

UNIVERSITY OF CALIFORNIA

Santa Barbara

Effects of Therapists Affirming and Non-affirming Reactions to Transgender Identity

Exploration on The Therapeutic Relationship: An Analogue Study

A dissertation submitted in partial satisfaction of the  
requirements for the degree Doctor of Philosophy  
in Counseling, Clinical, and School Psychology

by

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September 2016

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Effects of Therapists Affirming and Non-affirming Reactions to Transgender Identity

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by

Jennifer (Jay) N. Bettergarcia

## DEDICATION

This dissertation is dedicated to my curious, silly, and thoughtful daughter,

Arabella Lydia Bettergarcia,

who fills my heart with so much joy, laughter, and love each and every day.

I hope you always know how special you are

and that you too, can reach for the stars.

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## ABSTRACT

Effects of Therapists Affirming and Non-affirming Reactions to Transgender Identity

Exploration on The Therapeutic Relationship: An Analogue Study

by

Jennifer (Jay) N. Bettergarcia

Transgender individuals seek mental health counseling for a variety of reasons (Bockting, Knudson, & Goldberg, 2006). However, their experiences in therapy are not always positive, and some experiences are quite negative (Rachlin, 2002). The present study utilizes an analogue research design and video vignettes to investigate how a therapist's response to transgender identity exploration affects participants' perceptions of the therapist and the therapeutic relationship. The study utilized a series of mock therapy video vignettes that vary the way that a therapist responds to the client including transition affirming, non-binary affirming, and non-affirming responses. Transgender participants were asked about their plan to transition or not transition and were then randomly assigned to watch one of three mock therapy clips. Participants then completed a series of questions about their perception of the therapist's expertness, likability, trustworthiness, the session smoothness and depth, and their own feelings of positivity, and arousal. Results indicate that the non-affirming video condition had a significant negative effect on the participant's perceptions of the therapist and the quality of the therapeutic relationship. No significant differences were found between the transition affirming and non-binary affirming conditions. However, there was a trend for those who were not interested in transitioning to rate the non-binary affirming video more positively than the transition affirming video and those who were interested in transitioning to rate the non-binary affirming video slightly less positively than the transition

affirming video. This study provides a more nuanced understanding of the ways in which transgender individuals experience various affirming and non-affirming therapeutic approaches and how these perceptions may be different based on the participants plan to transition or not transition.

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## Chapter I: Introduction and Rationale

Transgender<sup>1</sup> individuals seek mental health counseling for a variety of reasons (Bockting, Knudson, & Goldberg, 2006). In addition to seeking services for general mental health and wellness, transgender individuals may also seek services for gender identity related concerns. For some, this can include talking about the possibility and the process of transitioning medically (e.g., genital surgery, hormones, etc.) and/or socially (e.g., change of name, pronouns, style of dress, etc.), from their birth-assigned gender to some other gender identity, while others choose not to take steps that would feminize or masculinize their body or appearance. For those who do want to transition medically, the Standards of Care (SOC) explain that mental health professionals evaluate, prepare, and refer clients for hormone therapy, chest surgery, or genital surgery (Coleman, et al., 2012). Indeed, transgender people may have specific experiences with therapists because of their<sup>2</sup> transgender identity, including the need for a letter of support if they seek to transition medically, exploration of gender identity, minority stress concerns, or coping with stigma related to one's transgender identity. In other cases, their desire to seek therapy may be unrelated to their gender identity, or tangentially related. Thus, transgender individuals may access counseling services for a number reasons, including both gender-related and non-gender-related concerns.

However, transgender individuals' experiences of therapy are not always positive, and some individuals have quite negative experiences (Rachlin, 2002; Shipherd, Green, &

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<sup>1</sup> The word transgender is used as an umbrella term throughout the study to include people across the transgender spectrum who identify as part of a binary gender category (i.e., man and woman) as well as those who do not identify with binary gender categories (i.e., non-binary, genderqueer, agender, bigender, etc.). This includes people who are interested in transitioning socially or medically as well as those who are not interested in transitioning or interested specific parts of a transition.

<sup>2</sup> The singular "they" and "their" are used throughout as a gender-neutral alternative to the pronouns he or she.

Abramovitz, 2010). Transgender clients have identified numerous factors that were unhelpful in therapy, including having to teach therapists about transgender issues and clinicians not knowing the difference between sexual orientation and gender identity (Benson, 2013). Additionally, there are concerns about being misunderstood and stereotyped because of the lack of education that therapists have about transgender issues (Benson, 2013). Indeed, few therapists receive training regarding transgender issues and most are not well equipped to work with transgender clients (Benson, 2013). Without research, training, and guidance regarding the complexity of experiences transgender people have in therapy, therapists are left with their assumptions, biases, stereotypes, and best guesses about how to work effectively with transgender clients. Given the vulnerability of this population, it is critical that clinicians have the training and guidance needed to provide transgender-affirming services, especially with a community that is often stigmatized, marginalized, and misunderstood (Shipherd, et. al., 2010).

Guidance does exist to help clinicians provide an affirming therapeutic approach that helps transgender clients in the process of transitioning from their birth-assigned gender identity toward their current gender identity (ALGBTIC, 2010; Coleman, et al., 2012). Indeed, various resources exist that help guide clinicians in their work with transgender clients who want to transition. The World Professional Association for Transgender Health (WPATH), American Psychological Association (APA), and the American Counseling Association (ACA) all provide competencies and standards of care (respectively) for mental health professionals working with transgender individuals (APA, 2015; ALGBTIC, 2010; Coleman, et al., 2012). These standards are meant to provide therapists with guidelines to help aid in the delivery of appropriate services for transgender clients, especially those who

want to transition. Although the research regarding transgender mental health services is still limited, there are recommendations and “best practices” throughout the literature based on both clinical experiences and some research.

However, transgender individuals do not always want a medical transition that includes hormonal or surgical procedures (Factor & Rothblum, 2008). Some individuals may not identify with binary gender categories of man and woman, and instead identify somewhere in between or outside of a binary understanding of gender. Some of these individuals may not be interested in transitioning socially, hormonally, or surgically, while others may be interested in transitioning socially but not interested in transitioning medically (Factor & Rothblum, 2008a). Although guidelines and recommendations aid clinicians in supporting transgender individuals, the approach tends to focus on assisting clients through the identity development process toward an expected transition process (Riley, Wong, & Sitharthan, 2011). The movement toward transgender affirming therapy, as a whole, has been beneficial to client’s seeking services, and yet, these models of understanding and working with transgender clients may not be well-suited for those who identify as non-binary or do not want to transition medically. Given the heterogeneity of the transgender community and the dominant narrative toward binary identity and transitioning, the recommendations may fall short when guiding clinicians to provide overall affirming therapy to all transgender clients, especially for those who do not fit the dominant paradigm. Transgender individuals are diverse in their desire for hormones and surgery and it is important that therapists understand the process of transitioning, for those who are interested, but also the various paths to relieving gender discomfort or dysphoria that do not include a medical transition.

Given the lack of research regarding best practices for counseling transgender clients

and a reliance on a transition-affirming model, it is unclear how accurate or adequate the competencies and standards of care are for working with transgender individuals who are diverse in their plan to transition or not to transition. Similar to the critique of the multicultural counseling competence (MCC) movement's lack of empirical evidence to identify, validate, and then measure multicultural competence (Atkinson & Israel, 2003), the guidelines for counseling practices with transgender clients have encountered a similar dilemma given the dearth of research guiding the development of these competencies. Additional research regarding transgender individuals and their interactions with therapists can provide a more inclusive and nuanced understanding of transgender people's experiences in therapy. Although guidelines and recommendations exist and provide clinicians with some direction in their work with transgender clients, research regarding the development of affirming therapeutic relationships with transgender clients is still lacking. Various scholars have indicated the need for additional research that focuses on mental health services with transgender individuals, specifically for those who identify as genderqueer, gender non-conforming, non-binary, or do not want to transition (Lennon & Mistler, 2010; Riley, Wong, & Sitharthan, 2011). Without such research, there is no way of knowing if the recommendations that are currently available are actually guiding therapists toward an affirming therapeutic approach for all transgender clients, especially those who do not fit the dominant paradigm. This is particularly important throughout the process of developing, nurturing, and repairing the therapeutic relationship.

It is still unclear how a therapist's response to a client's transgender identity may affect the client's perception of the therapist, comfort in therapy, willingness to engage in therapy, and the overall quality of the therapeutic relationship. Arguably, one of the most

important factors in therapy is the therapeutic relationship. The Task Force on Evidence-Based Therapy Relationships reviewed several meta-analytic studies regarding therapeutic relationships and released several suggestions for research and practice. The task force explains that treatment guidelines should address therapist's behaviors that facilitate the therapeutic relationship explicitly (Norcross & Wampold, 2011). Further, the therapeutic relationship should be tailored to specific clients such that the client characteristics and diagnosis are taken into account to enhance the relationship and the effectiveness of therapy (Norcross & Wampold, 2011). The proposed study seeks to address both of these recommendations with transgender clients by focusing on the interaction between the specific therapists' behaviors (i.e., transition-affirming, non-binary affirming, or non-affirming) and the client characteristics (plan to transition/have transitioned or no plan to transition) that may affect how the therapists' reactions are viewed and understood by the client, which may facilitate or impede the development of the therapeutic relationship.

### **Research Question and Hypothesis**

In this study, I investigate how therapist responses to transgender identity exploration affect the therapeutic relationship. An analogue research design was used to assess transgender participants' perceptions of the therapists' responses to a transgender client in a mock therapy session. In particular, the study focused on transgender participants' perceptions of (a) therapist attractiveness (i.e., likability), (b) therapist trustworthiness, (c) therapist expertise, (d) session depth (e) session smoothness, (f) participant's positivity, and (g) participant's arousal (i.e., feel energized as opposed to relaxed). The study was guided by the following two major research questions:

- 1) How does a therapist's response to a transgender client affect a

transgender participant's perceptions of the therapist and treatment?

- 2) How does the transgender participants' plan to transition or not transition affect their perception of the therapist's response?

This study examined three therapist responses: (1) affirming the client toward transitioning (transition affirming), (2) affirming a non-binary identity (non-binary affirming), and (3) not affirming the client's transgender identity (non-affirming). Further, this study also sought to explore the role of the transgender participant's plan to transition or not transition as it affected their perception of the therapist response.

### *Hypotheses*

The study tested the following hypotheses:

- 1) There will be a main effect of therapeutic focus, such that the therapeutic relationship will be rated higher for the transition affirming and non-binary affirming conditions as compared to the non-affirming condition.
- 2) There will be an interaction between the therapist response (i.e., transition affirming or non-binary affirming) and the participants transition plan (i.e., have transitioned/plan to transition or no plan to transition) such that the therapeutic relationship will be rated higher when there is a match between the therapist approach and the participant's transition plan (i.e., transition affirming response matches plan to transition and non-binary affirming response matches no plan to transition).
- 3) There will be a significant difference between un-matched groups (i.e., transition affirming condition does not match participants plan not to transition OR non-binary condition does not match with participants plan to transition) such that those who do not plan to transition who view the transition affirming condition will rate the

therapeutic relationship less favorably than those who plan to transition who view the non-binary affirming condition.

## **Chapter II: Review of the Literature**

### **Understanding Gender Diversity**

Understanding gender identity, transgender identity, and non-binary identities is a key component of providing transgender-affirming competent care (Goldberg, 2006), which is at least one part of developing cultural competence with this population (Hendricks & Testa, 2012). This may challenge clinicians to step outside of their understanding of gender identity to include non-binary identities, space for ambiguity, and a reexamination of assumptions, biases, and one's own gender paradigm (Hendricks & Testa, 2012). Some of the core competencies for at least one training model (Goldberg, 2006) include building knowledge, awareness, and sensitivity about transgender identity and transgenderism. For example, within this training model, knowledge about the differences between sex, gender identity, and sexual orientation is one of the most basic competencies that is central to transgender affirming clinical training (Goldberg, 2006). Further, knowledge about non-cisgender, non-binary identities and the diversity of experiences of gender identity, gender expression, and gender presentation are important for working with transgender clients, which may challenge one's assumptions about both sex and gender (Benson, 2013). Research with transgender clients supports these recommendations, with clients explaining that the helpful therapists they had seen were "well-informed" and that they "would only really go to a therapist if I knew they were GLBT-friendly or specializing in it now", explaining that, "the ones that I worked with knew what they were talking about, and they've had other clients that were transgendered before" (Benson, 2013, p. 31-32).

