissertation researcher completed all domaining, core ideas, and cross analysis. However, after completing each stage of analysis, the other team members reviewed the results, and the team as a whole came to consensus about how to represent the participant data. During the first stage of domaining, the dissertation researcher read the raw data to develop domains or topic areas. These domains were developed by a close review of the transcripts to determine what topic areas naturally arose from the interview data. After data were assigned to the domains, core ideas were developed for the data under each domain. Core ideas involved summaries of the data that captured participants' statements succinctly. Finally, in the cross analysis, categories (i.e., common themes) were developed from the core ideas by analyzing across cases to develop themes that emerged across participants. As noted, consensus plays an important role in CQR; at each stage in data analysis (i.e., domaining, coring, cross analysis), team members review data independently before coming together to discuss and arrive at a consensus about the best representation of the data. Any disagreements among team members are discussed until the team can reach consensus on their understanding of the data. After the team has come to consensus on all aspects in data analysis, the external auditor is the final check for consensus.

Throughout the CQR project, an auditor reviewed the primary research team's data analysis to ensure the quality of the developed domains, core ideas, and cross analysis. The auditor's role helped to affirm, expand, and challenge the research team's analysis. During each the stage of data analysis, the auditor ensured raw data were in the

correct domain; interview data were accurately captured in the core ideas; and finally, the cross analysis captured the themes occurring across participants. This detailed feedback from the auditor ultimately enhanced the trustworthiness and overall quality of the results.

Once categories from the cross-analysis were identified and audited, the dissertation researcher examined categories within the domains to count the number of cases represented. According to Hill and Knox (2021), the following terms describe categories: (a) if a category applies to all or all but one case, it is considered *general*; (b) if a category applies to more than half the cases up to the cut-off for general, it is considered *typical*; and (c) if a category applies to two or three and up to half the cases, it is considered *variant.* Applying the frequencies to this study with 12 cases, *general* described categories with 11–12 cases; *typical* described categories with 7–10 cases; and *variant* described categories with 2–6 cases. The dissertation researcher then compiled the categories and frequencies into a table to represent the findings of this study.

Conclusion

Given the absence of research related to TAP and TAP's implementation in clinical practice, a qualitative methodology was chosen for this study. Specifically, CQR was selected to capture the perceptions and experiences of exemplary therapists working with TNB clients. These participant clinicians were recruited through a two-step process, first being identified as an exemplar by an expert panel and then contacted to participate as an exemplar. Participants who met the study criteria met with me for an interview via Microsoft Teams. Chapters 4 and 5 present the findings, relate the results to prior research, and discuss limitations and current areas for future research.

CHAPTER IV: RESULTS

The results of this study are presented in the following three sections of this chapter. Results in this first section are participant context and preparation for providing trans-affirmative psychotherapy (TAP). Findings in this section reflect the personal and professional experiences that influenced therapists to work with trans and nonbinary (TNB) clients and the theories these therapists used to guide their work. The second section contains findings specific to providing TAP and working with TNB clients. Results in this section include aspects of TAP from intake to termination and challenges, barriers, and facilitators to delivering TAP. The final section provides participants' reflections on their experiences as TAP therapists and advice for future clinicians. As described earlier, categories are labeled with the following frequency descriptors based on a total of 12 cases: general or generally (i.e., 11–12 cases), typical or typically (i.e., 7–10 cases), and variant or variantly (i.e., 2–6 cases). Frequency descriptors, rather than the number of cases, are included with the results. Themes emerging in only one case were moved to an "other" category and are not described in this chapter.

Participant Context and Preparation for Providing TAP

Interview questions fell into three sections: Context and Preparation for Providing TAP, Providing TAP, and TAP's Effect on the Participant and Participant Advice for Future TAP Therapists. Interview questions in the first section of the interview asked participants three questions, resulting in four domains (see Table 1). These warm-up questions helped to understand participants' backgrounds and motivations for working with TNB clients and were meant to probe participants about their decisions to commit

some of their professional practices to working with TNB clients. Further, these questions were developed to understand what training, experiences, or theories contributed to participants' trans-affirmative practices. These questions served as foundation for the questions in the following section, Providing TAP. The findings from these initial questions are presented in Table 1.

Table 1

Domains, Categories, and Frequencies of Context and Preparation for Providing TAP

Domain	Category	Frequency*
Motivation to work with TNB clients	Wanted to give back to the LGBTQ+ community	Typical (8)
	Recognized need for services to TNB community	Typical (7)
Training, learning, and experiences that prepared P for Practicing TAP	Attended formal training	Typical (9)
	Worked in a professional setting with TNB clients	Typical (8)
	Received supervision or mentorship for working with TNB clients	Variant (6)
	Reviewed current literature	Variant (6)
	Academic preparation focused on trans community	Variant (4)
Personal or nonprofessional experiences that prepared P for practicing TAP	Lived experience as LGBTQ+	Typical (9)
	Experience as a client	Variant (3)
Theoretical influences on trans-affirmative practice	Integrated psychotherapy theory	General (11)
	Integrated disability theory	Variant (2)
	Integrated gender theory	Variant (2)

Note. * 12 total cases. General = 11–12, Typical = 7–10, Variant = 2–6

Motivation to Work With TNB Clients

Two categories emerged from the first domain about participants' motivations to work with TNB clients. Typically, participants described how their own experiences being queer and trans motivated them to become therapists who provide TAP and give

back to their community. Participants described wanting to provide the services that did not exist while they were growing up. One participant stated:

> I want to do the thing that didn't exist for me. Because when I was coming out, like in college, the queer support group, student group, that we ran, like it was still the kind where you had to call the office hour to get the code to find out where the meeting was meeting for that night.

Other participants described how important it was to provide services to trans clients because they themselves were trans. One participant described the importance of a "for us, by us" approach and spoke to the power of trans clients working with trans clinicians, noting:

> That's why I'm so connected to this [TAP]. So, you know, the short answer is to say, I'm trans, I wanted to work with trans people. But I think the longer answer is working with trans people helped me find myself. And having gone through the experiences that I did of not having language, and not having connection, and not having support in the community, and not knowing how to access it, I wanted to give people what I didn't have, you know?

Relatedly, in a second category, participants typically acknowledged there has long been a dearth of trans-affirmative services for TNB people and participants recognized a need for services to the TNB community. Participants described their awareness of nonaffirmative psychotherapy, of gatekeeping, and of clients facing barriers to care, all which inspired their decision to become trans-affirming clinicians and provide services to this community. Further, participants described wanting to work with minoritized clients who had histories of being pathologized with, as one participant described, "unnuanced diagnoses" like gender dysphoria. One participant described intentionally paying attention to those who might "fall through the cracks" and wanting to provide services to everyone in the community. Another participant described their motivation, stating:

> Because it's part of the community that I am a part of, because I have loved ones who are trans and gender nonconforming, because I've seen how damaging uninformed therapy services can be for trans and gender nonconforming people, it just feels really important that if I have the knowledge and I have the experience, to make sure that I'm utilizing it.

Training, Learning, and Experiences Preparing Participants for Practicing TAP

When asked to describe what training or experiences prepared participants to work affirmatively with TNB clients, two domains emerged: one related to professional experiences and another related to personal experiences. The first domain involved professional experiences and yielded five typical or variant categories.

Typically, participants described that attending formal trainings contributed to their preparation for practicing TAP. Participants described seeking out trainings each year to supplement their continuing education and bolster their work with trans clients. Participants found useful trainings related to letter writing letters for access to gender affirming medical and surgical treatments and working with trans individuals. Participants described feeling most "empowered" in trainings led by trans clinicians:

> I definitely at that time was also going to different trainings and just wanting to hear about, like, what are other people in the field doing? You know, what's really being advocated for? And you know, how - because several of my clients needed surgery letters at that time. So, I was like, well, how do I want to do that? How do I want to set it up? How do I, you know, figure out the formula that works for me, and also, like, the way that I would like my own letters to look so that they show up in a way that I feel good about […] And it's great […] all their trainings I like because they're by trans folks, you know, for health care workers to say, like, here's the stuff that you actually need to know if you're going to do this work

The second typical category described the importance of working in a professional setting with TNB clients before, during, and after training. Some participants indicated they had worked with trans individuals prior to graduate training in work settings, whereas others described having LGBTQ+ focused training placements. Within

these queer- and trans-focused agencies, participants received practical and didactic training alongside working with TNB clients. Participants noted the significance of their clinical experiences over those of formal trainings, describing important experiences such as cofacilitating groups and working with trans supervisors, clients, and trainers. As an example, one participant noted:

> And so, the space that I work in now, called [*group practice]*, is pretty well known in [*city]* or well established in [*city]* for working with queer folks, along with other populations. And they had a fellowship program, like a year-long fellowship program. And so, I applied, got into that program right after grad school knowing that I really wanted to receive that training, and another wonderful trans, trans identified therapist, a person who mainly works with trans folks, they kind of took me under their wing and were like, I have been facilitating a group for trans folks for years, I would like you to be a cofacilitator with me.

Of the variant categories, the first was related to supervision or mentorship specifically related to working with TNB clients. Participants described the value of being trained by colleagues who were trans themselves and were well known in their community for affirmative work with TNB clients. One participant noted:

> I would say my boss has also been a huge influence on how I understand and think about and approach working with trans and gender non-conforming clients . . . because I think it has been—it was helpful to learn from someone who had been through the process themselves.

Participants described supervision and mentorship taking place in a variety of settings. These activities included monthly didactic seminars, session material reviews, and individual and group supervision during which TAP was discussed at length.

As a second variant category, participants described reviewing current literature and engaging in personal learning. Participants discussed the importance of doing their own reading and consuming research to compile resources. One participant noted the

importance of continuing to conduct and review research because of the evolving nature of trans language and terminology.