The spectrum of experiences faced by transgender people is vast, and the trajectories vary based on gender identity, individual differences, phase of life, and a variety of other

factors. It is often assumed that the transgender community is a homogenous population, when in reality there are vast differences in identity, gender presentation, or desire for a social or medical transition (Riley, Wong, & Sitharthan, 2011). For example, terminology within the transgender community varies widely. The *transgender umbrella* is often referred to as a way to understand terminology used by those who identify with a gender other than the one assigned at birth (Riely, Wong, & Sitharthan, 2011). This may include those who identify as transgender, but also those who identify as transsexual, transgenderist, non-binary, genderqueer, cross dresser, or some other label that indicates some form of gender variance, a shift in one's gender identity, or nontraditional gender identity (Bockting, 2009; Carroll, Gilroy, & Ryan, 2002). Although some people may identify with a binary gender category (female, male, transgender female, transgender male), some people do not subscribe to a binary structure or understanding of gender and instead may identify as neither male nor female, both male and female, or some other combination of gendered identities (Hendricks & Testa, 2012). Identity labels within the transgender community are just as diverse as the desire to have or not have various types of medical interventions in order to feminize or masculinize the body. The desire to have limited or no medical intervention is especially prevalent among those who identify on a spectrum between female and male, or outside of the categories male and female, though it is not uncommon for those who identify within binary gender categories to also choose not to transition medically (Riley, Wong, Sitharthan, 2011).

Interestingly, one study found that of the participants sampled, 88% of male-to-female (MTF) and 76% of female-to-male (FTM) transgender-identified individuals reported taking hormones at the time of the study (Factor & Rothblum, 2008a). For genderqueer

participants, approximately one-third reported taking hormones at the time of the study and one-fifth reported no interest in ever taking hormones to feminize or masculinize their body (Factor & Rothblum, 2008a). Further, although some transgender individuals are interested in pursuing genital surgery to align their body with their gender identity, many are not interested. Of those sampled, 14% of MTFs, 31% of FTMs, and 64% of genderqueer identified people were not interested in genital surgery. Thus, the trajectory of experiences for transgender identified people do not always include hormones or surgical procedures, in fact, many do not even want a medical intervention of this sort. Some individuals may indicate that they are pre-op (before a surgical transition or transitions), post-op (after gender confirmation surgery or surgeries), or non-op (no desire for surgical transitions), though many may not use this language.

Given that transgender individuals are diverse in their desire for hormones or surgery, it would seem important for therapists to understand the process of transitioning, for those who are interested, but also the various paths to relieving gender discomfort or dysphoria that do not include medical interventions or the need for a letter of support. Although some clients may want or need a letter from a therapist to move forward with some aspects of their transition, it is important to note that this is not the only trajectory or the only way to move forward with one's identity as a transgender person, as evidenced by the statistics presented above.

### **History of Transgender Experiences with Mental Health**

There are often two different models that are used to understand transgender identity: the *transsexual model* and the *transgender model* (Kozee, Tylka, & Brauerband, 2012). The transsexual model focuses primarily on binary identity and the desire to transition. This

model seems to suggest that distress caused by gender identity concerns can be “fixed” or “cured” through medical interventions. It has been argued that this approach to understanding gender identity is pathologizing because it assumes that something is inherently “wrong” and a medical intervention can fix it (Kozee, Tylka, & Brauerband, 2012). The transgender model, on the other hand, focuses on affirming transgender identity and conceptualizes gender identity as a widely varying dimension. This model is a more affirming approach that provides a spectrum of options and does not limit its focus to gender confirmation surgery as a cure or a goal for all transgender people (Kozee, Tylka, & Brauerband, 2012).

Over the years, the field of transgender health care, including mental health care, has moved from a disease-based model of transgender and transsexual identity to an identity-based model (Bockting, 2009). The disease-based model of transsexual and transvestite identity dominated the clinical and medical landscape until fairly recently. For those who didn’t feel their sex as assigned at birth matched their gender identity, health care professionals first tried to help people become more comfortable with their birth assigned sex (Bockting, 2009). Then, in the 1950’s and 1960’s there was a movement toward helping “true transsexuals” to change their sex through gender confirmation surgeries (also known as sex reassignment surgery, or SRS) and hormone replacement therapy (HRT). True transsexuals were thought to be in the “wrong body” which meant that changing one’s body through hormones and surgery was the cure. Conversely, those who thought to be transvestites (i.e., thought to be paraphilic compulsive cross-dressers seeking sexual arousal) were not allowed to receive gender confirmation surgeries and instead were encouraged to contain their cross-dressing behaviors (Bockting, 2009). Both were considered mental

disorders as classified in the Diagnostic and Statistical Manual (DSM; American Psychiatric Association, 1980).

Often, the goal for “true transsexuals” was to “pass” as a person of the “other sex” and not be seen as a transsexual person (Bockting, 2009). However, although some people can pass through hormones, self-presentation, and surgeries, some people do not “pass” (Carroll, Gilroy, & Ryan, 2002). A movement toward self-actualizing a transgender identity began to alter how people conceptualized gender identity, the gender binary, and transsexual identity. People began coming out as full-time cross dressers who didn’t want genital surgery, calling themselves transgenderist (Bockting, 2009). During this time some of the transsexuals who had previously transitioned began to gravitate toward self-actualizing their transgender identities, often coming out as transgender and looking for others with whom they felt a sense of belonging— other transgender people (Bockting, 2009).

Since the 1980’s the field has moved away from this disease-based model, or a belief that something went wrong during development and must be corrected via a medical transition. Instead, transgender health care has moved toward an identity-based model in which clinicians facilitate the acceptance and coming out process and social stigma is understood to be the culprit of mental health concerns (Bockting, 2009). Transgender activists have called for a movement toward coming out as transgender and identifying as transgender as opposed to “passing.” Increasingly, we see more people coming to identify their gender identity as something outside of the gender binary and outside of the categories man and woman (Bockting, 2009; Bornstein, 1994).

### **Sources of Guidance for Psychotherapy with Transgender Clients**

Much like the multicultural counseling competence (MCC) movement that started in the late 1970s and early 1980s (Atkinson & Israel, 2003) counseling competencies for working with LGBTQ clients have grown rapidly over the past decade. Competencies for counseling transgender clients, in particular, have developed even more recently (ALGBTIC, 2010). The World Professional Association for Transgender Health (WPATH), the American Psychological Association (APA), and the American Counseling Association (ACA), have released standards of care, guidelines, and competencies (respectively) for therapists working with transgender individuals (ALGBTIC, 2010; Coleman, et al., 2012). These recommendations and standards are meant to provide therapists with guidelines to help aid in the delivery of appropriate and affirming services for transgender clients.

However, given the lack of research regarding best practices for counseling clients on the transgender spectrum<sup>3</sup>, it is unclear how accurate or adequate the competencies and standards of care are of working with transgender clients. A lack of empirical evidence exists to first identify and then validate and measure the applicability of the guidelines for counseling practices with transgender clients. The following section includes an overview of the sources of the recommendations including those written by professional organizations, clinically derived from experience, and elucidated via research.

**Professional Organizations.** There are three main sources of recommendations that provide guidelines, standards of care, or competencies for working with transgender clients that are discussed. These include the World Professional Association for Transgender Health (Coleman, et al., 2012), the American Psychological Association (APA, 2015), and the

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<sup>3</sup> *Transgender spectrum* is used to refer to all people who fall under the transgender umbrella including those who identify as transgender, transsexual, gender non-binary, or otherwise differently gendered from their birth assigned gender (i.e., not cisgender).

American Counseling Associations (ALGBTIC, 2010). These organizations are each described below.

***World Professional Association for Transgender Health (WPATH).*** In 2012, version 7 of the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) were released (Coleman et al., 2012). The original SOC were developed in 1979 under the Harry Benjamin International Gender Dysphoria Association, which eventually became WPATH (Coleman et al., 2012). The standards of care are meant to “provide clinical guidance for health professionals to assist transsexual, transgender, and gender non-binary people with safe and effective pathways to achieving lasting personal comfort with their gendered selves, in order to maximize their overall health, psychological wellbeing, and self-fulfillment” (Coleman, et al., 2012, p. 165).

The WPATH guidelines for therapists explain that the competencies for working with gender dysphoric adults include, as its foundation, a general competence in assessment, diagnosis, and treatment of mental health concerns. Additionally, the WPATH standards of care recommend additional steps to develop cultural competence with transgender individuals, such as, developing knowledge about the transgender community, advocacy, and policy issues that may affect the lives of transgender clients (Coleman et al., 2012). Specifically, the SOC provide guidance regarding the main tasks of therapists when working with transgender clients, including assessment, referrals, and providing psychotherapy (Coleman, et al., 2012).

***American Counseling Association.*** In 2010, the American Counseling Association (ACA) released suggested competencies for counseling transgender clients (ALGBTIC, 2010). The competencies were developed with an explicit goal to conceptualize them through

a multicultural, social justice, and feminist lens as to be explicit about the role of power and privilege in the clients' lives. It is important to note that these were written to complement the WPATH standards and provide more specific guidelines for those in counseling, rather than replacing the WPATH standards. The Counsel for Accreditation of Counseling and Related Educational Programs (CACREP; 2009) standards serve as the organizational model for the ACA competencies for working LGBT clients, broadly, (AGLBTIC, 2013) and with transgender clients, specifically (ALGBTIC, 2010). The model and subsequent competencies are divided into eight domains that include a focus on human growth and development, social and cultural foundations, helping relationships, group work, professional orientation, career and lifestyle development competencies, appraisal, and research. Additionally, they incorporate a framework from multicultural counseling competencies that include the development of knowledge, skills, and awareness, (Sue, Arredondo, & McDavis, 1992) which was also used in the development of the LGBT competencies (AGLBTIC, 2013).

The ACA competencies for counseling with transgender clients were developed by a committee of people who work with, advocate for, or have relationships with transgender individuals (ALGBTIC, 2010). The authors stress the importance of using both empirical and theoretical literature to develop the competencies, however, given that the availability of research in this area is lacking, much of the information gathered comes primarily from theoretical or clinical work rather than empirical research.

***American Psychological Association.*** In August of 2015, the American Psychological Association (APA) released Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. The stated purpose for the creation of the guidelines was to, “assist psychologists in the provision of culturally competent,

developmentally appropriate, and trans-affirmative psychological practice with TGNC people” (APA, 2015). The guidelines are intentionally aspirational in nature and meant to be used in tandem with other ethical principles, standards of care, and other transgender counseling recommendations. The APA guidelines define trans-affirmative practice as, “...the provision of care that is respectful, aware, and supportive of the identities and life experiences of TGNC people” (APA, 2015). There are 16 guidelines that are organized into five main groups, including, foundational knowledge and awareness; stigma, discrimination, and barriers to care; lifespan development; assessment, therapy, and intervention; and research, education, and training. Over the five years since the release of the ACA competencies (ALGBTIC, 2010) there has been a huge increase in the number of scholarly publications on transgender-related topics. However, this is still a relatively new and emerging area with limited peer-reviewed studies to guide the development of the guidelines. As with most of the guidelines and recommendations, the authors of the APA guidelines sought to include research when possible, but also noted that it was necessary to fill in the remaining gaps with books, reports, and other relevant anecdotal information from transgender individuals or clinicians who work with transgender clients (APA, 2015).

**Clinically derived recommendations.** A great deal of the rich knowledge about working with transgender clients has been derived directly from the experiences of clinicians who have experience working with transgender clients. These books and articles often provide case examples to help elucidate their insights about working with this population. A number of the articles provide general recommendations (see Carroll, Gilroy, & Ryan, 2002; Korell & Lorah, 2007; Lev, 2009; Raj, 2002), while others help to translate the competencies and guidelines into practice, either generally, or for a specific sub-group (Fraser, 2009;

Gonzalez & McNulty, 2010; Lennon & Mistler, 2010; Singh & Burnes, 2010; Singh, Boyd, & Whitman, 2010). Further, some articles provide guidelines that are not included in the ACA competencies or WAPTH standards of care, but are still relevant to counseling transgender people (Carroll, Gilroy, & Ryan, 2002).

A number of articles focus entirely on specific subgroups within the transgender community such as transgender adolescents and youth (Gonzalez & McNulty, 2010; Holman & Goldberg, 2006; Stieglitz, 2010), college students (Lennon & Mistler, 2010), prison populations (Alexander & Meshelemiah, 2010), or gender variant clients who do not fit the traditional transgender or transsexual paradigm (Riley, Wong, & Sitharthan, 2011). These specific sub-population articles and chapters are most helpful for therapists working in specialized settings or those who need additional guidance when working with a target population within the transgender community. For example, there are some specific concerns around career issues for transgender clients, including workplace microaggressions (Sangganjanavanich & Cavazos, 2010), which require additional considerations such as an increased push toward creating social change and a movement toward being an advocate for a client. Transgender individuals may need support as they navigate the process of transitioning in the workplace, finding employment after transitioning, and dealing with discrimination and harassment (Pepper & Lorah, 2008). Specific knowledge, understanding, and guidance is needed to work with clients who may be struggling with specific issues that are not well outlined in general guidelines and competency documents. Thus, these articles provide additional guidance for clinicians who may be working with clients in specific contexts and find themselves in need of more specific information.