The final variant category described academic preparation for working with TNB clients including diversity-related coursework in graduate school. During graduate training, two participants indicated they focused their writing projects on the trans community, and for one in particular, therapy with trans clients. Other participants indicated they had training in undergraduate gender and women's studies courses, which were foundational for understanding gender and gender theory.

Personal or Nonprofessional Experiences Preparing Participants for Practicing TAP

This domain captures personal or nonprofessional experiences and resulted in two categories: a typical category and a variant category. Typically, participants emphasized how their experiences as members of the LGBTQ+ community influenced their decisions to work with TNB clients. Participants described their connection to the queer and trans community wherein they "feel at home" with these clients. Further, participants described seeking community with trans people and stated trans people were "centered" in their lives through their personal and professional relationships. As an example, one participant noted:

> Many of my close people are trans, my partner is trans, my mentor [name of mentor] is trans. I think I just really spend a lot of time surrounding myself with other trans people and seeking out, you know, new information and new ways to support people and conceptualize what it's like to be a trans person in this time that we're all alive in right now.

Lastly, the variant category related to participants' experiences as clients in their own therapy journeys. These experiences ranged from "terrible" to more affirming therapy. One participant noted their personal affirming therapy experience and stated:

> And having gender-affirming therapy was immensely healing to me, possibly saved my life . . . I think the fact that she didn't write me off, that she accepted—just fully accepted my experience. And kind of talked through my options and let me know that, like, any gendered way of being that I ended up in was going to be okay. Having that support was really powerful. Life changing, and in a really positive way. And yeah, so I think that that relief at being allowed to explore that, you know, not coming up against the gatekeeping that I think is so present in so many institutions in the medical and mental health fields, around work with trans people, that I know so many people have faced. I was really, really lucky not to run into that and it made me—I think that sort of planted the seed for, like, you know, later on, when I was like, maybe I want to do this kind of work, I really don't want to be a gatekeeper. I want to be a facilitator.

Theoretical Influences on Trans-Affirmative Practice

When asked to describe how theory informed participants' trans-affirmative work with TNB clients, three categories emerged. In the first category, participants articulated a diverse representation of psychotherapy theory affecting their TAP, ranging from cognitive behavioral therapy to relational theories. Several participants identified taking a systemic approach to contextualize the contemporary and historical issues trans people face (e.g., antitransgender legislation) and relationships (e.g., family) influencing the lives of TNB clients. As an example, one participant described:

> A lot of the ways that I see theory showing up for me as a systems person is instead of looking at this person as an individual, like whether other people are in the room or not, we're all part of the systems that we're in and so, really looking at who are the people in your life? Who are the relationships you're in? And what are those systems? And how do they get bigger? And looking, you know, really at the larger systemic factors that show up in society and how do those create disparities or not? I think that's a big piece of the work that I do with my trans clients because a lot of what we're looking at is, you know, what are the barriers that show up that keep you from being able to live the life that you want?

Alongside the systemic approach, several participants indicated using a narrative approach. Participants described narrative therapy as an explicitly anti-oppressive theory that encourages clients to "externalize" the problem as transphobia, which, as one participant stated, is "as opposed to saying, like, you know, your gender is the problem."

Other participants described relational theories that share an emphasis on the genuine and authentic relationship that develops between client and therapist. One participant emphasized a healing relationship in therapy is one in which a client is fully accepted by the therapist and the client "heals" by "being seen and witnessed."

The remaining two categories included (a) integrated disability justice, and (b) integrated gender theory. Participants described how these theories informed their practice through overlapping concerns of transgender individuals and people with disabilities, including that trans individuals are sometimes themselves survivors of trauma and have chronic illnesses or disabilities. One participant noted the overlap between the experiences of chronic illness and trans identity:

> And then from a chronic illness and trans standpoint, like somatic experiential, like how does it feel to be in our body? And where can we resource from our bodies when maybe not all of our bodies feel safe, or parts of our body might feel safe.

Providing TAP

The second section of the interview asked participants to discuss a specific case and respond to questions about psychotherapy with a TNB client. The specific case portion of the interview consisted of eight questions to understand participants' experiences providing TAP to a specific TNB client. Participants were asked to discuss the following: (a) the intake process, (b) participants' approaches to the beginning of therapy, (c) development of a working alliance, (d) termination, (e) the influence of culture on TAP, (f) challenges and barriers encountered while providing TAP, (g) what aspects of their agency or clinical setting facilitated or supported the provision of TAP,

and (h) how therapy with this client was similar to and different from work with cisgender clients. The findings from the case-specific questions are presented in Table 2.

Table 2

Domains, Categories, and Frequencies of Providing TAP

Domain	Category	Frequency*
Intake process	Integrated TAP components during intake interviewing	General (12)
	Openly discussed name and pronouns	Typical (9)
	Self-disclosed own identity	Variant (4)
	Created an affirming environment	General (12)
	Used affirming paperwork	Typical (9)
	Provided affirming spaces	Variant (4)
	Addressed gender during intake	Typical (10)
Beginning of PT and developing a working alliance	Explored gender	General (12)
	Actively helped client explore their gender	General (12)
	Explained to clients that therapist is unable to determine if client is trans	Variant (3)
	Focused on building the therapeutic relationship	General (12)
	Encouraged client agency in discussing presenting concern	Typical (8)
	Used self-disclosure	Variant (5)
	Provided psychoeducation about trans-affirmative healthcare	Variant (4)
Termination	Assisted with post-therapy needs	General (12)
	Referred clients to TAP providers	Variant (5)
	Evaluated client's support and resources	Variant (6)
	Discussed potential for future therapy	Variant (4)
	Tapered toward termination	Typical (9)
Cultural considerations	Explored intersecting identities	Typical (10)
	Sought to be aware of cultural difference	Variant (2)
	Explored client's family culture	Variant (2)
Challenges and barriers encountered while providing TAP	Accessing trans-affirmative healthcare	Typical (7)
	Client Experienced societal bias	Variant (4)
	Client's personal relationships were non-accepting of client's trans identity	Variant (4)
	Made errors as a therapist	Variant (2)
	Client financing trans-affirmative healthcare	Variant (2)
Aspects of agency or setting that support P in providing TAP	Affirming trans professional community	Typical (9)
	Agency communications with clients were trans-affirmative	Typical (7)
	Practices in LGBTQ+ setting	Variant (3)

Domain	Category	Frequency*
Comparison between TAP and working with cis-clients	Used the same therapeutic approach for all clients	Typical (7)
	Addressed discrimination with TNB clients	Variant (5)
	Intentionally explored gender with TNB clients	Variant (6)

Note. PT = Psychotherapy. * 12 total cases. General = 11–12, Typical = 7–10, Variant = 2–6

Intake Process

When asked to describe the intake process, participants' responses yielded three categories the participant integrated TAP components during intake interviewing, created an affirming environment, and addressed gender during intake (see Table 2). Generally, participants discussed specific TAP components incorporated into intake interviewing. Among the specific aspects of TAP incorporated into the intake process, two subcategories emerged, one typical and one variant. Typically, participants described the open discussion of names and pronouns during the intake process. Participants noted if legal names were needed for insurance purposes, they would explicitly tell the client why this name was needed. Participants described the limitations of intake paperwork in capturing client identity, and noted they explicitly discuss what names and pronouns the client uses in their intake. Other participants described using gender-neutral language for important others in the client's life until the gender of those others becomes known, and thereafter, participants noted they try to use correct name and pronouns for those individuals. For instance, one participant described:

> You know, just respecting different pronouns. The intake I'm thinking of, they had an ex who was also non-binary, so making sure that I'm respecting pronouns of people in their universe as well. And not ever making assumptions about gender based on what people are talking about or what their names might be […].

The variant subcategory related to TAP components of intake interviewing included participants' self-disclosure of their own identities. Such disclosures incorporated aspects of participants' identities, including their trans identity and their

pronouns, among other salient identities—thereby encouraging clients to ask questions about the therapist. One participant described their nuanced considerations for when to disclose, explaining:

> When I work with trans clients, sometimes in the intake interview, I disclose my identity and sometimes I don't. . . . I don't want my identity, if you will, to influence what they share with me or not, necessarily. And so, I allow, again, from that person-centered point of view, you're in charge, let's talk about this, whatever you want to talk about, we'll talk about here.

The second general category related to intake interviewing involved creating an affirming environment. A typical subcategory emerged wherein participants indicated the importance of affirming paperwork for the intake process. Participants noted the importance of creating and using documents, electronic health records, and paperwork that were inclusive and asked for name and personal pronouns in an affirming way. Examples of these efforts included offering space for clients to self-describe self-identifications (e.g., sexual/affectual orientations, gender, pronouns).

Variantly, a subcategory related to creating affirming spaces emerged. Participants described using safe-space stickers in their physical office spaces to create an affirming environment. Further, participants detailed conveying their affirmation through their *Psychology Today* profiles and websites to communicate that they work with TNB clients. One participant described this communication by saying:

> And so, when I had a *Psychology Today* profile, I spoke specifically around the fact that my main areas of work were in working with trans and gender expansive folks and LGBTQ folks, and I separate those out in the writing because I think oftentimes people will say LGBTQ because they think they're supposed to, but really what they mean is gay folks.

Lastly, a category emerged related to participants' explicit discussion of gender in the intake. Participants described discussing their clients' experiences of being trans,

experiences with gender dysphoria, and level of outness with important others. Participants emphasized the importance of prefacing gender questions with the caveat that clients do not need provide any more detail than they are comfortable sharing.