In addition to providing general guidance about working with transgender people and specific sub-groups or topics, there are also articles that provide guidance for utilizing specific psychotherapeutic interventions, theories, or practices with transgender clients. King (2012) writes about using a relational approach with transsexual clients wherein the therapeutic alliance is co-created and is an integral part of the therapeutic process. Livingstone (2008) focuses on a person-centered approach to working with transgender and transsexual clients in psychotherapy, including the use of empathy, affirmation, and relational depth. Gender role conflict theory has also been used as a framework for understanding and working with transgender clients in a therapeutic context (Wester, McDonough, White, Vogel, & Taylor, 2010). In addition to guidelines and experiences of working with transgender clients, there are also recommendations that focus on training therapists (Kalra, 2013) and other health care professionals (Goldberg, 2006).

**Research-based recommendations.** The information gleaned from research regarding counseling transgender spectrum client's focus largely on specific topics that affect the transgender community, often at higher rates, such as mental health and HIV, substance abuse, and discrimination (Grant, et. al., 2010). Beyond focusing on the problems and hardships transgender people may face, there is also a growing literature focusing on non-pathologizing (Benson, 2013), strength-based research, some of which looks at resilience within the transgender community (Kidd, Veltman, Gately, Chan, & Cohen, 2011; Singh, Hays, & Watson, 2011; Singh & McKleroy, 2011). Additionally, there are some studies that focus on transgender people's experiences of mental health services (Benson, 2013; Grant, et. al., 2010), barriers to mental health care (Shipherd, Green, & Abramovitz, 2010), and experiences with severe mental illness and psychiatric services (Kidd, et al., 2011).

Many of the research articles use qualitative methodology, including phenomenology (Benson, 2013; Singh, Hays, & Watson, 2011; Singh & McKleroy, 2011), case studies (Patton & Reicherzer, 2010; Smith, Shin, & Officer, 2011), or grounded theory methods (Kidd, et. al., 2011; Walinsky & Whitcomb, 2010). There are also some studies that utilize quantitative methodology such as surveys (Budge, Adelson & Howard, 2013; Shipherd, Green, & Abramovitz, 2010) or mixed method approaches (Hassmann, Morrison, & Russian, 2008). The following section provides additional information regarding the content of the recommendations and guidelines for transgender-affirming mental health care by looking at the reasons that transgender people seek therapy, overall experiences in therapy, and barriers to care.

### **Experiences of Transgender People In Therapy**

**Reasons for seeking psychotherapy.** Transgender clients seek therapy for a wide array of issues and topics as previously described. Although some transgender individuals may seek therapy to talk specifically about gender identity, gender dysphoria, or transitioning, many do not. Clients may seek mental health care for a variety of reasons that may have less to do with gender identity or transitioning, specifically, and more to do with their quality of life or severe mental illness (Benson 2013; Kidd, Veltman, Gately, Chan, & Cohen, 2011). Clinicians may interact with transgender clients for a variety of reasons including evaluation and treatment of gender identity concerns, evaluation and treatment planning for mental health concerns, psychotherapy for individuals, couples, or families, or for brief assessment, consultation, or referrals (Bockting, Knudson, & Goldberg, 2006). In a study of transgender people in British Columbia, approximately half of the participants indicated seeking counseling for gender identity related concerns (52%), a third indicated

seeking mental health services for an assessment in order to pursue hormones or surgery (32%), and over a third indicated that they sought therapy for issues that were not related to their gender identity (39%) (Goldberg, Matte, MacMillan, & Hudspith, 2003).

In a qualitative research study, participants explained the various reasons that they sought counseling, including both gender identity and quality of life concerns (Benson, 2013). Quality of life included overall well-being, relationship issues, and working through emotions (Benson, 2013). Some reported seeking therapy to work on anger issues, anxiety, depression, or other mental or emotional health issues, recognizing later that these may have been linked to their transgender identity (Benson, 2013). One client explained, “Transgendered individuals are going to come to a therapist and most of their issues have nothing to do, specifically, with being transgendered. 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). Even though many transgender clients seek mental health services for quality of life concerns, participants in this study also recognized that it was important for them to be able to talk about their gender identity when presenting with quality of life concerns. One participant noted, “I was very lucky because the person I went to knows about transgendered issues... I didn’t go to her because of transgender issues; I went to her for depression. I was just overwhelmed... and I knew that I couldn’t talk to a counselor about my depression and so forth if they weren’t aware about [my female identity] being a major part of my life” (Benson, 2013, p.28). Even though the client wasn’t focusing on gender identity concerns, it was still important to the client that the clinician was open to and aware of her transgender identity.

Transgender clients also seek services specifically for gender identity specific

concerns, including self-exploration of gender identity, coming out or talking to family and friends about gender identity (Benson, 2013), or a letter of support for surgery or hormone therapy (see Coleman et. al., 2012). For some, interactions with mental health care providers, specifically for a letter of support, can be a frustrating experience. One participant in an interview study explained, “I think it’s annoying that I have to go and convince somebody that I’m trans and have them write a letter” (Benson, 2013, p.28). Some clients may choose not to disclose a trauma history, for example, because of a lack of trust or the desire to receive a letter of support (Wharton, 2007). For others, the opportunity to prepare for the changes that hormones and surgery bring can be a positive and satisfying experience as was the case for a participant who noted, “I just recently went to a psychiatrist...about my hysterectomy, and they wanted to make sure that was right for me, and we both agreed that it was right for me to get it done and that I’m ready” (Benson, 2013, p. 28).

Transgender individuals may also seek therapeutic services for severe mental illness concerns. For those who identify as transgender and also live with severe mental illness, the experience of stigma is often interrelated and experienced for both identities (Kidd, et al., 2011). Therapy is often sought to manage symptoms of a severe mental illness either in inpatient or outpatient care, where their gender identity concerns may be attributed to their psychosis or delusional thoughts, whether or not this is actually the case (Mizock & Fleming, 2011).

**Overall experiences in therapy.** The experiences of transgender individuals in therapy can vary widely, though it is not uncommon for transgender individuals to have their identity challenged or negated by clinicians who lack the knowledge or skills to effectively work with transgender individuals (Riley, et al., 2011). In a focus-group study of transgender

people's experiences with health care, participants explained that they often have to educate their therapist about transgender issues (Sperber, Landers, & Lawrence, 2005). Participants also reported that therapists they had seen, in general, had a lack of experience with transgender adults and youth. Many of the participants explained that they had been disappointed with the mental health services they received (Sperber, Landers, & Lawrence, 2005). The lack of understanding about gender identity and transgender identity can be seen in quotes given by participants. One participant explained that his therapist asked, "Why didn't you just stay a woman?" while another trans-man reported hearing, "You are just a different kind of woman", leaving the participant feeling hurt and insulted (Spencer, Landers, & Lawrence, 2005, p. 82). Often, misgendering, or the use of non-preferred name and pronouns can leave the client feeling disrespected, uncomfortable, and unsafe (Israel, Gorcheva, Burnes, & Walther, 2008).

This frustration regarding the lack of experience that therapists have working with transgender issues was a common theme in another qualitative study. Participants explained that they believed that "therapists are not well-informed about transgender issues" (Benson, 2013, p. 29). This included conversations about therapists not being educated properly on transgender issues and complaints that therapists rely too much on transgender clients to spend time educating them about transgender people, issues, and topics, even though the client was the one paying for sessions (Benson, 2013). One participant explained, "I think most of them listen to the transgendered clients so that they can learn something about the issue. I think for the most part they don't know beans about what makes a transgendered person tick" (Benson, 2013, p. 30).

Further, participants expressed frustration and concerns that therapists do not know

the difference between sexual orientation and gender identity, or understand the diversity of experiences that transgender people face (Benson, 2013). Many participants expressed doubt that a cisgender therapist would understand them or help them and they worried about being misunderstood and stereotyped (Benson, 2013). One participant noted, “I just had therapists who have crazy, off-the-wall ideas and just did not really understand who I was or really taken the time to understand. They just want to apply a bunch of stuff to me... I’ve just had experiences where [therapists] just don’t seem to really care... they just seem preoccupied and they’re not even trying to understand me” (Benson, 2013, p. 29).

For those who live with severe mental illness the experiences they have with mental health care providers are often critical to their recovery (Kidd, et al., 2011). However, as one study found, the experiences of discrimination were quite common from providers and other clients with regard to one’s gender identity (Kidd, et al., 2011). Similar to other transgender individuals seeking therapy, participants expressed frustration when having to educate therapists about their gender identity, especially when experiencing strong emotional distress. One participant explained, “When you go into the unit you’re already sick enough, you wouldn’t be going into a unit if you weren’t. You don’t want to have to educate everybody.... you’re probably suicidal, you probably wish you were dead, and then you have to explain yourself all over again” (Kidd, et al., 2011).

**Barriers to mental health services.** Common barriers to seeking mental health services often include perceived stigma (Vogel, Wade, & Hackler, 2007), access to services (Mizock & Fleming, 2011), or the means to pay for services (Kenagy, 2005). For transgender individuals there can be additional barriers to seeking mental health care, including a clinicians’ lack of awareness regarding transgender issues (Benson, 2013; Kenagy, 2005,

Mizock & Fleming, 2011; Sperber, Landers, & Lawrence, 2005) as well as prejudice, discrimination, insensitivity, or hostility (Kenagy, 2005; Lombardi, 2009; Lombardi, Wluchins, Priesing, & Malouf, 2001). In a survey of transgender people's use of mental health services, the top two reasons given for not seeking services were cost and knowing someone who had a bad experience with therapy (Shipherd, Green, & Abramovitz, 2010). The authors explain that many of the barriers were not unique to gender identity concerns, including not wanting to talk about oneself, fear of their problems being part of their medical record, and not wanting to be seen as incompetent in dealing with one's own problems (Shipherd, Green, & Abramovitz, 2010). Though these are not necessarily specific to gender identity concerns, they may be heightened for transgender individuals who are even more worried about having to talk about themselves or their health records.

Many of the respondents reported having a past negative experience or knowing others who had bad experiences, however, it is unclear if it was because of insensitivity to transgender issues or something else (Shipherd, Green, & Abramovitz, 2010). Many of the participants who did seek therapy reported depression, anxiety, and relationship issues as reasons for seeking therapy— areas in which clinicians are often well versed and knowledgeable. For transgender people seeking therapy for something other than gender identity, clinicians can do a lot of good by taking steps to increase their cultural sensitivity, without needing extensive training regarding gender identity *specific* therapy (Shipherd, Green, & Abramovitz, 2010). However, for many transgender people, their identities and lived experiences may be hard to disentangle from their experience of anxiety, depression, or general emotional distress, so some level of knowledge, awareness, and skills are still necessary (Benson, 2013, Kidd, et al., 2011).

For people who identify as transgender and those who have a severe mental illness, the barriers to treatment are often compounded given the lack of access to resources individuals in either group often face (Mizock & Fleming, 2011). People with a severe mental illness tend to utilize familial support more often, yet those who identify as transgender may struggle with the lack of assistance and support from their families because of their gender identity (Mizock & Fleming, 2011).

Even when a transgender person is able to overcome the previously mentioned barriers to seeking treatment, there can also be issues of mistrust, skepticism, and a lack of openness with a clinician if they choose to participate in therapy (Benson, 2013). Given that clinicians are often in the role of “gatekeeper” some clients may choose not to be forthcoming about difficulties or actual struggles they are experiencing (Lev, 2004). This may be because they worry that talking about any of their actual struggles might impact their likelihood of receiving a letter from that therapist (Lev, 2004). Clients who present in therapy wanting a letter may seek to “prove” that they meet criteria for a letter (Lev, 2004). This barrier would seem to affect the quality of the therapeutic relationship, the openness of the client, and ability of the therapist to actually help support the client through any challenges, worries, difficulties, or emotional processing that the client may actually want or need.

**The therapeutic relationship with transgender clients.** Given what we know about transgender individuals’ barriers to seeking therapy and their experiences in therapy, the therapeutic relationship and working alliance would seem to be critical components to a successful therapeutic process and outcome. For example, research finds that the working alliance between a therapist and client seems to be more important for those who have less social support (Leibert, Smith, & Agaskar, 2011). Whereas those with higher levels of social

support improved regardless of their reported therapeutic alliance with the therapist, those with less social support improved faster when they reported having a better working alliance with the therapist (Leibert, Smith, & Agaskar, 2011). For transgender individuals who have limited social support from friends, community members, or family due to stigma or discrimination, the therapeutic alliance may be even more crucial to their positive therapeutic outcomes. In a phenomenological study of transsexuals in therapy, participant's experiences in therapy centered around fear and self-preservation, such that many suppressed their transgender identities in therapy (Scarpella, 2010). For the participants in the study, the conflict between self-preservation, desire or need to transition, and fear of the clinicians' power as gatekeeper created conflicts and challenges in their trust of the clinician and the therapeutic relationship (Scarpella, 2010).

**Willingness to seek or return to therapy.** Transgender individuals tend to be at higher risk for mental health concerns given the social stigma they encounter (Bockting, et al., 2013; Budge, Adelson, Howard, 2013; Kidd, et al., 2011; Mizock & Mueser, 2014; Nuttbrock, Rosenblum, & Blumenstein, 2002). Though there has been an increased focus on transgender affirming therapy, as noted above, transgender individuals do not always have positive perceptions of counseling and many have had negative experiences with mental health care (Benson, 2013; Sperber, Landers, & Lawrence, 2005). Given these negative perceptions and experiences, a person's willingness to either seek therapy or return to therapy may be compromised. Research suggests that those who have a positive attitude toward counseling, low levels of self-concealment, high distress, and low levels of social support are most likely to report a willingness to seek counseling services (Leech, 2007). Stigma is also linked to an individual's willingness to seek therapy. Using a structural equation model,

researchers found that perceived social stigma regarding the use of psychological services contributes to a person's self-stigma, which influences attitudes toward help-seeking, and finally, their willingness to seek mental health services (Vogel, Wade, & Hacker, 2007). Given what is known about transgender people's experiences in therapy, barriers to care, and willingness to seek treatment, the following section focuses on providing transgender-affirming therapy.

### **Transgender-Affirming and Non-affirming Therapy**

“A trans-affirmative approach necessitates that counselors affirm transgendered persons; advocate for political, social, and economic rights for the transgendered; and educate others about such issues (Carroll, Gilroy, Ryan, & 2002).”

Transgender-affirming therapy can include many affirming practices, but, generally speaking, it can be defined as, “...a therapeutic approach that adopts a positive view of transgender clients by respecting their self-defined identities and addresses the impact of a normative gender society on their lives” (Benson, 2013, p. 23). Clients report that helpful therapeutic encounters included those in which the therapist was knowledgeable about transgender issues, provided support through a transition, or were generally helpful and affirming (Israel, et al., 2008). Given the varied experiences of transgender and gender non-binary people in therapy and the varied recommendations in the literature regarding affirming care, the following is divided into four sections: overall affirming therapy, transition affirming therapy, non-binary affirming therapy, and non-affirming approaches. The transition affirming and non-binary affirming sections provide more detailed and nuanced understandings of the overarching affirming therapy approach while the non-affirming section provides information regarding both current and historic approaches that have been shown not to be helpful, and in some cases, to be harmful for transgender individuals.

Working with transgender clients requires an understanding of the transgender community, gender identity, and language concerns. The following recommendations focus on language, understanding gender diversity, and the various roles of therapists, which can be thought of as providing the building blocks for working with transgender clients in various situations, whether or not the client wants to focus on gender identity concerns, specifically.

**Language.** Language and pronoun use with transgender clients has been identified as being important, if not critical, in the process of providing transgender-affirming care. Therapists should also have a working understanding of the terminology used within the transgender community, which is constantly evolving and may differ by time and place (Benson, 2013; Carroll, Gilroy, & Ryan, 2002; Goldberg, 2006). It is important that people use the client's correct name, correct gender pronoun (Bockting, Knudson & Goldberg, 2006; Goldberg, 2006; Mizock & Fleming, 2011), and the gender identity label they identify with (see Factor & Rothblum, 2008a for research on transgender spectrum identity labels). Using the client's correct name and gender pronouns can help the client feel safe and comfortable in therapy (Israel, et al., 2008). There have also been recommendations for specific language changes to the Standards of Care, version 6, some of which were adopted for SOC version 7 (Lev, 2004) in an attempt to reduce pathologizing language. For example, the word patient was replaced with client, diagnosis was abandoned and replaced with assessment, and when appropriate, the use of gender identity disorder (GID) was replaced with terms such as gender dysphoria or gender concerns (Lev, 2004).

Additionally, it can also be important for therapists to focus on more than just the negative aspects of gender identity concerns, like gender dysphoria, but rather on the more positive experiences, such as gender euphoria, or the positive feelings associated with living

as one's identified gender, or true self (Benestad, 2010). This slight change in language might help to reframe and refocus both transgender individuals and their treatment providers from the more typical focus on the negative and painful experiences of dysphoria to the more positive feelings of euphoria and what is gained from becoming more congruent with one's gendered self (Benestad, 2010).

### **Role of Therapists.**

***Gender Dysphoria.*** The WPATH Standards of Care (Colman, et al., 2012) explain that, "*Gender dysphoria* refers to the discomfort or distress that is caused by a discrepancy between a person's gender identity and that person's sex assignment at birth and the associated gender role and/or primary and secondary sex characteristics" (Colman, et al., 2012, p. 168). Treatment for gender dysphoria is highly individualized and may or may not include masculinization or feminization of the body through hormones, surgery, and/or gender role changes (Coleman et al., 2012). The recommendation for health professionals regarding gender dysphoria includes affirming one's gender identity, exploring various ways and options for expressing gender identity, and assisting clients in making decisions about the various options, including medical, psychological, and social changes that may help alleviate the experience of gender dysphoria (Coleman, et al., 2012).

The SOC provide a more detailed outline of tasks and recommendations for therapists working with people who are experiencing gender dysphoria. First, it is recommended that an in-depth assessment of the person's gender identity, gender dysphoria, history of their dysphoria, general mental health, and social support be taken and used to inform the diagnosis or lack of diagnosis. Second, providing information about the various ways of alleviating gender dysphoria and the diversity of gendered experiences, expressions, and

identities is an important task of therapists that can help inform the client's decision to move forward with a medical and/or social transition, or no transition. Therapists also assess, diagnose, and treat the mental health needs of clients that may or may not be specifically associated with their gender identity. These concerns should be taken into account when creating the treatment plan with the client. Finally, the therapist can also assess and prepare a client for hormones and/or surgery when applicable (Colman, et al., 2012).

Given that therapists are tasked with assessment, it is important to note that in some instances it may be unclear if a person is experiencing some form of gender variance during a psychotic episode, without identifying as transgender when the episode has passed, or if they identify as transgender and are also having a psychotic episode (Mizock & Fleming, 2011). Based on four case study examples, Mizock and Fleming (2011) suggest some recommendations for the clinical care of those who simultaneously either have gender concerns or identify as transgender, while also being diagnosed with a serious mental illness (see Garret, 2004 for recommendations for the treatment of a transgender identified client with schizophrenia).

***Choosing to transition.*** It is important that therapists who work with clients wanting to transition have specialized knowledge and training given the vast array of gendered identities, gendered expressions, options for transitioning, and ways of alleviating gender dysphoria (Hendricks & Testa, 2012). The WPATH SOC explains that the alleviation of gender dysphoria may require surgery and hormones for some, just one of these options for others, while other transgender-identified clients choose neither of these (Colman, et al., 2012). A research participant speaks to this, explaining, "...And then they get out the Harry Benjamin Standards and then try and fit everyone into those standards which I don't think are

very appropriate sometimes. Most counselors that I am familiar with end up trying to fit a person into a profile rather than develop the profile around who the unique person is” (Benson, 2013, p. 30). Some may choose to transition socially with or without medical intervention, thus, with all the possible options available, treatment options should be highly individualized for each client (Coleman, et al., 2012).

Transgender-affirming therapists should also have an understanding of the possible complexities of their client’s relationships including family, loved ones, and friends (Benson, 2013). Research suggests that more distress may be experienced in the early stages of transition process (Budge, 2012). It is important to note that transgender people who have more social support are less likely to use avoidant coping strategies, which can help reduce anxiety and depressive symptoms throughout the transition process (Budge, Adelson, & Howard, 2013).

***Case Management and Logistics.*** Therapists are often part of team of health care providers who are involved in the assessment and treatment of transgender clients who choose to transition medically. Therapists who work with transgender clients have been considered “gatekeepers” between the client and their desire for a medical transition, including hormones and surgery (Coleman, et al., 2012; Lev, 2009). The WPATH SOC, version 7, explains that the role of therapists in this area is to assess, and when applicable, refer the client to medical professionals who prescribe hormones or conduct gender confirmation surgery (Colman, et al., 2012). However, as previously noted, having to get a letter from a therapist in order to access hormones and surgery has been a barrier between transgender individuals wanting to medically transition and the therapists who is positioned as a gatekeeper (Lev, 2009). However, the authors of the WPATH SOC 7 (Coleman, et al.,

2012) make a clear statement that psychotherapy, or a minimum number of sessions, is *not* a requirement for hormonal or surgical treatment. This distinction means that the therapists can conduct a mental health screening or assessment, without requiring psychotherapy, though, psychotherapy is still highly recommended (Coleman, et al., 2012).

Overall, transgender-affirming therapy includes an understanding that not all transgender people have the same gendered trajectories or ways of alleviating distress or gender dysphoria (Riley, Wong, & Sitharthan, 2011). Not all transgender people's experiences of their gender identity are the same and thus, they shouldn't be treated as such (Riley, Wong, & Sitharthan, 2011). The following sections provide a more nuanced description of transition affirming therapy and non-binary affirming therapy beyond the general transgender-affirming practices previously described. Given the various needs of transgender individuals in therapy, it is important to understand the different foci that therapy can take with respect to transgender people who want to transition or those do not want to transition.

**Affirming therapy for transgender clients who transition.** In addition to the general guidelines for working with transgender clients, some clinicians may focus on providing transition affirming therapy, in which they focus on the client's stated or assumed desire to move through a series of stages toward an "integrated" transgender identity. Devor (2004) provides a 14-stage transsexual identity development model that begins with anxiety (stage 1) and identity confusion (stage 2), progresses toward tolerance of transsexual identity (stage 7), acceptance of transsexual identity (stage 9), transition (stage 11), and eventually, integration (stage 13) and pride (stage 14). The identity development stages are modeled after the Cass (1979) model of homosexual identity development. The model explicitly focuses on

transsexual individuals, though it is also said to be applicable to individuals who identify as transgender rather than just transsexuals (Devor, 2004). Though the authors explain that these stages are flexible, not all people follow the same trajectory, and some revisit or skip stages (Devor, 2004), the idea of the model, typically in a more simplistic form, has become a common way of understanding transgender and transsexual identity— a mostly linear model with a progresses toward a medical transition.

**Affirming therapy for non-transitioning transgender clients.**

“...there is a need for the evaluating psychologist to have an advanced level of understanding of gender identity, gender expression, the ways that individuals might present as gender variant, and the transition options available to them” (Hendricks & Testa, 2012).

As discussed above, there is a need for clinicians to have the knowledge, awareness, and skills to provide transgender-affirming counseling for those who wish to transition or are considering transitioning, either socially, medically, or surgically. Additionally, there is also a need for clinicians to understand the various experiences of transgender people who do not identify with binary gender labels and/or are uncertain about transitioning. For example, some non-binary or genderqueer identified people may seek to make the categories of male and female more flexible, identify their gender somewhere across a gender spectrum or outside of it, make attempts at dismantling sex and gender systems, or choose a gender presentation that purposefully subverts gender (Richards, et. a., 2016).

Psychotherapy has been shown to be beneficial for transgender clients regardless of their desire for gender confirmation surgery (GCS) (Bockting, Robinson, Benner, & Scheltema, 2004). For example, Hendricks & Testa (2012) write about the importance of understanding not only gender identity, but also gender expression and the various ways that people might present as gender variant and gender non-binary in their mannerisms, style of

dress, or secondary sex characteristics (facial hair, muscle tone, etc.). There are various ways of alleviating gender dysphoria (for those who experience dysphoria) and there are also gender non-binary individuals who may not experience gender dysphoria in the same way or to the same extent as other transgender individuals (Coleman, et al., 2012). However, for clinicians working with clients who choose not to pursue a social or medical transition, or choose some part of a transition, but do not want gender confirmation surgery (GCS), clinical guidance and research is limited (Richards, et. al., 2016; Riley, Wong, & Sitharthan, 2011).

Narrative therapy has been posited as a strength-based approach that may be particularly useful with transgender clients (Chavez-Korell & Johnson, 2010). The authors argue that narrative therapy allows for clients to tell their story and because reality is understood as socially constructed with no absolute truth it can be used to as an affirming therapy tool (Chavez-Korell & Johnson, 2010). This may be of particular interest for therapists working with clients who identify as gender non-binary or do not want to transition since narrative therapy can provide a framework from which to move away from a dominant narrative, namely a narrative that prescribes a general trajectory toward transitioning. Regardless of what therapeutic tools and techniques are used, non-binary individuals should be supported in their ability to be flexible, fluid, and ambiguous in their gender identities and expression (Nieder, 2014; Richards, 2016).