Beginning of Psychotherapy and Developing a Working Alliance

When asked to describe how being trans affirmative affected participants' approaches to the beginning of therapy and developing a working alliance, five categories emerged: explored gender, focused on building the therapeutic relationship, encouraged client agency in discussing presenting concern, used self-disclosure, and provided psychoeducation about trans affirmative health care (see Table 2). Generally, participants discussed exploring gender with their clients, resulting in two subcategories. The first general subcategory described how participants actively helped their clients explore their gender; for instance, participants described the exploration of gender transition such as (a) trying new pronouns and names and (b) working through medical-affirming procedures clients might be considering. One participant recalled how this exploration is combined with psychoeducation, noting:

> There was definitely a psychoed[ucational] component with this particular client in the early stages . . . what can trans look like? What does trans identity look like? Like, let's separate expression versus identity. Let's talk about different ways that people express their identities beyond binary ways of expressing identity, encouraging the client to look for expressions that felt closer to their identity.

Relatedly, one participant described helping a client explore their gender by cutting out snippets from magazines that represented their authentic gender. Other participants described the importance of the client's emotions, fears, and hopes about transition; anticipated or experienced transphobia from others in their life; and concerns of internalized transphobia or being "trans enough."

Variantly, participants described situations where a client would implicitly ask for the therapist to confirm whether they are trans. In these situations, participants described explaining to clients that it is not their role as a therapist to decide for the client if the client is trans, but rather to explore gender and come to an understanding of their gender for themselves. One participant described this scenario, noting:

> They [clients] will often come in and want me to tell them if they're trans or not. . . . And I always tell people, I can't answer that question for you. I can ask you a lot of questions about your identity, I can tell you if your story feels similar to other people's stories, other trans people's stories. We can talk about what it would mean if you were or were not trans. But at the end of the day, that's a decision that you have to make for yourself, and I put no judgment on whatever decision you make.

Additionally, participants reported focusing on building the therapeutic alliance, which yielded five categories. One participant described how they are committed to seeing the client for who the client says they are, noting and the client can only heal by "being seen and witnessed." Another participant noted they believe the core of trans-affirmative practice requires the following:

> The ability to see somebody for who they tell you they are . . . with no hesitation, no question, no qualm. It's like, you say this is who you are, that you are. And I'm here to help you become more of that.

Other participants indicated knowing information about TNB clients helps clients feel safe and confident that they will not be misunderstood about being trans.

Typically, participants noted the importance of client agency in discussing their presenting concerns at the outset of psychotherapy. Participants described letting clients decide what to discuss in therapy and being guided by the client's wants and needs. One participant described the importance of a trans client's agency and self-determination as a "really crucial part of [their] trans affirmative practice . . . how to create avenues for

choice and to instill a practice of self-determination from the get-go." Participants described listening with curiosity and no agenda in a "slow and steady process," with reminders to clients that they are in charge.

Variantly, participants described how using self-disclosure influences the beginning of therapy and the working alliance. Instances of self-disclosure included concepts such as participants sharing their own trans identities, especially if clients had experienced nonaffirming situations elsewhere. One participant described sharing how they reacted to being misgendered in public to practice responding differently to such treatment.

Finally, a variant category related to providing psychoeducation about trans-affirmative healthcare emerged. Psychoeducation in this category was related to navigating insurance for coverage of gender-affirming medical and surgical treatments (e.g., hormone therapy, chest surgery). Participants felt some clients look to their therapist for support in understanding language, labels, and medical care; the process of coming out in the workplace; and navigating relationships.

Termination

Descriptions of psychotherapy termination yielded two categories: assisted with posttherapy needs and tapered toward termination (see Table 2). Of these categories, the first was general, with three variant subcategories, and the second was typical. Generally, participants described assisting clients with posttherapy needs. These needs were described in variant subcategories related to providing referrals, evaluating the client's resources and support, and discussing the possibility of future therapy.

In the first variant subcategory, participants described the importance of finding affirming providers to whom they felt comfortable referring their clients; for instance, if clients are moving out of state and require a new provider, participants noted they will work to identify trans-affirming therapists, specialists, and providers for clients. In support of these referrals, participants also described calling and vetting possible referrals to ensure they are trans affirming.

Also variantly, participants described evaluating the client's support networks and identifying what support might be needed upon termination. In some instances, participants described providing community resources or support groups. In other cases, participants assessed their clients' family, career, and general support networks. This evaluation also acted as an opportunity for clients to reflect on what supports they may need.

The final variant subcategory related to posttherapy needs was related to discussions regarding therapy in the future. These discussions were focused on clients reflecting on how to determine if they want or need to return to therapy. Further, participants described helping clients understand that if they wanted to return to psychotherapy, they could reengage with that therapist or seek a different clinician.

Typically, participants described tapering toward termination and considerations of termination. Among considerations, participants indicated they may schedule check ins with clients who are transitioning and who may need additional support. Indicators of moving toward termination were described as evidence the client had worked through their presenting concerns and had arrived at a good place in their life. One participant spoke to the goal of termination as an integration, noting:

> My goal in closing sessions or preparing for termination is really helping people, you know, integrate the work that they've done. And certainly, I have participated in some of that work, but it really is—it is their work. It's their life. And you know, whether that is about setting boundaries at work, or figuring out if they want to get top surgery or processing trauma . . . helping people notice that they are the people who made those shifts happen

During tapering, participants described helping clients reflect on this progress and growth. Further, termination was a time to consider how to have healthy goodbyes in the therapy relationship and in other relationships.

Cultural Considerations

Data analysis yielded three categories related to cultural considerations: explored intersecting identities, sought to be aware of cultural difference, and explored clients' family cultures. Of these categories, one typical and two variant categories emerged. Typically, participants indicated they make efforts to explore the intersecting identities of their clients. Some participants described helping clients explore intersecting identities and their relationships to societal privilege; for instance, in some instances, White clients who transition may experience a loss of privilege in society as a result. One participant described the following scenario, explaining:

> They've struggled internally with their feelings about gender, they've carried a lot of privilege, being perceived as a cisgender, straight, White male from a privileged class background. So, one of the things that we've been reckoning with in therapy is, sort of, the giving up of certain layers of privilege around gender and trans status, and the giving up of certain expectations of safety and trying to be, like, trying to be honest in our assessment of how people will respond and how they will move through the world in different settings and in different ways.

This quote highlighted the consideration that for some clients, their privilege changed because of transition. Other participants described adjacent issues, wherein being White may have provided access to resources and education that might not otherwise be available to them. Whereas, for participants' TNB clients of color or religious clients,

there were discussions about their experiences of acceptance as trans people in their communities.

Variantly, participants indicated they sought to remain aware of cultural differences between themselves and their clients. Considerations included participants' understanding how their socioeconomic status, gender, or race may differ from their clients. In understanding these differences, participants described wanting to understand how these differences may impact interactions with clients.

In a final variant category, participants indicated they explored their clients' family cultures. These discussions primarily involved the clients' cultural norms experienced in their families as related to other cultural variables (e.g., regions in which the clients were raised). Participants described further how they might discuss how each client's family influences their understanding of gender.

Challenges or Barriers Encountered While Providing TAP

Descriptions of challenges or barriers encountered while providing TAP reflected one typical category and four variant categories: accessing trans-affirming health care, experiencing societal bias, navigating clients' personal relationships nonaccepting of their trans identities, making errors as a therapist, and financing trans-affirmative health care. Typically, participants described accessing trans-affirmative health care as a barrier. Lack of access to affirming mental health and medical care was lamented by one participant, who said, "I'd love to get them [clients] in an environment where they're not experiencing microaggressions every day" and another, who noted, "In some ways, it feels like limitations on the extent to which I can guarantee them trans-affirmative care." Further, participants described preparing their clients for the potential of "terrible"

medical experiences, which may be “invasive” and result in clients being misgendered and mistreated.

Variantly, participants described how societal bias experienced by clients is a challenge or barrier. Societal transphobia and the pathologizing of trans identities through gender dysphoria diagnosis were both cited as barriers. Participants described how they felt diagnoses were based on the medical model and “puritanical values” in society and created barriers for clients to access gender-affirming medical and surgical treatments (e.g., needing a letter for surgery with diagnosis).

Participants also variantly described the role of their clients’ personal relationships as a barrier. Several participants noted how parents or other family members respond or accept a client’s gender influences how much the client can “lean” into their authentic gender. One participant indicated the biggest barrier is parents, as they influence clients’ feeling of family acceptance.

Variantly, participants also acknowledged the role therapy errors play in sessions. Participants recognized they could make errors, and their learning is ongoing. One participant described the importance of obtaining additional supervision and research when working with some clients. One participant indicated:

> And I think a mistake that some therapists make that I think makes them unaffirming is their excitement of you realized this thing about yourself! getting in the way of actually being in the muck of it, because there’s also grief that comes along with this process, right? We’re potentially losing parts of ourselves or parts of ourselves are evolving in ways we didn’t imagine they would. And so, yeah, I think another part of that maybe is holding on to my own stuff, my own reactions and being aware of that, without projecting that onto the client in a way that would, in my opinion, be inappropriate.

Lastly, participants indicated financing trans-affirmative healthcare was a barrier. Difficulties with insurance (i.e., lack of insurance or insurance coverage of gender-

affirming healthcare) were cited. Alongside insurance issues, resources generally were noted as a barrier. Participants described helping clients consider their options in how to deal with lack of resources for their surgical and medical care.

Aspects of Agency or Clinical Setting Supporting Participants in Providing TAP

Results identified aspects of the agency or clinical setting that support participants in providing TAP. Three categories emerged: affirming trans professional community, trans-affirmative agency communications with clients, and practices in the LGBTQ+ setting (see Table 2). Of these categories, there were two typical categories and one variant category. The first typical category described the importance of professional communities with trans people in them. Participants cited agencies run by trans people, consultation groups, and clinical settings that include several trans clinicians and colleagues who also work with TNB clients as supporting the provision of TAP. One participant described the impact of trans-led agencies, noting:

> It's run by a trans person, like there's lots of trans people around. . . . So, it's not just cis people who are kind of imposing expectations onto trans folks, but you know, our community's also part of leading that therapy service as well.

The second typical category described the importance of an agency practicing trans-affirmative communication with clients to be supportive of TAP. Affirming communications included inclusive paperwork, affirmative behaviors by administrative staff (e.g., asking for pronouns), and lists of trans-affirming referrals available. Participants described thoughtfulness about their online system or electronic health records so (a) all providers knew clients' names and pronouns and (b) clients did not have to correct the agency or fear being invalidated by providers.

Finally, in a variant category, participants described working in an LGBTQ+ setting was supportive of providing TAP. These participants often worked in LGBTQ+ community centers or private practices catering to the LGBTQ+ community. One participant described how working in a “queer” setting increased their confidence in their work and provided the agency with a culture of critical thinking and challenging assumptions, while leaving behind harmful norms.

Comparison Between TAP and Working With Cisgender Clients

Exploring the comparison between working with trans and cisgender clients resulted in one typical category and two variant subcategories: used the same therapeutic approach for all clients, addressed discrimination with TNB clients, and intentionally explored gender with TNB clients. Participants typically indicated they use the same therapeutic approach or theories with trans clients as they do with cisgender clients. One participant stated:

> I think it's probably the same. I don't have many cis clients. And so, I think the way that I work is just the way that I work. But you know, part of my values in my work is, like, I think everybody, not in a, like, everybody gets the same, cookie cutter approach, but, like, you know, when I'm working with anyone, I want to see them as a person. And I want to see them as a person with the parts of themselves that make them them. And so, you know, what the identities are may change, but I don't necessarily know that that changes my approach for how I am in the work. But I also think it's important as a clinician to be consistent across the board with whoever you're working with.

Participants noted they view each client as a unique individual and focus on the therapy relationship. Participants also indicated they often explore gender with clients whether they are TNB or not, because everyone has a relationship to gender.

Variantly, participants indicated TAP differs from working with cisgender clients because of the need to address discrimination with TNB clients; for instance, one participant noted they do not discuss the history of psychology with cisgender clients

because it is not relevant, whereas with TNB clients, psychology has pathologized trans clients. Similarly, participants described talking with TNB clients about their interactions with other settings (e.g., workplace, medical providers) and the possibility for discrimination. Further, participants described being less oriented to finding resources for cisgender clients than trans clients who may struggle to find resources.

Finally, in a variant category, participants noted they intentionally explore gender with TNB clients. These participants acknowledged the issue of gender arises for cisgender people but the conversations are different and less frequent with trans clients. One participant noted trans clients interact with their identities differently than cisgender clients.

TAP's Effect on participants and Conclusion

The closing questions of the interview asked participants three questions, yielding three domains (see Table 3). The closing questions were meant to help participants reflect on the influence TAP has had on their personal and professional lives. The findings from these closing questions are presented in Table 3.

Table 3

Domains, Categories, and Frequencies of TAP's Effect on the Participant and Participant Advice for Future TAP Therapists

Domain	Category	Frequency*
TAP's influence on P's clinical practice	Fulfilled as a clinician	Typical (9)
	Helped P question their biases	Variant (6)
Impact of TAP on P	Helped P feel more positive	Variant (6)
	Deeper understanding of self	Variant (4)
	Sought to offer additional advocacy work	Variant (4)
	Helped P be more flexible	Variant (3)
P's advice to future TAP therapists	Know and listen to the trans community	Typical (7)
	Challenge your assumptions	Variant (6)
	Engage in self-reflection	Variant (5)
	Be curious with TNB clients	Variant (3)

Learn to use pronouns and attend to language	Variant (2)
Learn to tolerate client feedback and your errors	Variant (2)

Note. P = Participant. * 12 total cases. General = 11–12, Typical = 7–10, Variant = 2–6

TAP's Influence on Participants' Clinical Practices

Within the first domain, two categories emerged: fulfilled as a clinician and helped participants question their biases. Typically, participants described feeling fulfilled as clinicians after working as TAP therapists. Participants described feeling satisfied working as TAP clinicians because TAP aligned with their values and contributed to them feeling more confident as therapists. As an example, one participant said:

> [TAP] made me feel more confident as a therapist. I think in previous roles . . . working within a model that I didn't fully feel aligned with, working within systems that, in some ways, went against my values, I often felt stymied and it interfered sometimes with the work that I could do with my clients.

Further, participants indicated TAP helped them become more flexible and nondefensively respond to clients while being challenged in positive ways, with one participant noting these experiences took them "out of their comfort zone." One participant described the bidirectional relationship between their personal and professional life such that this work helped them understand their own gender and made them happier, ultimately making them a better therapist.

Variantly, participants described how TAP helped them questions their biases. Participants indicated their biases about gender had been challenged; for instance, one participant indicated making intentional efforts to "decouple" ideas taught about the physical body from implications about gender (e.g., a beard implies man). Another participant commented on the notion of flexibility in their thinking in session, saying:

> It's [TAP] invited me to be much more mentally flexible. Like, I think I've gone from kind of thinking about things, not even in terms of binary but, like, the world is full of duopoly, right? Like, it's this or that, it's this or that. We don't even know that there are options and so, one of the things that I have found subsequent to working with trans folks is that I have found for myself that the first two things I think of reflexively for any answer are probably wrong. And I just throw them out.

Relatedly, participants described alongside the mental flexibility, questioning default assumptions and biases helped them to "step out of binaries."

Impact of TAP on Participants

The second closing question related to the personal impact of TAP on participants yielded four variant categories: helped participants feel positive, deeper participants' understanding of self, sought to offer additional advocacy work, and helped participants to be flexible. In the first variant category, participants described feeling more positive after providing TAP to TNB clients. As one participant indicated, they were "forever changed because of the people [the participant] has shared space with" and noted TAP has "unimaginably widened" their experience of the world. Other participants indicated the satisfaction of working toward their "true north," noting they can see the positive impact they have had on others.

In another variant category, participants described having a deeper understanding of self from providing TAP. This deeper understanding was both related to understanding their own gender and the concept of gender more fully. One cisgender participant indicated they thought more critically about gender and as a result was able to understand the experiences of TNB clients more fully. In the third variant category, participants indicated providing TAP encouraged them to seek other opportunities for advocacy. Participants described considering other ways to provide resources through volunteering

and being an ally to other communities; one participant described recognizing the "interconnectedness" of oppression and a desire to help "dismantle" oppression wherever it exists.

Variantly, the final category related to the personal impact of TAP on participants. The participants indicated an increased sense of flexibility that manifested in their lives in an openness to accepting all people and an expanded view of the world. One participant described the flexibility in understanding the "nuances" of gender and sexuality.

Participants' Advice to Future TAP Therapists

The concluding question of the interview asked participants to reflect on any advice they had for future TAP therapists and resulted in one typical category and five variant categories: know and listen to the trans community, challenge assumptions, engage in self-reflection, be curious with TNB clients, learn to use pronouns and attend to language, and learn to tolerate client feedback and personal errors. Typically, participants emphasized the importance of knowing and listening to the trans community. Participants suggested if clinicians do not know trans people, they should find trans people with whom to build relationships outside of the clinical setting. One participant suggested that often, people's "weird feelings" about trans individuals come from lack of contact with the TNB community. Other participants suggested following trans content creators on social media and listening to a broad range of trans perspectives. One participant noted the importance of exposing oneself to a broad range of trans experiences, saying:

> And to experience that from a number of different perspectives because I think that also creates more space to not assume that everybody who sits down across from you in your therapy room is going to have the same story because they won't.

Relatedly, participants emphasized the importance of listening to trans people while also acknowledging trans people as the experts of trans experiences and identity, positing their input should be incorporated into trainings.

In the first variant category, participants discussed challenging assumptions around gender, transition, and biases. One participant encouraged future TAP therapists to think critically about "whether [they] think being trans or transitioning is a bad or harmful thing and where that's coming from." Yet another participant indicated a related challenge to future TAP therapists to understand that hormones are not a "bad thing" and transition is a "menu of options" rather than checklist criteria.

Variantly, participants encouraged future TAP therapists to engage in self-reflection. One participant stated the importance of getting a personal therapist and, "We don't get fucked up alone. And we don't stay unfucked up alone and we certainly can't help our clients past where we've gotten." The same participant further indicated TNB therapists are "uniquely prepared" to exercise TAP; however, some may have issues with "overidentification" due to their own trans identity and their need for support to unpack countertransference issues. Further, one participant explained how self-reflection is important, saying:

> […] something that I tell people is that you don't have to be trans to do this work. I don't think that I am a good trans affirmative clinician because I am trans. I do think that it changes and shapes the work. Think of it as a black and white photo, it's not any better than a color photo, it's just different depth. And different vibrancy, right? I think perhaps my work with trans people is a little bit more vibrant but not inherently better than work that a cis gender person might do with a trans person. So, I've trained a lot of clinicians, both very individually, in trans affirmative practice as well as more broadly in trainings, and kind of my general model is one, you need to understand your own relationship to gender, and be willing to do a deep dive into your relationship to gender, both on a personal level and your understanding on a macro level. So, really being willing to do that personal reflective work and exploration of self, because you need to identify

> your own narratives and how they're going to show up in the space, and you need to identify and tied to that, the biases that are going to show up in the space, […].

A variant category related to curiosity with TNB clients also emerged. Participants indicated the importance of asking questions about a client's gender while avoiding being invasive. One participant described how they believe clinicians are sometimes afraid to ask questions about gender, but noted this hesitation can do more harm than good at times:

> I find that with clinicians, too, they're so worried about just saying the wrong thing, or asking the wrong thing, or like, what if I offend someone? And so, I think it's trans affirming to ask questions . . . "Where else do you feel dysphoric? How have you coped with the dysphoria? Have you tried tucking?" Like, I don't know, and a lot of clinicians on staff wouldn't feel comfortable asking that, but like, why would you not ask it if this is integral to what they're [TNB clients] experiencing right now? So, the curiosity, asking questions, and feeling comfortable with if I say something wrong, catching it, hoping they say something or noticing, so that I can ask.