**Non-affirming therapy for transgender clients.** As previously explored, transgender individuals' experiences in therapy have not always been positive (Bockting, 2009). Psychology is moving toward a more transgender-affirming approach to working with transgender people, however, there are still non-affirming practices that occur for transgender individuals in therapy (Benson, 2013). The Substance Abuse and Mental Health Services

Administration (SAMHSA) released a report that takes a strong and decisive stand against conversion therapy for LGBTQ youth (2015). Though the report focuses on children and adolescents, the reported is clear that no peer-reviewed research has demonstrated the efficacy of conversion therapy with gender minority youth and they raise concerns about the ethics of such practice and the potential for harm (SAMHSA, 2015). Even with the move toward promoting affirming therapies, transgender individuals often report experiencing problematic interactions in therapy (Benson, 2013; Kidd et al., 2011; Sperber, Landers, & Lawrence, 2005). Non-affirming practices can be blatant, as is often the case with conversion therapies or gender reorientation therapies, but they can also include a subtle disapproval or discomfort with transgender clients and topics.

One of the subtler aspects of non-affirming therapy can include microaggressions (Nadal, 2008). Microaggressions have been defined as “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups” (Nadal, 2008, p.23). In a qualitative study of nine transgender men and transgender women, researchers identified 12 types of microaggressions targeted at transgender and gender-binary people (Nadal, Skolnik, & Wong, 2012). These included the use of transphobic and/or incorrectly gendered terminology, assumptions of a universal transgender experience, exoticization, discomfort/disapproval of transgender experience, endorsement of gender normative and binary culture or behaviors, denial of the existence of transphobia, assumption of sexual pathology or abnormality, physical threat or harassment, denial of individual transphobia, denial of personal body privacy, familial microaggressions, and systemic and environmental microaggressions (Nadal, Skolnik, & Wong, 2012).

## **Counseling Process and Outcome Research**

Process and outcome research in counseling psychology focuses on the mechanics of change in therapy and the related outcomes (Hill, Nutt, & Jackson, 1994). Transgender people's experiences in therapy can be studied using process and outcome research, which can expand the understanding of the behaviors between the client and therapists that affect the therapeutic process and treatment outcomes. *Process research* focuses on things that happen in session, including both overt and covert behaviors of the therapist, the client, and interactions between the client and therapist (Hill & Corbett, 1993). *Outcome research* looks at the changes that happen for the client as a result of the therapy experience. Outcomes can be studied in the moment for more immediate and specific outcomes, like the outcome after a particular event, or over time and across sessions (Hill & Corbett, 1993). This study focuses on the process of therapy and the perceptions transgender participants have about the therapeutic relationship.

**Common Factors.** Process and outcome research suggests that there are four main factors that influence client outcomes in therapy regardless of the theoretical orientation. These include extra-therapeutic factors, therapy techniques, client expectancy, and common factors (Lambert & Barley, 2001). Extra-therapeutic factors include things that occur outside of therapy that influence and affect therapeutic outcomes (Leibert, Smith, & Agaskar, 2011) and have been shown to account for approximately 40% of the variance in client outcome (Lambert & Barley, 2001). For transgender and gender non-binary people, this may include their degree of social support, various life experiences, and motivation for therapy. Common factors include things such as empathy, warmth, compassion, and the therapeutic relationship, which have been shown to account for approximately 30% of the variance in

client outcomes (Lambert & Barley, 2001). Expectancy effects refers to the client's beliefs about treatment, including their belief about whether or not they believe therapy will be helpful, and in what ways it may or may not be helpful for them. This expectancy and specific techniques used by clinicians each account for approximately 15% of the variance in client outcomes (Lambert & Barley, 2001).

**The Therapeutic Relationship.** The therapeutic relationship can be conceptualized as, "...the feelings and attitudes that counseling participants have toward one another, and the manner in which these are expressed" (Gelso & Carter, 1985, p. 159). The research and theorizing about this unique relationship is extensive because of its importance in therapeutic process and outcome research (Ackerman & Hilsenroth, 2003). For example, Norcross and Lambert (2011) suggest that approximately 20% of the variance in therapeutic outcome is due solely to the therapeutic relationship. Three components of counseling relationships have been hypothesized, including, the working alliance, the transference relationship, and the real relationship (Greenson, 1967). This model comes from a psychoanalytic tradition, but has been expanded, updated, and refined, both theoretically and empirically, to be applicable to various theoretical orientations, rather than being limited to a psychoanalytic or psychodynamic approaches (Gelso, 2014).

The therapeutic alliance between a therapist and client includes not only the emotional bond between a therapist and a client, but also the collaboration and willingness to be invested in the process (Nuetzel, Larsen, & Prizmic, 2007). It can be conceptualized as having three components, including the tasks (the actual work of therapy), bonds (the interpersonal connection, attachment, trust, and confidence), and goals (agreed upon objectives in therapy) (Lambert & Barley, 2001). Therapeutic alliance has been shown to be

a strong predictor of client's self-reported general adjustment, including positive affect, self-esteem, connectedness with others, and optimism (Neutzel, Larsen, & Prizmic, 2007).

Ackerman and Hilsenroth (2003) explain that certain personal attributes tend to contribute positively to the alliance between the client and the therapist, regardless of a specific therapeutic orientation. These positive personal characteristics include being: flexible, experienced, honest, respectful, trustworthy, confident, interested, alert, friendly, warm, and open (Ackerman & Hilsenroth, 2003). Similarly, the therapeutic alliance is positively correlated with various techniques used by the clinician in session. These techniques are typically not associated with a specific theoretical orientation, but rather the general relationship building strategies that therapist use to develop rapport with the client. These included techniques such as: exploration, depth, reflection, being supportive, noting past therapy success, accurate interpretations, facilitating expression of affect, being active, affirming, understanding, and attending to patient's experiences (Ackerman & Hilsenroth, 2003).

Process and outcome research show that specific therapist variables, including the client's perception of the therapist's trustworthiness, expertness, and attractiveness (or general likability), are linked to the therapeutic relationship. In a study of clients with psychosis, clients' ratings of trustworthiness, expertness, and attractiveness were positively linked to their ratings of the therapeutic relationship (Evans-Jones, Peters, & Barker, 2009). A client's perception of the therapist's expertness and attractiveness have also been linked to a stronger working alliance, which is highly predictive of client outcomes in therapy (Roland, 2010). Further, volunteer rater's perceptions of a therapist's trustworthiness, attractiveness, and expertness are higher when a therapist explicitly focused on the therapeutic relationship

in sessions (Kivlighan, 2010).

Additionally, perceptions of the session itself also seem to impact the therapeutic alliance. A client's evaluation of a session, including the depth and smoothness as well as their own feelings of positivity and arousal (i.e., feeling energetic and excited as oppose to relaxed, calm, and quiet) are related to their ratings of the working alliance (Mallinckrodt, 1993). In a cross cultural study, Greek clients' perceptions of session depth, comfort, smoothness, and their own positive feelings after a session were related to their rating of the therapeutic alliance, while Canadian client's perception of session depth and the therapist were related to their ratings of the therapeutic alliance (Stalikas, & Pavlatou, 2008). Thus, client perceptions of the therapist and their perceptions of the session both impact their rating of the therapeutic relationship and alliance.

### **Analogue Research Designs**

Analogue research in counseling psychology is a type of experimental design that is made to mimic some part of the counseling process and includes a manipulation of some aspect of the client, therapist, or therapeutic process (Heppner, Wampold, & Kivlighan, 2007; Hill & Corbett, 1993). Analogue studies are often used in psychotherapeutic research to study the process and outcome of various modes of treatment by controlling extraneous variables, thereby increasing internal validity (Reynolds & Streiner, 1998). Research in counseling psychology tends to utilize analogue methods in two main lines of research inquiry: looking for the most potent characteristics and optimal conditions for psychotherapy practice, and studying the social influence of the therapist's behaviors on client's perceptions of that therapist (Heppner, Wampold, & Kivlighan, 2007). Analogue research designed to study the social influence process often focus the client's perception of the therapist's

trustworthiness, expertness, and attractiveness as related to a specific counselor behavior (Heppner, Wampold, & Kivlighan, 2007), as is done in this study.

In addition to the two different foci of the analogue study, there are various types of analogue designs. Munley (1974) outlines five distinct types used in counseling psychology: (1) Audiovisual counseling studies with the therapist's behavior as the dependent variable, (2) Audiovisual counseling studies with the client's behavior as the dependent variable, (3) Quasi-counseling interview studies with the client behavior as the dependent variable, (4) Quasi-counseling interview studies with the therapists behavior as the dependent variable, and (5) Experimental tasks not directly resembling a counseling interview. Audiovisual (i.e., video) analogue studies have a few advantages over other types of analogue studies (Munley, 1974). Using an audiovisual analogue design to study therapist behaviors allows for the same therapist stimulus to be used across a number of participants with very specific manipulations (Munley, 1974). Using videos allows the client to rate specific units of the therapist's behavior, thereby increasing the precision of the study (Munley, 1974). Interestingly, client participant ratings in audiovisual analogue studies differ when the participant sees just the therapist, or both the therapist and the client in the video (McKittrick, 1981). One study found that those who saw only the therapist tended to rate the therapist more positively with regards to trustworthiness and expertness than those who watched a video with both the client and therapist (McKittrick, 1981).

Though analogue studies are high in rigor and experimental control, the consequence is often a reduction in the generalizability of the results to clinical applications (Hill & Corbett, 1993; Munley, 1974; Reynolds & Streiner, 1998). However, the more similar the study is to the actual process and experiences of counseling, the more the results can be

generalized to counseling (Hill & Corbett, 1993). Analogue methods are also critiqued because of the lack of believability, either because the participant is not actually engaging in a therapeutic exchange (Hill & Corbett, 1993; Munley, 1974) or because the participant's that are typically recruited usually are not experiencing the type of distress that actual client's would experience (Munley, 1974; Reynolds & Streiner, 1998). Critics note that participants are often not actively seeking counseling, experiencing distress, or trying to change a behavior, but rather fulfilling course credit or interested in free counseling (Munley, 1974; Reynolds & Streiner, 1998). However, even with these critiques of analogue research methods, some scholars note that analogue designs can be appropriate to study parts of the process, such as a client's initial impression of the therapist, as opposed to the on-going process of therapy that occurs over time (Hill & Corbet, 1993). Analogue designs can also be particularly useful in the early stages of process and outcome research, when specific treatment options or techniques can be tested with clients (Reynolds & Steiner, 1998).

## Chapter III: Method

### Design

This study used a video vignette analogue research design, which was meant to mimic the conditions of a therapy session (Heppner, Wampold, & Kivlighan, 2007). Analogue research is done by isolating the variable of interest and purposefully altering it in each condition, while simultaneously controlling for extraneous variables, allowing for a greater specificity and precision in the delivery of the independent variable (Heppner, Wampold, & Kivlighan; 2007). The present study was modeled after a dissertation study that focused on therapist responses to client disclosure of sexual orientation (Walther, 2010). Walther's (2010) study used three different therapist reactions to sexual orientation disclosure and two different visual cues in the therapy office space to understand how the therapist reactions and LGB affirming or neutral visual cues affect the participant's perception of the therapist and the session. The present study is similar, but instead, utilized videos of a mock therapy session with actors playing the role of therapist and a client questioning their gender identity.

In this study, the video of the therapeutic encounter used for the various conditions was exactly the same, except for a brief portion of the video clip that was edited to include one of following three conditions: transition affirming, non-binary affirming, or a non-affirming therapist response. The participant's plan to transition or not transition was also measured and served as the second independent variable: plan to transition/in the process of transitioning/have already transitioned or no plan to transition. The goal of the present study was to understand how slight variations in the therapeutic encounter may effect the participant's perceptions of the therapist and how their own desire to transition or not to transition may affect this perception. The primary dependent variables include (a) therapist

attractiveness, (b) therapist trustworthiness, (c) therapist expertise, (d) session depth (e) session smoothness, (f) participant's positivity, and (g) participant's arousal.

## **Participants**

Participants included individuals who identified as being on the transgender-spectrum (i.e., transgender, transsexual, genderqueer, non-binary, androgynous, etc.), reported being over the age of 18, and lived in the United States at the time of the study. Targeted recruitment strategies were used to capture a sample of transgender participants who were diverse in their gender identities and in their plan to transition or not transition. Thus, participants were recruited via LGBTQ, transgender-specific, and genderqueer-specific listservs, email lists, social media (i.e., Facebook), community centers that support transgender individuals, and Amazon Mechanical Turk (MTurk).

MTurk is an online labor market managed through Amazon.com that allows researchers, also known as requesters, to post research studies and to gather data from participants, who are known as workers (Goodman, Cryder, & Cheema, 2013; Mason & Suri, 2011). Research suggests that compared to the general population, these workers tend to be younger (around 30 years old), overeducated and underemployed, less extraverted, less religious, and more liberal (Paolacci & Chandler, 2014). MTurk workers also tend to be more diverse than college samples, but not representative of the population as a whole, with Asian workers being overrepresented and Black and Latino workers being underrepresented in U.S. samples (Berinsky, Huber, Lenz, 2012). Studies show that MTurk participants are not significantly different in attentiveness or honesty compared to other sampled populations (Paolacci & Chandler, 2014). Approximately two-thirds of the participants in this study were

sampled from MTurk and a comparison of demographic characteristics between the MTurk participants and community-sampled participants in this study is included (see table 1).