The final two categories were related to learning. The first variant category of participant advice to future TAP clinicians encouraged them to learn to use client pronouns and attend to language. Learning to use TNB client pronouns was especially noted for therapists who might not know trans people in their lives and should subsequently practice using gender-inclusive language. Further, participants felt therapists should conduct independent research about TNB terms and not ask clients to educate them on the language.

Lastly, the final variant category of participant advice to future TAP clinicians was to learn to tolerate client feedback and clinical errors. Participants noted the importance of learning how to repair from unintentional microaggressions and to practice tolerating feedback from clients when they have made a mistake.

CHAPTER V: DISCUSSION

This study examined what aspects of psychotherapy exemplar psychotherapists considered essential to conducting trans-affirmative psychotherapy (TAP) and those factors that may facilitate or challenge the provision of such therapy. Researchers and clinicians have written extensively about TAP (Chang et al., 2017; Singh & dickey, 2017), and have regarded TAP as the consensus approach to psychological care for transgender and nonbinary (TNB) clients (Singh & dickey, 2017). Professional organizations such as the American Psychological Association (APA) and the American Counseling Association (ACA) have established practice guidelines that help prepare clinicians for their work with TNB clients. Among other topics, the APA's (2015) *Guidelines for Psychological Practice With Transgender and Gender Nonconforming People* (*Guidelines*) included assessment, therapy, and intervention. Although the *Guidelines* provided a comprehensive review of the minimal available empirical research, these guidelines were general and without substantial guidance regarding conducting psychotherapy in session with TNB clients (APA, 2015). Consequently, this study sought to understand how TAP clinicians practice and the preparation and learning needed.

In all areas of clinical practice, perhaps unsurprisingly, participants emphasized the importance of addressing gender. Participants addressed gender at several points throughout the therapy process while also acknowledging the importance of client agency in discussing gender. Given the findings that suggesting therapists may be prone to either over-emphasizing or under-emphasizing gender with TNB clients (e.g., Mizock & Lundquist, 2016) these findings added essential nuance such that from our participants' perspectives, one approach critical to TAP appeared to be giving appropriate weight to

gender. Participants emphasized the importance of neither ignoring nor inflating the role of gender in a client's life; instead they sought to take a balanced approach. Further, participants encouraged client agency in discussing their presenting concerns so that clients themselves were determining and guiding their goals for treatment. In addition, participants provided TAP with thoughtful considerations of *micoraffirmations* (Anzani et al., 2019) or subtle acknowledgement of trans identity and which were affirming of trans clients throughout all aspects of treatment. The following sections discuss these and other findings in greater detail, beginning with the participants' contexts and preparation for providing TAP. After discussing the findings, limitations, and implications, future research directions are explored.

Context and Preparation for Participants Providing TAP

Participants noted several personal and professional motivations, trainings, experiences, and theories contributing to their TAP practice. The following sections address the context and preparation of these exemplar clinicians.

Motivation to Work With TNB Clients

Participants' experiences as LGBTQ+ contributed to their desire to serve the TNB community. Their motivation was also influenced by wanting to give back to their community and an acknowledgment that there is a need for quality services. It seems reasonable to assume that LGBTQ+ clinicians, who may have had difficulty accessing affirmative care themselves, would have a greater sense of motivation to provide services to TNB clients who may otherwise be underserved or marginalized in care (e.g., Elder, 2016; James et al., 2016; Morris et al., 2020). Further, participants described giving back to their own LGBTQ+ communities as providing something that did not exist for

participants when they were growing up, as such support was scarce. This study's findings were not unlike prior research related to the motivations of future therapists and trans-affirmative therapists who reported a desire to help others with similar painful experiences contribute to society (Hill et al., 2013) and to fill a need for services in their community (Stryker et al., 2022). TNB clients often struggle to find affirmative healthcare (Snow et al., 2019), and this study's participants appeared to essentially be responding to the needs of their community.

Training, Learning, and Theoretical Influences

Participants indicated the most common forms of TAP training and learning occurred through continuing education, formal work, or clinical training in a professional setting with TNB clients. A common thread in these findings was the influence of TNB-led training, mentorship, and exposure to clinical work with TNB clients. Few of this study's participants described having academic preparation during undergrad or graduate school focused on the trans community, which likely reflected the era in which they were trained. For these clinicians, instead of a formal pathway for TAP training in graduate education, continuing education and pursuit of LGBTQ+-focused training sites were supportive avenues for obtaining this training. There has been a notable increase in training opportunities in the last five years, and research has suggested that clinicians' self-reported number of hours of TNB-specific training is correlated with overall higher TNB-sensitive competence (Obasi et al., 2023). Although it was not clear from this study's participants what continuing education training was most helpful, they expressed the helpfulness of training led by trans individuals. Unsurprisingly, the clinicians who were motivated to provide quality clinical care were more likely to increase their

expertise through self-study and didactic and clinical training. Moreover, several participants were located in major U.S. cities, which may have contributed to the availability of more frequently offered TNB- and TAP-based training opportunities.

When participants discussed their use of theory in clinical practice, they indicated integrating various psychotherapy theories alongside theories of gender and disability theory. Though trans-affirmative applications of psychotherapy exist, such as cognitive behavioral therapy (Austin & Craig, 2015) and exposure-based interventions (Lange, 2021), participants in this study described using a variety of theoretical approaches. Rather than applying any specific psychotherapy theory to TAP, they flexibly drew from various theories that appeared to work for them based on their individual perspectives. The inclusion of gender theory has been used among TAP theorists (e.g., Spencer et al., 2021) but disability theory less so. However, these clinicians held a heightened awareness of the marginalization and trauma experiences of TNB clients, and which may align with the marginalization experiences of those with disabilities and chronic illness. Therefore, TAP clinicians may want to attend to emerging research related to the intersections of trauma, disability, chronic illness, and TNB clients.

Providing TAP

The findings in this area spanned the course of treatment, from intake paperwork and intake interviews to termination of treatment. Findings related to (a) cultural considerations in the therapy dyad, (b) challenges and barriers to providing TAP, (c) aspects of participants' agencies or clinical settings that supported them, (d) and advice for future clinicians are discussed.

Intake

Participants' approaches to TAP involved intentionally integrating affirmation during intake to establish a sense of inclusion for TNB clients. Participants in this study aimed to create an environment that conveyed affirmation and acceptance of trans people explicitly and implicitly. For instance, participants described integrating explicitly affirming clinical materials (e.g., the website, intake forms, and pride flags in the office). If a client's name differed from their legal name, clinicians asked for this legal name while providing context for why this step was necessary (e.g., for insurance purposes). Additionally, participants intentionally addressed names and pronouns during the intake interview to avoid assumptions about the gender of either the clients or others in their clients' lives. Efforts such as these appeared to relate to what prior research (Anzani et al., 2019) has called *microaffirmations*, or small interpersonal gestures that may feel validating to a therapy client. These interpersonal gestures and environmental affirmations were intended to develop rapport with clients, creating a therapy relationship that could help to support future work with these clients.

It seems reasonable to suggest, given that these exemplar therapists were aware of how often assumptions are made about gender (e.g., based on names and phenotype) or that forms usually do not include places for trans people to self-identify, that participants were alert to the need to be more inclusive. In other words, this study's participants knew that clients may feel marginalized when paperwork does not capture their identity, a notion referred to as *institutional erasure* (Bauer et al., 2009) and therefore sought to acknowledge client identities at the outset of therapy. As a result, participants'

affirmative gestures communicated a sense of inclusion to clients who may commonly have had their gender assumed or ignored by others.

Some participants indicated they would disclose their identities to the client at intake. These participants may have viewed this self-disclosure as a tool for developing the working alliance. In particular, participants indicated self-disclosing, especially if the client had prior negative experiences in therapy. Self-disclosure generally helps model client disclosure, allowing clients to share their concerns freely. Self-disclosure of the therapist's identity has been deemed a promising evidence-based relationship variable (EBRV) in strengthening the therapy alliance among gender and sexual minority clients (Ellis et al., 2020). Efforts to affirm clients in the psychotherapy setting appear to be repair efforts for past or anticipated negative psychotherapy experiences documented in previous research (e.g., Mizock &Lundquist, 2016; Morris et al., 2020). Further, these affirming considerations may be absent in general practice settings or other areas of the client's daily life.

Beginning of Psychotherapy and Developing a Working Alliance

Perhaps the most critical finding of this study was related to how participants developed a working alliance with TNB clients by openly discussing gender and focusing on the therapy relationship. These findings are critical partly because of existing TNB psychotherapy research, which has highlighted the errors of prior therapists when addressing gender in psychotherapy with TNB clients. From previous research, clients have reported their therapists as either inflating the role of gender in an individual's presenting concerns or ignoring gender altogether (e.g., Mizock & Lundquist, 2016).

Critically, in this study, clinicians placed a dual emphasis on exploring gender while encouraging client agency (i.e., client-led) in discussing their presenting concerns.

Participants explored gender by discussing how concerns such as gender dysphoria, stigma, or social support may influence the client's lived experience. In some cases, participants assessed a client's goals for transition, if any, and what relevance these goals might have to their presenting concerns. For these participants, the therapy relationship may have been strengthened in part due to their attention to the relationship, knowing that clients may have experienced dissatisfying relationships or negative therapy in the past. Similar to the self-disclosure finding, this attention to the relationship may be seen as a relational repair, considering how TNB clients may have experienced relational ruptures (e.g., in therapy and other relationships). Unsurprisingly, these highly skilled clinicians, who had advanced knowledge and training in TAP, exhibited comfort in exploring gender, which may contribute to a strong therapy relationship as well. Conversely, less-knowledgeable clinicians may hesitate to explore gender with TNB clients due to fear of self-presentational concerns (e.g., not knowing enough about TNB concerns). Meaningfully, through exploring gender openly with TNB clients, participants noted they were able to establish a solid therapeutic relationship that conveyed their affirmation and expertise. This study's findings mirrored prior analogue research, which found that TNB clients believe therapists to be likable, trustworthy, and expert when they take an affirming approach (Bettergarcia & Israel, 2018).

A critical example of gender exploration described by participants was that TNB clients sometimes asked the therapist to confirm whether the client was trans. For these participants, when a TNB client asked for this confirmation, participants stated explicitly

that they could not determine if the client was trans. Instead, participants recalled helping clients actively explore their gender collaboratively and in a client-led manner, thereby avoiding a hierarchal approach. Given the history of mental health professionals who acted as gatekeepers to gender-affirming medical and surgical treatments (GAMSTs; Budge, 2015), these findings may suggest clients are conditioned to expect therapists to deem them "trans enough." Further, that clients may present with doubt or uncertainty, and that our participants made space for clients to explore uncertainty and all other aspects of their identity.

Interestingly, participants did not view their therapeutic approach and exploration of the role of gender as different when working with cisgender clients. Participants believed gender plays a role in every client's life and, therefore, is relevant to the therapeutic approach to working with clients of all genders. Presumably, exemplar TAP therapists are particularly attuned to the role gender plays in people's lives, irrespective of being trans. These findings remind therapists to consider and address the role of gender in every client's life, rather than just their transgender clients (Spencer et al., 2021). Though participants indicated they may be more likely to explore gender with TNB clients, they did so more intentionally with TNB clients.

Relatedly, participants indicated that throughout therapy, they felt that providing psychoeducation about insurance, trans-affirming referrals, the impact of hormone therapy, or transition-related changes was essential to building the therapy relationship with TNB clients. Although not all TNB clients prepare for gender-affirming medical care or present to discuss gender, this study's findings suggested that TAP clinicians must discuss and offer psychoeducation about gender-affirming care (APA, 2015; Chang et al.,

2018). Providing psychoeducation may also reflect Bettergarcia and Isreal's (2018) findings related to expertise, such that clinicians who can give this psychoeducation are seen to be more expert, thereby positively influencing the therapy relationship through their knowledge and affirmation.

As described by participants, developing a positive working alliance with TNB clients is clinically complex. TAP requires ongoing attunement to the client's goals for therapy, encouraging client agency and understanding to what extent gender exploration plays in those goals. Whereas prior research had not described the clinical complexity of these varied tasks, findings from this study highlighted the need for ongoing investigation of these clinical tasks and their relationship to the working alliance.

Termination

Participants described that during the termination of therapy, they were focused on assisting clients with posttherapy needs. For instance, posttherapy needs were identified as possible referrals to other TAP providers if the client relocated. No research had explored termination with TNB clients, making the findings of this study unique. Although the findings appeared to have some overlap (e.g., knowing when to reengage in therapy) with the termination behaviors of therapists generally (Norcross et al., 2017), the findings of this study were primarily related to trans-affirmative resources. Termination behaviors of these TAP therapist participants reflected their awareness of barriers to obtaining trans-affirmative care. As such, these participants described intentionally referring clients to TAP providers and sometimes vetting those providers to ensure they were trans-affirming. Participants helped clients consider when they may need to return to therapy, and perhaps subsequently recognized that clients may need to acutely return to

therapy as TNB clients experience further challenges, identity-related or otherwise. Relatedly, in the termination process, the participants discussed exploring with clients what resources or areas of support would be necessary for them post-termination, reflecting practice guidelines that encouraged therapists to assist their TNB clients with accessing resources (APA, 2015).

Cultural Considerations

Among study participants, attending to and exploring intersecting identities was a core feature of cultural considerations. Participants provided nuance not previously found in existing literature; for instance, participants described facilitating intersectional explorations when trans clients of color experienced discrimination and bias, which influenced their transition experiences, or how TNB clients from religious backgrounds may encounter difficulties in their faith communities. Further, participants described that for some trans clients, their privilege levels (e.g., socioeconomic privilege) may provide access to resources more quickly than other trans individuals (i.e., gender-affirming surgeries). Here, explorations of intersecting identities manifest in what Adames and colleagues (2018) called *strong intersectionality*; in session, these explorations elucidate how multiple identities of privilege or inequality may impact clients.

Additionally, participants described evaluating their intersecting identities and how they impact their work with clients, aligning with a multicultural orientation standard in the counseling field (Davis et al., 2018). Therefore, the participants must also engage in an intrapersonal process, a stance of cultural humility that necessitates an accurate view of self—including limitations, multiple identities, privileges, and experiences of oppression. Davis et al. (2018) described this intrapersonal process as

allowing the therapist to be more oriented to their client; as such, this internal exploration may be an essential addition to the interpersonal process of exploring the client's intersecting identities.

Challenges and Supports for Providing TAP

Participants described barriers to providing TAP as being primarily external to the therapy dyad; for instance, participants mentioned clients had difficulty accessing or financing GAMSTs. These findings suggested TAP therapists must be willing to provide education about potential barriers found outside therapy and prepare clients for potentially harmful healthcare experiences, in addition to being knowledgeable about available options for healthcare. Findings from this study were consistent with a previous examination of cisgender therapists (Salpietro et al., 2019), wherein barriers were primarily identified as being outside the therapy dyad and in the realm of institutional and healthcare barriers (e.g., access, trans-affirming medical providers).

Though results from this study supported external barriers that influence TAP, the findings did not speak explicitly to client concerns described in past research (e.g., affordability, fear of being misunderstood, poor experiences with prior therapists; Benson, 2013; Elder, 2016; Hunt, 2014). Although it is difficult to draw comparisons due to this study's participants, who are clinicians, there was a notable disconnect such that therapists in this study and in prior research identified barriers external to the dyad (e.g., transphobia), whereas clients in previous research identified barriers within the dyad (e.g., mistrust of therapist). Generally, it seemed reasonable to assume some of these challenges were avoided because this group of highly skilled therapists was likely alert to potential barriers in session and thus could prevent some errors. However, due to self-

presentational concerns, participants may have been less likely to note errors or barriers common to the therapy dyad. Considering these findings, it may be essential to understand further what barriers or challenges exist within sessions (e.g., errors, rupture).

In contrast to barriers, participants identified supports primarily focused on developing affirmative clinical environments. Consistent with conceptual literature (Chang et al., 2018), the office environment is essential to TAP; when taken in tandem with the aforementioned findings about establishing an explicitly inclusive environment, these findings suggested participants were positively influenced in their provision of TAP due to their clinical environment. Participants discussed a trans-positive environment throughout their agency, from consultation groups to supervision and all-gender bathrooms. Additionally, the positive influence of trans-affirmative communications with trans clients through paperwork or via administrative staff was also seen as necessary for providing TAP. These findings described how clinicians and agencies intentionally created clinical environments that avoided some barriers experienced outside the clinic by TNB clients. This intentionality was likely time-consuming and effortful for clinicians, though ultimately supportive in providing TAP. These findings extended beyond the available literature by adding the influence of a trans-positive environment, including visual representation in the space alongside trans employees and leaders to help support clinicians in providing TAP. These findings were novel because no research has previously explored the impact of the setting, facility, or agency where clinicians work.

TAP's Influence on Participants

This study sought to understand the impact of TAP on the participant, as both an individual and a clinician. Participants described feeling a sense of fulfillment in their

work, along with increased confidence. For these participants, their fulfillment related to the motivations noted previously—that to provide TAP, they could meaningfully support a marginalized group of which they were a member. Such support may have come as members of marginalized communities who had felt disempowered in certain settings, where working and contributing positively to their community provided a sense of meaning and fulfillment. The impact of conducting psychotherapy on the psychotherapist has not been studied extensively; however, the findings overlapped with existing research, which suggested therapists felt more open and privileged to continue to grow personally due to their work (Rabu et al., 2016).

Advice for Future Therapists

For participants of this study, knowing and listening to trans people, challenging assumptions, and engaging in self-reflection were the most common advice to future clinicians. The act of knowing and listening to the trans community was essential to this study's participants and was evident in many of the findings. Central to this advice was the privileging of trans voices, which have been marginalized throughout history. Participants offered suggestions to consume media made by TNB people and other trans-produced content (e.g., movies, YouTube). By listening to the trans community, there is essential exposure to learning that trainees might otherwise have to learn from their clients, which may burden clients to educate clinicians (McCullough et al., 2017).

Although clinicians are increasingly open to working with trans clients, many are poorly trained for TAP and rarely asked to reflect on their biases toward TNB clients in graduate school (Whitman & Han, 2016). Study participants indicated that providing TAP helped them question their biases and identified self-reflection and avoiding

assumptions as crucial to delivering TAP. Meaningfully, these reflections came from highly skilled therapists, perhaps who were more likely to engage in such self-reflection. These findings suggested increased opportunities for reflection and challenging one's biases and assumptions related to working with TNB clients would be helpful during training.

Limitations

Findings from this study enhanced the existing, though limited, TAP knowledge base. Before suggesting how this study's results can contribute to future training, practice, and research, limitations in these findings are first discussed. Participants noted motivations to give back to their community, so selection bias should be considered a potential limitation. Mainly because the participant pool was comprised of a highly skilled and expert-nominated base of individuals, the participants' experiences cannot be used to explain the attitudes or behaviors of other mental health clinicians. Further, participant motivations to foster awareness of TAP may have dissuaded them from disclosing aspects of providing TAP that are more challenging due to self-presentational concerns, particularly as noted in barriers to providing TAP. Additionally, participants largely reflected perspectives of therapists who are members of the communities they serve (i.e., LGBTQ+ clinicians working with TNB clients). A limitation, then, may be in understanding the perspectives of other clinicians (i.e., cisgender therapists) in particular study findings related to providing TAP and the training and learning they have received.