Table 1

*Number of participants from MTurk sample, community-based sample, and total sample*

	MTurk Sample		Community-based Sample		Total sample	
	N	% of MTurk	N	% of community	N	%
<b>Current Gender Identity</b>						
Female	15	5.2	11	9.2	26	6
Male	8	2.8	10	8.3	18	4
Transgender Woman	57	19.7	14	11.7	71	17
Transgender Man	50	17.3	30	25	80	20
Genderqueer	129	44.6	29	24.2	158	39
Something else	27	9.3	25	20.8	52	13
<b>Birth-Assigned Sex</b>						
Female	175	60.6	85	70.8	260	63
Male	112	38.8	34	28.3	146	36
Intersex	2	.7	1	.8	3	1
<b>Current Age</b>						
18-23	93	32.1	40	33.3	133	33
24-29	98	33.9	22	18.3	120	29
30-39	69	23.8	20	16.6	89	22
40-49	17	5.8	20	16.6	37	9
50-59	9	3.1	8	6.6	17	4
60-69	1	.3	3	2.5	5	1
70+	1	.3	1	.8	2	1
<b>Ethnicity</b>						
European-Am./White	224	77.5	95	79.1	319	78
African Am./Black	28	9.6	4	3.3	32	8
Latin@/Hispanic	21	7.2	1	.8	27	7
Asian American	14	4.8	5	4.1	19	5
American Indian/Alaska Native	14	4.8	5	4.1	19	5
Middle Eastern	5	1.7	1	.8	6	2
Native Hawaiian/ Pacific Islander	2	0.6	1	.8	3	1
<b>Socio-Economic Status</b>						
Poor	58	20.1	20	16.7	78	19
Working class	81	28	25	20.8	106	26
Lower-middle class	55	19	24	20	79	19

Middle class	62	21.5	30	25	92	23
Upper-middle class	17	5.9	13	10.8	30	7
Upper class	3	1	0	0	3	1
Education						
Less than HS diploma	2	.7	1	.8	3	.7
Completed HS diploma/GED	29	10	10	8.3	39	9.7
Trade/vocational school	7	2.4	0	0	7	1.7
Some college, no degree	105	36.3	42	35	147	35.7
Completed Associates degree	38	13.1	7	5.8	45	11.2
Completed Bachelors degree	74	25.6	22	18.3	96	23.9
Some graduate school	10	3.5	9	7.5	19	4.7
Completed graduate or professional degree	20	6.9	25	20.8	45	11.2
Geographic Location						
Urban	98	33.9	58	48.3	156	38
Suburban	127	43.9	39	32.5	166	41
Rural	47	16.3	13	10.8	60	15

A total of 655 participants completed the study and after cleaning the data, 409 were deemed to be usable for this study (see data analysis section for an explanation of the data cleaning method). The descriptive statistics and analyses that follow apply to this usable sample.

Participants were asked about their current gender identity and their sex assigned at birth. A small percentage identified their current gender identity as female (6%;  $n = 26$ ) or male (4%;  $n = 18$ ), while many more identified as transgender woman (17%;  $n = 71$ ) and transgender man (20%,  $n = 80$ ). Over a third of participants identified at genderqueer (39%;  $n = 158$ ), 13% identified as “something else” ( $n = 52$ ), and very few identified as intersex (1%;  $n = 4$ ). When asked about their sex as assigned at birth, two-thirds indicated that they were assigned female at birth (63%;  $n = 260$ ), one-third indicated that they were assigned male at birth (36%;  $n = 146$ ), and a few indicated that they were assigned intersex at birth (1%;  $n =$

3). Participants were also asked about their gender identity label, were provided with various response options, and were asked to indicate all that applied. The most common gender identity labels included genderqueer (40%;  $n = 164$ ), queer (33%;  $n = 135$ ), woman (28%;  $n = 113$ ), man (24%;  $n = 98$ ), and transgender/ist (23%;  $n = 94$ ). A substantial number also indicated labels such as Female to Male FTM (18%  $n = 75$ ), Male to Female MTF (12%:  $n = 50$ ), trans man (18%;  $n = 72$ ), genderless (17%;  $n = 68$ ), agender (13%;  $n = 55$ ), androgyne (13%;  $n = 51$ ), pre-op transsexual (11%;  $n = 50$ ), bigender (10%;  $n = 39$ ), and two-spirit (8%;  $n = 33$ ), among others.

Participants answered questions about their current age, the age they began questioning their gender identity, and the age at which they came out to themselves as transgender, gender non-binary, or a gender identity different than the sex they were assigned at birth. Participant's current age was grouped mostly into decades, except for the 18-29-year-old age range, which includes more than a decade. More than half of participants reported being in the 18-29-year-old age range, thus, this group was divided into two categories (18-23 and 24-29) to provide more precision. The 18-23-year-old age range accounted for approximately one-third of the participants (33%;  $n = 133$ ) and those in the 24-29-year-old age range accounted for a little less than one-third of the participants (29%;  $n = 120$ ). Approximately one-fifth of participants were 30-39 years old (22%;  $n = 89$ ), one-tenth were 40-49 years old (9%;  $n = 37$ ), fewer were 50-59-year-old (4%;  $n = 17$ ), and far fewer were 60-69 years old (1%;  $n = 5$ ) or over 70 years old (<1%;  $n = 2$ ).

Participants were asked to indicate the age at which they began questioning their gender identity. Response options included specific age categories, with most participants indicating that they began questioning their gender identity between 4-10 years old (29%;  $n =$

117), 11-15 years old (27%;  $n = 112$ ), and 16-20 years old (24%;  $n = 98$ ). Approximately one-tenth reported beginning to question their gender identity between the ages of 21-25 (10%;  $n = 40$ ), with fewer indicating 26-30 years old (2%;  $n = 10$ ), 31-40 years old (2%;  $n = 8$ ), or over 40 (1%;  $n = 6$ ). Some participants also indicated that they began questioning at a younger age, three years old or younger (4%;  $n = 18$ ). When asked about the age at which they came out to themselves about their gender identity, participants most often reported ages in the late teens and early twenties, though some reported being three years old or younger, and others indicated coming out to themselves in their fifties and sixties. Over one-third indicate that they came out to themselves between age 16-20 (39%;  $n = 159$ ) and just under one-third reported coming out to themselves between 21-25 years of age (29%;  $n = 120$ ). Fewer reported coming out to themselves between 26-30 (8%;  $n = 33$ ), 31-40 years of age (5%;  $n = 20$ ), 41-50 years of age (2%;  $n = 10$ ), 51-60 years of age (1%;  $n = 4$ ), or 61 years or older (<1%;  $n = 2$ ).

When asked about sexual orientation, participants were asked to select all options that applied. Approximately three fourths of participants indicated pansexual (24%;  $n = 97$ ), bisexual (23%;  $n = 95$ ), or “other” (24%;  $n = 98$ ), which were the most common responses. Others indicated that they identified as gay (10%;  $n = 39$ ), lesbian (13%;  $n = 52$ ), or heterosexual (12%;  $n = 49$ ). In terms of ethnicity, participants were also asked to select all options that applied. Most of the sample indicated European American/White (78%;  $n = 319$ ) and fewer identified as African American/Black (8%;  $n = 32$ ), Latino(a)/Hispanic (7%;  $n = 27$ ), Asian American (5%;  $n = 19$ ), American Indian/Alaska Native (5%;  $n = 19$ ), Middle Eastern (2%;  $n = 6$ ), Native Hawaiian or Pacific Islander (1%;  $n = 3$ ), or “other” (5%;  $n = 21$ ).

Socio-economic status seemed evenly distributed between poor (19%;  $n = 78$ ), working class (26%,  $n = 106$ ), lower-middle class (19%;  $n = 79$ ), and middle class (23%,  $n = 92$ ), while fewer identified as upper-middle class (7%;  $n = 30$ ), and upper class (1%;  $n = 3$ ). Many of the participants had some post-secondary education, with most completing at least some college (86%;  $n = 352$ ). Nearly a quarter completed a bachelor degree (23%;  $n = 96$ ) and 16% had some graduate school experience or completed a graduate or professional degree ( $n = 64$ ). In terms of geographic location, there were similar numbers of urban (38%;  $n = 156$ ) and suburban (41%;  $n = 166$ ) participants, and fewer rural participants (15%;  $n = 60$ ). When asked about the political climate where they live, nearly half reported that it was somewhat or mostly liberal (43%;  $n = 177$ ), one-third reported somewhat or mostly conservative (32%;  $n = 131$ ), and 19% reported a moderate political climate ( $n = 78$ ).

Participants were also asked about their interest in transitioning medically (i.e., hormones, top surgery, bottom surgery, etc.). Over one-third of participants indicated that they were not interested in transitioning medically (38%;  $n = 155$ ), while approximately one-third indicated that they were interested in transitioning medically (34%;  $n = 138$ ). Fewer indicated that they were already in the process (19%;  $n = 76$ ), or they had already transitioned (10%;  $n = 40$ ).

Participants were asked about their past experiences in therapy, if applicable. Most participants (80%) indicated that they had been to see a counselor or a therapist at some point in their lives ( $n = 325$ ), and 19% reported no current or previous therapy experience ( $n = 76$ ). Of those who indicated that they had received therapy, one-third reported that they had a mostly positive experience in therapy (33%;  $n = 136$ ), another third reported mixed positive and negative experiences (29%,  $n = 118$ ), and fewer reported neutral experiences (9%;  $n =$

37) or mostly negative experiences (7%;  $n = 30$ ). Participants were also asked about their reasons for seeking therapy, including topics unrelated to gender identity (39%;  $n = 158$ ), both gender-related and unrelated topics (38%,  $n = 155$ ), gender-specific concerns (23%;  $n = 92$ ), and wanting a letter for hormones or surgery (17%;  $n = 71$ ). Most reported that they received individual therapy (76%;  $n = 309$ ), approximately a quarter reported experiences in group therapy (24%;  $n = 99$ ), and few reported having experiences with couples therapy (8%;  $n = 34$ ). Participants were also asked how many different therapists they had seen, and approximately half reported having one to three different therapists (48%;  $n = 198$ ), 17% reported seeing four to six different therapists ( $n = 70$ ), and others reported seeing seven or more (9%,  $n = 37$ ).

There were some demographic differences between MTurk participants and community-sampled participants that are worth noting (see table 1). First, the MTurk sample included higher percentage of genderqueer-identified participants (44.6%) compared to the community sample (24.2%). There were similar percentages of 18-23 year-olds between the two samples (32-33%), however, 24-39 year olds were more heavily represented among MTurk users, compared to the community sample, and participants over 40 tended to be more heavily represented in the community sample compared to MTurk. The MTurk participants were somewhat more diversity than the community sample, with a larger percentage of African American/Black and Latin@/Hispanic participants. The Mturk participants were more likely to report being poor or working class (48%) than the community-based participants (37%). There were similar percentages of MTurk participants and community-sampled participants who reported some college experience. However, there was a higher percentage community-sampled participants who reported having completed a

graduate or professional degree compared to the MTurk sample. Both samples reported living in more urban and suburban areas as compared to rural living, however, the Mturk sample tended to report more suburban and rural living than the community sample, which was more likely to report living in urban areas.

An a priori power analysis indicated that 36 participants would be sufficient to conduct a MANOVA with six groups and seven dependent variables detecting a significant effect ( $\alpha = .05$ ) of moderate size (.25) with a power of .95. To ensure power of .80 for planned contrasts following a significant MANOVA, approximately 300 participants were needed across the six groups with an effect size of .25 and a bonferroni correction for alpha ( $\alpha = .01$ ). Thus, approximately 50 participants were needed in each cell.

### **Procedure**

Participants were recruited via MTurk, listservs, email lists, social media, and community centers that support transgender individuals. Participants were directed to an online survey where they were shown the informed consent and were asked to participate. Participants then answered a series of pre-video questions. For example, participants were asked if they live in the United States and over the age of 18. Participants who reported that they did not live in the United States or were younger than 18 years old were thanked for their time and removed from the study. For those who participated through MTurk, an active MTurk account was necessary to find and complete the survey. MTurk collects information about the location and various qualifications that participants have, such as approval rates for previous work, and total number of tasks successfully completed. For this study, MTurk participants had to live in the United States and have at least a 95% approval rating for

previous MTurk work to qualify for the study. The survey was also set to “private” and could not be seen if the participant did not meet these qualifications.