Though many findings had overlapping consistencies in empirical research, they were interpreted cautiously due to the general paucity of research. Additionally, the existing comparison research was largely qualitative and based on the retrospective recall

of study participants instead of direct observation of therapy sessions. Qualitative research has innate limitations, including controversy about the ability to generalize findings and how researchers analyze the findings (Hill & Knox, 2021). The consensual qualitative research (CQR) method sought to address some of these limitations through bracketing biases at the project's outset, alongside the consensus process, which considered various viewpoints to arrive at the meaning of data (Hill & Knox, 2021). The racial homogeneity of the participant sample and researchers was also a limitation, as all participants were White.

Further, the interview protocol was given to participants before the interview, per CQR recommendations (Hill & Knox, 2021). Offering the protocol in advance gave participants time to consider their responses, a crucial CQR guideline (Hill et al., 2005). Still, allowing participants to consider their answers may have resulted in self-preserving editing, meaning the participant may have edited out details that would make the participant look poorly.

Implications

Despite the limitations of this study, several notable implications existed for the findings of this study. Implications for professional development and future research are explored in the following sections.

Professional Development

Participants emphasized the need to know and listen to the trans community and added a particular emphasis on training environments that trans people lead. Recent calls have been made by an APA Division 17 Task Group (McGinley et al., 2020), which has published resource materials for incorporating trans issues into counseling psychology

curricula. These materials seek to educate trainee clinicians and to increase the number of TNB counseling psychologists. Due to accreditation and curriculum needs, clinical training often cannot address working with all special populations; hence, the pursuit of competency is the responsibility of the individual clinician (Morris et al., 2020). That said, recent research has suggested that graduate-level TNB-related training has increased (Obasi et al., 2023), and this study's participants pointed to the importance of trans-led training opportunities.

As mentioned, therapists' work with TNB clients is clinically complex and draws on varied skills, behaviors, and attitudes. Some behaviors notably mentioned in this study included participating in self-disclosure, fostering client agency, building the therapy relationship, and providing information about trans-affirming healthcare. Findings further suggested training in an LGBTQ+ setting or direct experience working with TNB clients will improve the clinician's preparation. As such, trainees should try to identify such opportunities during their training and which may give them access to the resources, training, supervision, and mentorship identified by our participants.

Future Research

TAP, given its limited empirical research, is an emerging area of research with significant room for future investigations. In echoing previous researchers (Budge & Moradi, 2018; McCullough et al., 2017), this current study pointed to the potential benefit of increased process and outcome research. Process-based research can help to understand what occurs in psychotherapy and how it contributes to outcomes (Crits-Christoph & Gibbons, 2023). Findings from this study related to self-disclosure, client agency, and affirmation may overlap with influential relationship variables such as the

working alliance, empathy, goal consensus, collaboration, and positive regard. In concert with previous research related to EBRVs (e.g., Ellis et al., 2020), the findings supported that aspects of the therapy relationship are foundational to the provision of TAP. Relatedly, a clinically complex area that emerged in the findings was related to clients asking participants to confirm if they were trans. From these findings, it may be helpful to understand how therapists inform their TNB clients about their roles, the history of gatekeeping in psychotherapy, and discussions of gender.

Some researchers have suggested future studies should focus on TAP-adapted treatment protocols (e.g., transgender affirmative cognitive behavioral therapy) and test their efficacy with TNB clients (Hope et al., 2022). However, process-based research and therapy (Moskow et al., 2023) is idiographic and moves away from specific therapy protocols. Process-based therapy is evidence-based and approaches the client individually, which may better speak to the clinical complexity of TAP.

The study's findings showed a disconnect between what clients and therapists identify as barriers to care. In previous research, clients described negative experiences in therapy (e.g., microaggressions; Mizock & Lundquist, 2016; Morris et al., 2020) as barriers to therapy. Meanwhile, the sample of therapists in the current study described most barriers as external to the dyad (e.g., family concerns, systems-level barriers). This disconnect made sense because this study used a sample of highly skilled therapists, which may differ considerably from therapists with whom past research participants or clients worked. There is room to investigate aspects of TAP that may be challenging within the therapy dyad (e.g., rupture and repair, countertransference). Previous research

by Ellis et al. (2020) described that managing countertransference has some support for an EBRV and would be another process-based variable to study related to outcome.

Additionally, it would be helpful to observe the therapist and clients in a moment-by-moment or micro-analysis to understand the interpersonal behaviors of the dyad. This method may apply to topics related to study findings (e.g., disclosure, agency). Further, because previous research has focused on negative therapy experiences, increasing focus on positive therapy experiences would be helpful due to the number of TNB people indicating they wish to seek therapy (James et al., 2016).

Conclusion

In summary, this study examined what aspects of psychotherapy that exemplar psychotherapists considered essential to conducting TAP. Participant findings provided clear guidance that can be applied to work with TNB clients. First, participants intentionally created affirming clinical environments and explicitly affirmed their TNB clients. These affirmative gestures set the stage for developing the therapy relationship and providing TAP. Further, these intentionally affirmative efforts were seen as a repair—first, in the acknowledgment that TNB clients may have had negative therapy experiences in the past and then, more broadly, that TNB individuals often face negative healthcare experiences. These highly skilled clinicians were aware of the barriers to care for TNB clients and discussed being careful not to repeat them.

Importantly, these highly skilled therapists described actively exploring gender with their clients while neither inflating nor underemphasizing the role of gender in a client's life. Instead, clinicians supported client agency in establishing goals for treatment and in explorations of gender. For these participants, their lived experiences as members

of the LGBTQ+ community were central to their training, preparation, and provision of TAP (e.g., self-disclosure). Significantly, the lived experiences of clinicians contributed to their competency and readiness to provide TAP and support the aforementioned calls to increase the number of trans psychotherapists in the field. Relatedly, participants placed an essential emphasis on knowing and understanding the perspectives of the trans community, which is especially important for cisgender therapists who wish to be affirming in their practice.

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APPENDIX A

DEMOGRAPHIC FORM

Trans-Affirmative Psychotherapy Project

Demographic Form **Note: Consent and Demographics will be distributed via Qualtrics*

Demographic form:

Age: _____

Name: _____
Gender: _____ Pronouns: (e.g., they/he/she): _____
Sexual/Affectual orientation: _____
Race: _____
Ethnicity: _____
Your Phone Number (to reach you for interview):
_____

Your Email Address: _____

Program you completed (check box): Clinical psychology
Counseling psychology
Counselor education
Master's in counseling

Graduate program Accreditation (please select one): APA
CACREP

Total years of post-degree clinical experience:_____
Total years providing transaffirmative therapy:_____

How many clients do you see on average per week?_____

Of these, how many are TNB?_____

Please describe your current clinical setting:
_____

What sort of training have you receive for working with TNB clients prior to licensure?
_____

What sort of training have you have received for working with TNB clients since you were licensed?
_____

How would you rate the level of training and preparation you received during graduate school to conduct trans-affirmative psychotherapy?

1	2	3	4	5	6	7
Not prepared			Neutral			Highly prepared

How would you rate the level of training and preparation you've received from supervisors to conduct trans-affirmative psychotherapy?

1	2	3	4	5	6	7
Not prepared			Neutral			Highly prepared

- *Convenient times you can be reached by phone during the next few weeks (please indicate if you plan to be away in the next few weeks):*

Days/Evenings	Time (**please indicate time zone**)
_____	_____
_____	_____
_____	_____
_____	_____

THE INFORMATION YOU PROVIDE HERE WILL BE SECURED BY THE PRIMARY RESEARCHER AND WILL NOT BE RELEASED IN THE DATA SET. ANY MANUSCRIPT ARISING FROM THIS STUDY WILL PRESENT SUCH DATA ONLY IN AGGREGATE FORM.

_____ Please indicate the address to which the results may be sent in 12-18 months.

APPENDIX B

INTERVIEW PROTOCOL

Trans-Affirmative Psychotherapy Project

Thank you for your interest in our study of trans-affirmative counseling and psychotherapy practice. We are grateful for your insights and contributions to this project. Just as a brief overview, the interview questions will explore your clinical work with trans clients, as well as your training to work with such clients. For a portion of the interview, you will be asked to reflect on your work with a former or current client that exemplifies trans-affirmative therapy.

As a reminder, the following are the participant eligibility requirements: *Eligible participants will be a) practicing counselor or psychologist whose post-licensure practice has included work with at least 20+ trans or nonbinary clients, b) licensed, c) graduates of an APA-accredited clinical psychology, counseling psychology graduate program or CACREP-accredited counseling program, d) nominated as an exemplar psychotherapist by at least one member of an expert nomination panel (e.g., individuals who have published or presented widely on issues related to counseling with transgender individuals or have extensive knowledge of psychological services with trans clients), and finally, e) identify oneself as a trans-affirmative psychologist or counselor. Additionally, if not conducting clinical work full-time, participants must be seeing clients in a psychotherapeutic capacity, at least quarter-time (e.g., ~ 8-10 hours weekly or 40 hours monthly).*

Opening question

1. Why did you decide to commit some of your professional practice to working with TNB clients?

General Trans-Affirmative Therapy Questions

2. What training or experiences helped prepare you to work with TNB clients?

3. Please describe how theory informs your trans-affirmative therapy practice.

Case Specific Trans-Affirmative Therapy Questions

4. For the following questions, please recall a specific client with whom you've worked on TNB concerns.

    a. Please describe intake with this client.
    b. Please describe the assessment process with this client
    c. How did you approach the beginning of therapy with this client?
    d. How did you develop a working alliance with this client?

e. How did you approach the end of therapy with this client? Any specific considerations for termination?

f. How did culture inform the nature of your therapeutic work with this client?

g. What challenges/barriers did you encounter in conducting trans-affirmative counseling with this client?

h. What supported or facilitated trans-affirmative therapy with this client?

i. How was your therapy with this client a) similar to and b) different from your work with non-trans clients?