In order to ensure relatively equal distribution of participants who want to transition and do not want to transition across the three therapist response conditions, participants were asked about their plan to transition or not, which divided them into two categories that were then each randomly assigned to one of three video conditions. After viewing the video, the participants were asked to complete a series of questionnaires including the Counselor Rating Form-Short (CRF-S; Corrigan & Schmidt, 1983), Session Evaluation Questionnaire (SEQ; Stiles, 1980), Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970), Transgender Adaptation and Integration Measure (TG AIM; Sjoberg, Walch, & Stanny, 2006), Transgender Congruence Scale (TCS; Kozee, Tylka, & Bauerband, 2012), and a demographics questionnaire. At the end of the study, all participants were thanked for their time and given resources for mental health counseling services. Community-sampled participants were also offered the opportunity to enter a drawing for the chance to win one of two \$50 gift card incentives. Participants who found the study through MTurk were told that their MTurk participation would yield \$.50, they would be entered into a drawing for the chance to win one \$50 gift card incentive (an MTurk “bonus”), and were offered the opportunity to use the community-sample link instead to be entered into the gift card drawing with two chances to win. Those who chose to participate through MTurk were redirected back to MTurk after completing the study to earn \$.50 for their participation.

### **Video Condition**

The videos of the staged mock therapy sessions with actors playing the role of therapist and client were utilized instead of in-person mock therapy with a participant as the

client. This design allowed for greater control of the therapist response manipulation across conditions. Additionally, this design allowed for more participants to complete the study, which is important because it increased the generalizability of the results. The transgender community is diverse in identity, presentation, desire to transition, and, most likely, their reactions to therapist's response. The ability to sample a greater number of participants using therapy videos, as opposed to in-person mock therapy sessions, allows for more variability in the perceptions transgender participants have about the therapeutic response conditions.

Furthermore, the audiovisual stimuli were chosen instead of reading vignettes to encourage participants to engage more fully with the conditions. The use of video helps to reduce the variability that might occur if people were asked to imagine the session from the information provided on a vignette. By controlling the visual cues (including the room layout and the therapist and client's body language) and the audio cues (including timing of speech and tone of voice) across all of the conditions, the participants are not asked or expected to fill in any gaps that may be caused by having people imagine the scenario when reading a vignette. Further, video will be used to elicit a stronger reaction from participants that might not be present when simply reading a vignette.

For each condition, the same mock therapy session video was used with only slight variations in the delivery of the manipulation (see Appendix A). In the first condition (transition affirming), the therapist explained the process of transitioning to the client with no details for other options. This condition represents an affirming therapeutic practice that assumes that most or all transgender clients want to transition and supports the client this process. In the second condition (non-binary affirming), the therapist affirms the client's exploration of their gender identity and gender fluidity without assuming the client is

interested in transitioning. This condition represents an affirming therapeutic practice that does not assume that most or all transgender clients want to transition, while supporting clients who identify as non-binary. In the third condition (non-affirming), the therapist is not affirming of the client's transgender identity during the session. This condition likely reflects practice as usual for therapists who are not attempting to be affirming of a person's transgender identity, but may be trying to be helpful in some way.

The script was designed to focus on the therapist's response while allowing enough space in the script for the client to explain and explore their discomfort with their gender. The three scripts were created by the first author who had identified as transgender and began transitioning, but currently identifies as non-binary, has conducted research on transgender issues, and has worked with transgender clients who do and do not want to transition. The scripts were reviewed by several individuals prior to creating the films, first, by the researcher's advisor who has conducted research on transgender issues and by the researcher's dissertation committee. A counseling psychologist with extensive clinical and research experience with transgender clients and participants also reviewed the video scripts. Three doctoral students in counseling psychology who have conducted research about transgender and LGB issues, and a genderqueer identified person who was in the process of socially and medically transitioning also reviewed the videos. The reviewers were asked to comment on the believability of the interaction, the extent to which the script elicited the appropriate sentiment that matched the condition, and other comments, suggestions, and changes. The feedback received was positive and many of the suggested changes were made to aid in the continuity and believability of the story across conditions.

The videos were also created to focus the participants' attention on the therapist. This was done by focusing on camera angles that highlight the therapist and by using more clips of the therapist than the client in the video editing process. This was done because the study was designed to understand the participants' perceptions of the therapist. It was also important that the client's gender exploration and their responses to the therapist were plausible across all three video conditions to protect the integrity of the analogue design. In fact, the client's response never changes across all three video conditions, only the therapist response changes, and only in specific instances. The reviewer feedback assisted with this issue of consistency and believability, as did some of the suggested changes that were made during the filming process by the actors, the researcher, and the videographer. These changes helped the video have a more realistic and conversational style rather than feeling overly scripted. The actors were often encouraged to try to capture the meaning and the tone of the script, while using their own words. However, portions in which the therapist was delivering one of the three experimental manipulations were kept as close to the script as possible to ensure consistency between the three versions, thereby increasing experimental control. The video editing process was conducted by a videographer and video editor and overseen by the researcher with feedback from the researcher's advisor to ensure the videos were edited in a way that fit with the meanings of the three conditions, the scene transitions were smooth enough to seem real rather than forced or artificial, and for content and video length. The video editor recommended removing early segments of the video that seemed repetitive or non-essential to help reduce the overall length of the videos, which also helped with the overall flow. The final videos were approximately six to seven minutes in length.

## **Measures**

**Counselor Rating Form- Short (CRF-S; Corrigan & Schmidt, 1983).** The CRF-S (Appendix B) was included to assess participant's perceptions of the therapist across the conditions. The CRF-S is a 12-item measure frequently used to measure expertness, attractiveness (or likability), and trustworthiness of a counselor on a seven-point Likert scale. The 12 items on the CRF-S were derived from the original Counselor Rating Form (CRF; Barak & LaCrosse, 1975) in an attempt to improve the CRF by reducing the reading level required to participate, keeping the strong validity and reliability of the measure, and reducing the number of items for ease of use. The original 36 CRF items are comprised of three dimensions, *expertness*, *attractiveness*, and *trustworthiness*, with 12-items per dimension that are rated on 7-point Likert scales with bipolar positive and negative adjective anchors.

The CRF-S changed the number of items and the structure of the response options such that the negative and positive adjective anchors were replaced with “not very” and “very” at opposite poles of the bipolar rating scale. The authors argue that the negative items used on the original CRF were socially undesirable (e.g., phony, deceitful, stupid, and unattractive) and respondents typically did not rate counselors as being on the negative end of the scale (Corrigan & Schmidt, 1983). Changing the response options from positive and negative adjectives on the CRF to “not very” and “very” on the CRF-S was done to increase the variance. The CRF-S also reduced the number of items to include four items for each of the three dimensions for a total of 12 items. The items were chosen based on previous factor-loadings from the CRF and the ease of understanding and comprehending the items at an 8<sup>th</sup> grade level (Corrigan & Schmidt, 1983). The three dimensions and corresponding items include: attractiveness (friendly, likable, sociable, warm), expertness (experienced, expert,

prepared, skillful), and trustworthiness (honest, reliable, sincere, trustworthy) (Corrigan & Schmidt, 1983).

The CRF-S was validated across two studies. In the first study, participants were asked to view three 15-minute video clips from the *Three Approaches to Psychotherapy* that show interviews with Carl Rogers, Fritz Perls, and Albert Ellis and rate the person in each clip using the CRF-S. In the second study, clients at two mental health clinics were asked to participate in the study, rating their therapist using the CRF-S (Corrigan & Schmidt, 1983). Confirmatory factor analysis was used to validate the three dimensions of the CRF-S. The three-factor model explained the most variance as opposed to a single factor model. Across these studies of the CRF-S, the reliability for the attractiveness subscale ranged from  $\alpha = .89$  to  $\alpha = .93$ , the expertness subscale ranged from  $\alpha = .85$  to  $\alpha = .94$ , and the trustworthiness subscale ranged from  $\alpha = .82$  to  $\alpha = .91$ . Cronbach's alpha for the CRF-S composite score and subscales with the current sample were high (Composite CRF-S  $\alpha = .98$ . CRF-S Attractiveness subscale  $\alpha = .96$ , CRF-S Expertness subscale  $\alpha = .97$ , and Trustworthiness subscale  $\alpha = .96$ ).

**Session Evaluation Questionnaire (SEQ; Stiles, 1980).** The SEQ (Appendix C) was included to assess participant's perceptions of the session across the video conditions. The SEQ measures depth, smoothness, positivity, and arousal of a therapeutic encounter using a 7-point semantic differential scale with a different number of items depending on which version, or form number (1-5). Stiles (1980) explains that the SEQ is meant to measure the impact of the session rather than the long term outcome of therapy or the benefit to the client by gathering (a) ratings of the actual session itself and (b) the participant's feelings after the session. For all versions of the SEQ, two distinct sentence stems and a series of adjective

pairs are used to measure the client's evaluation of the session (depth and smoothness) and the clients post session affect (positivity and arousal) (Stiles & Snow, 1984). Participants are asked to rate these dimensions by placing an X on the line between the adjectives to indicate their assessment of the session (Stiles & Snow, 1984). In the evaluation portion of the measure, the client is asked to complete the stem, "This session was:" followed by the first set of bipolar adjective pairs such as *bad-good*, *difficult-easy*, *shallow-deep*, and so on. These items focus on the session depth and smoothness, where *depth* refers to the power of a session including how deep, valuable, and special it was (as opposed to shallow, worthless, empty, or ordinary), while *smoothness* refers to the degree of comfort and pleasantness from the session, including how easy, pleasant, and safe it was (as opposed to rough, difficult, or dangerous) (Stiles, 1980; Stiles & Snow, 1984). For the post session affect, the stem reads, "Right now I feel:" with rating scales that included *happy-sad*, *angry-pleased*, *involved-detached*, and *calm-excited*, among others. The affect portion seeks to measure both positivity and arousal, where Stiles and Snow (1984) explain that *positivity* refers to the comfort and happiness of a session without fear or anger, and *arousal* refers to the participant feeling activated and excited. The categories and subscales were all derived using factors analysis, which provided four factors that were extracted using the principle-axis method (Stiles, 1980). Reliabilities were reported for the client's rating of session depth ( $\alpha = .87$ ), session smoothness ( $\alpha = .93$ ), positivity ( $\alpha = .89$ ), and arousal ( $\alpha = .78$ ). With the current sample, the reliabilities were high for most subscales, session depth ( $\alpha = .90$ ), SEQ smoothness ( $\alpha = .88$ ), SEQ positivity ( $\alpha = .82$ ), though SEQ arousal was lower ( $\alpha = .66$ ).

**Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970).** The ATSPPH is a 29-item scale that assesses a participant's

willingness to seeking psychologist support across four dimensions: recognition of the need for help, ability to tolerate stigma, interpersonal openness, and confidence in therapists on a 4-point Likert scale (0-3). The scale was created in collaboration with several mental health professionals across a number of settings who developed the preliminary items that focused on seeking professional help. The pool of 47 items was then reduced to 31 items by a panel of clinical and counseling psychologists and psychiatrists (Fisher & Turner, 1970). These items were tested with high school students, nursing students, and summer college students and two items were excluded from the final scale. The internal reliability of the ATSPPHS ranged from  $\alpha = .83$  to  $\alpha = .86$ . Test-retest reliability over days, weeks, and 2 months all indicated high reliability ratings, with all  $\alpha > .7$ , and most  $\alpha > .8$  (Fisher & Turner, 1970). A factor-analysis was conducted and four factors were extracted, including the recognition of the need for psychotherapeutic help, stigma tolerance, interpersonal openness, and confidence in mental health practitioner, though Fisher and Turner (1970) caution that the scale should be used as a whole, rather than as separate measures because the reliabilities for sub-scales were only modest. The reliability of this scale in the current sample was high ( $\alpha = .85$ ).

**Transgender Adaptation and Integration Measure (TG AIM; Sjoberg, Walch, Stanny, 2006).** The TG AIM is a 15-item scale that includes three subscales measuring gender-related fears, psychosocial impact of gender status, and coping and gender-reorientation efforts on a 4-point Likert scale. The authors explain that the TG AIM might be a useful tool for measuring the psychosocial adjustment and adaptation of those who experience gender incongruence or as a screening tool for gender dysphoria (Sjoberg, Walch, & Stanny, 2006). The TG AIM was included in this study to better understand the possible

gender related factors that may influence participants' perceptions of the various affirming and non-affirming conditions.

The TG AIM was tested with transgender women ( $n = 108$ ) to assess various concerns of transgender individuals, including quality of life concerns, such as well-being, adjustment, and integration. Factor analysis was used to extract four factors, of which, three factors had adequate to high internal consistency (Gender related fears,  $\alpha = .81$ ; Psychosocial Impact of Gender Status,  $\alpha = .72$ ; Coping and Gender Reorientation Efforts,  $\alpha = .73$ ), and the fourth factor (Gender Locus of Control,  $\alpha = .59$ ), that was not adequate. For the current sample, the composite scale and subscales were all found to have moderate to high reliability scores (Composite score,  $\alpha = .67$ ; Gender related fears,  $\alpha = .76$ ; Psychosocial Impact of Gender Status,  $\alpha = .79$  Coping and Gender Reorientation Efforts  $\alpha = .82$ ).