Closing Questions

5. How has providing trans-affirmative therapy influenced your clinical practice?

6. How has providing trans-affirmative therapy affected you?

7. What advice would you give trainee clinicians to better serve TNB clients affirmatively?

8. Why did you choose to participate in this study?

9. How are you feeling as our interview comes to a close?

APPENDIX C

CONSENT FORM

Trans-Affirmative Psychotherapy Study
Marquette University Agreement of Consent for Research Participants

When I sign this statement, I am giving consent to the following basic considerations:

I understand that the purpose of this research study titled, "A Study of Exemplar Trans-Affirmative Psychotherapists: A Consensual Qualitative Research Study" is to examine the experiences of trans-affirming counselors and psychologists. I understand that the study takes place in one digitally recorded telephone or in-person interview, lasting approximately 1.5 hours in total. I also understand that there will be approximately 8 to 14 participants in this study.

I understand that the interview involves a discussion of my experiences with transaffirmative counseling, and I understand that I will also be asked to complete a brief demographic form.

I understand that all information I reveal in this study will be kept confidential. All of my data will be assigned an arbitrary code number rather than using my name or other information that could identify me as an individual. I understand that Dr. Alan W. Burkard (Dissertation Advisor) will retain a file linking my name to the code number for the duration of the data analysis in a password-protected computer file, and that this file will be deleted when the data analysis is completed. If the results of the study are published, I will not be identified by name. I understand that de-identified individual quotations may be used in the publication, and that pseudonyms will only be used in connection with any such excerpts. I understand the data will be destroyed by shredding paper documents three years after the completion of the study, and that electronic recordings will be deleted after the completion of the study. Finally, I understand that de-identified electronic transcripts will be kept indefinitely.

I understand that the risks associated with participation in this study are minimal but may include some minor discomfort when talking about my experiences of counseling trans and nonbinary individuals. I also understand that my participation may inform the profession's understanding of challenges and areas of needed improvement in the training and supervision of transaffirmative counselors. I understand that participating in this study is completely voluntary and that I may stop participating in the study at any time without penalty or loss of benefits to which I am otherwise entitled. I understand that by participating in this study I will be compensated for my time receiving $15 dollars either to be given directly to me on a Visa gift card, or alternatively, donated to a trans organization or initiative of my choice. I understand that all data collected prior to my

terminating participation in the study will be destroyed. I also understand that I may skip any question during the interview.

All of my questions about this study have been answered to my satisfaction. I understand that if I later have additional questions concerning this project, I can contact Alan Burkard, Ph.D. at XXX-XXX-XXXX or xxxxx@marquette.edu. Additional information about my rights as a research participant can be obtained from Marquette University's Office of Research Compliance at XXX-XXX-XXXX.

_____ Date:_____
(signature of person giving consent)

_____ Date:_____
(signature of researcher) Location: Marquette University

APPENDIX D

EMAIL TO PROSPECTIVE NOMINATORS OR PARTICIPANTS

Trans-Affirmative Psychotherapy Project
**Link to Qualtrics Nomination*

Dear XXXXX,

Based on your expertise and professional reputation, you have been identified as an individual with valuable insight regarding trans-affirmative counseling practice. I would like to request your assistance with a consensual qualitative research study. Our goal is to identify psychologists and counselors who are exemplar trans-affirmative clinicians and who have practiced extensively with trans and nonbinary (TNB) individuals. For this study, trans affirmative counseling or practice is defined as: "[…] counseling that is culturally relevant and responsive to transgender or gender nonconforming (TGNC) clients and their multiple social identities, address the influence of social inequities on the lives of TGNC clients, enhances TGNC client resilience and coping, advocates to reduce systemic barriers to TGNC mental and physical health, and leverages TGNC client strengths" (Singh & dickey, 2018).

I ask that you nominate psychologists and/or counselors whom you believe are highly skilled at trans-affirmative counseling and whom you would recommend to a trans individual seeking counseling services. You may nominate yourself and as many other clinicians as you wish, meeting the following eligibility criteria:

Eligible participants will be a) practicing counselor or psychologist whose post-licensure practice has included work with at least 20+ trans or nonbinary clients, b) licensed, c) graduates of an APA-accredited clinical psychology or counseling psychology graduate program or CACREP-accredited counseling program, and d) nominated as an exemplar psychotherapist by at least one member of a nomination panel (e.g., individuals who have published or presented widely on issues related to counseling with transgender individuals and/or have extensive knowledge regarding work with trans clients), and finally, e) identify oneself as a trans-affirmative psychologist or counselor. Additionally, if not conducting clinical work full-time, participants must be seeing clients in a psychotherapeutic capacity, at least quarter-time (e.g., ~ 8-10 hours weekly or 40 hours monthly).

Please include an email address for each nominee (or for yourself if applicable). Participants who are nominated will be asked to complete a 60- to 90-minute phone interview about their practice with TGNC clients. Informed consent will be provided and available on the Qualtrics platform for ease of completion. Your response to materials will be kept confidential. Nominees will not be informed of who nominated them.

Participants in this study will be compensated $15 for their contribution and the amount can either be given directly to them on a Visa gift card, or alternatively, can be donated to a trans organization or initiative of their choice.

Thank you for taking the time to contribute to this study. Please contact me if you have any questions.

Additional questions, concerns, or inquires may be directed to my advisor, Dr. Alan Burkard by email at xxxxx@marquette.edu

Thank you for your consideration,

Shannon Skaistis, M.S.
Doctoral Candidate
Department of Counselor Education and Counseling Psychology
Marquette University
Schroeder Health & Education Complex
560 N. 16th St.
Milwaukee, WI 53233
xxxxx@marquette.edu

APPENDIX E

EMAIL TO PROSPECTIVE PARTICIPANTS

Link to Qualtrics Nomination
Trans-Affirmative Psychotherapy Project

Dear XXXXX,

Recently, you were identified by one or more individuals from a nomination panel (individuals who publish widely on trans-affirmative psychotherapy and/or work extensively with trans individuals in clinical settings) as an exemplar trans-affirmative clinician. These nominators identified you as a highly skilled clinician working with trans and nonbinary clients and someone they would recommend to a trans individual seeking counseling services. As a result, we are requesting your participation in our study to understand how you engage in trans-affirmative psychotherapy . We are hoping that you are willing to give approximately 1.5 hours of your time to share some of your experience in this important area. Let us provide you will some preliminary details on the criteria and method for the study.

For this study, eligible participants will be practicing counselors or psychologists whose post-licensure practice has included work with at least 20+ trans and nonbinary (TNB) clients, and who are graduates of an APA-accredited clinical psychology or counseling psychology graduate program or a CACREP-accredited counseling program. They must also be licensed mental health providers, and must identify as a trans-affirmative psychologist or counselor. Trans-affirmative counseling or practice is defined as: "[…] counseling that is culturally relevant and responsive to TGNC clients and their multiple social identities, address the influence of social inequities on the lives of TGNC clients, enhances TGNC client resilience and coping, advocates to reduce systemic barriers to TGNC mental and physical health, and leverages TGNC client strengths" (Singh & dickey, 2018). Lastly, if not conducting clinical work full-time, they must be seeing clients in a psychotherapeutic capacity, at least quarter-time (e.g., ~ 8-10 hours weekly or 40 hours monthly).

Participation in this study involves one audio recorded telephone interview that will take approximately 1.5 hours to complete. The interview will focus on general training and theory that informs your practice, as well as reflection on a specific TNB client you've worked with and the course of that psychotherapy. The recording, as well as the resulting transcript and data, will be assigned a code number so that you cannot personally be identified. After transcription, all recordings will be erased. The study was reviewed and approved by the institutional review board at Marquette University.

We hope that you will participate in this important investigation, as we believe that understanding how you engage in trans-affirmative psychotherapy will help in the training and continuing education of trans-affirmative clinicians. You will be

compensated $15 for your time, and the amount can either be given directly to you on a Visa gift card, or alternatively, can be donated to a trans organization or initiative of their choice.

If you choose to participate, please follow this Qualtrics Link [*link*] to complete the Consent and Demographic forms. Here you will also find the description of the study and complete eligibility criteria, in addition to the option to nominate other trans-affirmative clinicians. In completing these forms, you be asked to provide dates and times when you would be available for an interview. You will then be contacted to schedule the interview.

Thank you for taking the time to review the aims of our study and giving your consideration to participate in this study. Your input will contribute to providing recommendations for trans-affirmative counseling practices. Please contact me if you have any questions.

Additional questions, concerns, or inquires may be directed to my doctoral advisor, Dr. Alan Burkard, by email at xxxxx@marquette.edu

Thank you for your consideration,

Shannon Skaistis, M.S.
Doctoral Candidate
Department of Counselor Education and Counseling Psychology
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560 N. 16th St.
Milwaukee, WI 53233
xxxxx@marquette.edu

APPENDIX F

COMPENSATION DESIGNATION

Trans Affirmative Psychotherapy Project

Thank you for participating in this study on trans-affirmative psychotherapy. You will be compensated $15.00 for your participation. This amount can either be given directly to you on a Visa gift card, or alternatively, can be donated to a trans organization or initiative of your choice. Please indicate your preference below:

I would like my $15 compensation to be:

1. Given to me via a Visa gift card: _____

2. Given to one of the organizations below (select one):

    Sylvia Rivera Law Project (https://srlp.org) _____

    The Okra Project (https://www.theokraproject.com) _____

    The National Queer and Trans Therapists of Color Network Therapy Fund (https://www.nqttcn.com/mentalhealthfund) _____

3. Initiative of my choice: _____