**Transgender Congruence Scale (TCS; Kozee, Tylka, Bauerband, 2012).** The TCS (Appendix F) is a 12-item measure created to assess the degree of feeling genuine, authentic, and comfortable with one's transgender identity across two factors: appearance congruence and gender identity acceptance on a 5-point likert scale. Appearance congruence refers to perceptions transgender individuals have about how their external appearance represents their gender identity. The gender identity acceptance factor represents the degree to which a person accepts their gender identity and has pride in their identity. Again, this measure was included to understand the possible factors that might influence participants' perceptions of the affirming and non-affirming video conditions. The TCS was cross validated across two studies and confirmatory factor analysis (CFA) indicated that the TCS measure is reliable ( $\alpha = .92$ ), as is the appearance congruence subscale ( $\alpha = .94$ ) and the gender identity acceptance subscale ( $\alpha = .79$ ). The TCS and both subscales were positively correlated with satisfaction

with life and negatively correlated with symptoms of anxiety, depression, and body dissatisfaction (Kozee, Tylka, & Bauerband, 2012). For the current sample, the reliabilities were for the TCS scale and corresponding subscales were high (Composite  $\alpha = .92$ ; Appearance congruence  $\alpha = .94$ ; gender identity acceptance  $\alpha = .82$ ).

**Demographic Questionnaire.** A demographic questionnaire (Appendix G) was also utilized that includes questions about basic demographics, birth assigned gender and current gender identity, previous experiences in therapy, and transgender-specific questions. The gender identity demographic items (i.e., birth assigned gender and current gender identity) are modeled after the two question method for assessing gender categories, which has been shown to reduce missing data about gender and increase precision of measurement for transgender and cisgender individuals (Tate, Ledbetter, & Youssef, 2012). Basic demographic items such as age, income, geographic location, and marital status were included as they may affect the ways in which participants perceive the therapist in the three different video conditions. Research shows that income is a significant predictor of trustworthiness, attractiveness, and expertness ratings, while marital status is a significant predictor of perceived expertness (Corrigan & Schmidt, 1983). A participant's age may also play a significant role in their perceptions of the therapist in the various video conditions, as there has been an increased acceptance and visibility of transgender people over time. An older transgender person may have more negative experiences with therapists than a younger transgender identified participants, which may affect their perceptions of the affirming and non-affirming therapist. Further, there may be transgender-specific variables that influence responses including length of time identifying as their current gender identity or one's plan to

transition. Previous experiences in therapy and may also affect participants' responses, especially if these previous experiences were particularly positive or negative.

**Validity Items.** Attention check items were included to ensure participants were paying attention to the study, rather than simply clicking through quickly. For example, participants were asked the same question twice or asked to answer a question in a specific way (i.e., "For this item, please indicate disagree"). Participants were asked to indicate their current gender identity and birth assigned sex at the beginning and end of the study.

Additionally, participants were asked to indicate if they experienced any technical difficulties with the video or with any other portion of the study to ensure that technological problems did not interfere with responses and results.

## Chapter 4: Results

### Preliminary Analyses

**Validity Items and Attention Filters.** Preliminary analyses began with a thorough data cleaning process to remove data that may not be valid. First, attention filter items were examined. Attention filter items were meant to capture participants who may be answering quickly or randomly. This included asking the same question about hormone use twice within the same scale. Nearly one-fifth of the total sample ( $n = 655$ ) indicated a different response to the same question (19%,  $n = 123$ ). These participants were removed from the study since the item was meant to capture those who were not paying attention to the study. Another attention check item asked participants to click a specific response option (i.e., participants were asked to click the ‘disagree’ button). Of the remaining sample ( $n = 532$ ), 41 participants (8%) indicated the wrong response option leaving a total of 491 participants.

The following items were meant to capture data from those who did not identify as transgender and either entered the study by accident or were attempting to earn the MTurk incentive without actually completing the study. One of these items asked participants to indicate their current gender identity at the beginning and end of the study. A total of 59 participants (12%) indicated different responses for these items and were removed from the study, leaving 432 participants. Participants also answered the same question about assigned birth sex toward the beginning and end of the study. Approximately 2% ( $n = 7$ ) indicated a different response to these items and were also removed from data analysis.

A cross tabs analysis was run to assess for those who reported the same assigned birth sex and current gender identity, which seemed to indicate that they were cisgender. A total of 19 participants indicated that their birth assigned sex was the same as their birth assigned

gender identity. Each of these participant's data was reviewed to ascertain whether or not they actually identified as transgender or gender non-binary. Some of these participants indicated that they were cisgender via the open-ended comments, including, "...happy with the gender I was born with", or "I am not transgender". Others had answers that seemed to indicate that they were not participating fully, including discrepancies in age (i.e., current age indicated as 22 and age of coming out as transgender indicated as 49), and odd statements in open-ended responses such as, "I'm a man interested in fine looking women", or "to persuade you... to change your mind". Four of the participants who were flagged in the cross tab analysis were not removed because other response options indicated that although their birth assigned sex and current gender identity matched, they seemed to be in the process of coming out as non-binary or genderqueer. A total of 15 participants were removed via the cross tab analysis.

Finally, participants answered questions about any technical difficulties they may have encountered in the process of completing the study. During the course of the study, participants who indicated that they either didn't watch the video or encountered technical difficulties with the video were not allowed to continue the study. Participants who remained in the study were asked to indicate whether or not they encountered any technical problems throughout the study. Thirty-one participants indicated that they encountered some technical difficulties, but upon reviewing the comments, none of these participants were removed since they all seemed reasonably able to continue the study. For example, some participants noted that they had trouble viewing the video or had trouble loading the pages quickly but were able to view it in a new browser or on a different device without difficulty. All of these

participants seemed to have watched the video and had no other trouble with other part of the study that might indicate their removal from the analyses.

After removing all questionable data via the attention filters, cross tabs, and validity check items, a total of 409 of the original 655 participants remained for data analysis.

**Participants across conditions.** Participants were first grouped into one of two categories based on their plan to transition or not transition. Participants from each of these groups were then randomly assigned to view one of the three video conditions. Results indicate that approximately one-third of participants were assigned to each of the video conditions: 33% Transition affirming (n=136), 37% Non-binary affirming (n=153), and 29% Non-affirming (n=120). In terms of the participant’s plan to transition or not transition, two-thirds of the participants indicated that they were either interested in transitioning, in the process of transitioning, or had already transitioned ( $n = 254$ ; 63%), while approximately one-third indicated no plan to transition ( $n = 155$ ; 38%). Table 2 shows the distribution of participants across the six conditions.

Table 2

*Number of Participants Across Condition*

	Transition Affirming	Non-binary Affirming	Non-affirming
Transition	87	95	72
No Transition	49	58	48

**Descriptive Statistics.** An analysis of the preliminary descriptive statistics was conducted to identify the mean, standard deviation, and range across all the main measures, including the following: the three subscales of the counselor rating form (CRF) including

trustworthiness, expertness, and attractiveness; four subscales of the session evaluation questionnaire (SEQ), including positivity, arousal, smoothness, and depth; four subscales from the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS), including recognition of the need for help, ability to tolerate stigma, interpersonal openness, and confidence in mental health professionals; three subscales from the Transgender Adaptation and Integration Measure (TG AIM) including, gender-related fears, psychosocial impact of gender status, and coping and gender-reorientation efforts; and the two subscales of the Transgender Congruence Scale (TCS), including appearance congruence and gender identity acceptance. The results of the descriptive analyses and the possible range for each scale are listed in Table 3

Table 3

*Descriptive Statistics Across Measures*

	Mean	SD	Observed Range	Scale Range
CRF Trustworthiness	20	7.09	4-28	4-28
CRF Expertness	17.62	7.58	4-28	4-28
CRF Attractiveness	19.4	6.67	4-28	4-28
SEQ Depth	4.32	1.44	1-7	1-7
SEQ Smoothness	3.78	1.4	1-7	1-7
SEQ Arousal	3.49	.91	1-6	1-7
SEQ Positivity	4.06	.85	2-6	1-7
ATSPPHS	29.87	6.15	10-40	10-40
TGAIM Coping	16.01	5.09	6-24	6-24
TGAIM Impact	9.19	2.19	4-14	4-16
TGAIM Fears	11.4	3.75	5-20	5-20
TCS Acceptance	3.78	1.04	1-5	1-5
TCS Congruence	2.7	1.1	1-5	1-5

### Correlations Between Dependent Variables.

Prior to conducting the main analysis, a series of Pearson correlations between dependent measures was conducted to test the MANOVA assumption that the dependent measures included were moderately correlated. The correlation analysis included the following measures: CRF attractiveness, CRF expertness, CRF trustworthiness, CRF composite, SEQ depth, SEQ smoothness, SEQ positivity, and SEQ arousal (see table 4). Correlations between the counselor rating form subscales were high, nearly .8 or higher, which led to the formation of the CRF composite score. The analysis also indicated that most dependent variables were moderately correlated, though SEQ arousal was not well correlated with the other measures. As such, SEQ arousal was removed from the main MANOVA analysis.

Table 4

*Correlations Between Counselor Rating Form and Session Evaluation Questionnaire*

Variables	1	2	3	4	5	6	7	8
1. CRF Attractiveness	--							
2. CRF Expertness	.79**	--						
3. CRF Trustworthiness	.82**	.89**	--					
4. CRF Composite	.92**	.95**	.96**	--				
5. SEQ Depth	.67**	.76**	.73**	.76**	--			
6. SEQ Smoothness	.62**	.64**	.62**	.66**	.57**	--		
7. SEQ Positivity	.63**	.67**	.68**	.70**	.64**	.66**	--	
8. SEQ Arousal	-.08	-.11	-.15**	-.13	-.80	-.14**	-.09	--

## Main Analyses

A two-factor, between-subjects multivariate analysis of variance (MANOVA) was conducted, in which the therapy video condition (transition-affirming, non-binary affirming, and non-affirming) and plan to transition (plan to transition or no plan to transition) served as the two independent variables. The Counselor Rating Form (Corrigan & Schmidt, 1983) and the Session Evaluation Questionnaire subscales of session depth, session smoothness, and participant's positivity (Stiles & Snow, 1984) served as the dependent variables. Evaluations of the assumptions for MANOVA revealed some concerns about multivariate normality and homogeneity of variance-covariance matrices. Box's M was used to test the homogeneity of the variance-covariance matrices and the Box's M value of 64.49 and the associated non-significant  $p$  value of .134 indicated that the covariance matrices between groups were assumed to be equal. Levene's test was used to test the homogeneity of variance. Levene's test was not significant for the CFR composite score,  $F(5, 205) = 1.3, p = .265$ ; SEQ smoothness,  $F(5, 205) = 1.08, p = .370$ ; or SEQ positivity,  $F(5, 205) = 1.02, p = .405$ . However, the assumption of homogeneity of variance using Levene's test was violated for SEQ depth,  $F(5, 205) = 2.74, p = .02$ . Thus, a more conservative  $p$  value of  $p < .001$  was used for SEQ depth to account for this violation.

***Hypothesis I:*** *There will be a main effect of therapeutic focus, such that the therapeutic relationship will be rated higher for the transition affirming and non-binary affirming conditions as compared to the non-affirming condition.*

The first hypothesis was tested to examine the main effects based on the video conditions (transition affirming, non-binary affirming, non-affirming). It was hypothesized that participants would rate the transition affirming and the non-binary affirming videos more favorably than the non-affirming video across all dependent variables.

A MANOVA was conducted using the following therapeutic relationship variables: counselor ratings, session depth, session smoothness, and positivity. The SEQ arousal and ATSPPHS were not included in this MANOVA analysis because of the lack of a moderate correlation with other dependent measures. Results for this MANOVA indicate that there was a statistically significant difference in the perception of the therapist and session based on the video condition viewed with a medium to large effect size,  $F(8, 404) = 9.55, p < .0001$ ; Wilk's  $\Lambda = 0.71$ , partial  $\eta^2 = .159$ .

The test of between subject effects indicated that the therapy video watched had statistically significant effects on CRF composite,  $F(2, 205) = 34.28; p < .0005$ ; partial  $\eta^2 = .25$ ; SEQ session depth  $F(2, 205) = 21.73; p < .0005$ ; partial  $\eta^2 = .18$ ; SEQ session smoothness ( $F(2, 205) = 26.56; p < .0005$ ; partial  $\eta^2 = .21$ ); and SEQ participant's positivity  $F(2, 205) = 28.06; p < .0005$ ; partial  $\eta^2 = .22$ , all with large effect sizes.

Tukey's HSD post-hoc tests indicate that there was a significant difference between the transition affirming video condition and the non-affirming video condition across all dependent variables (CRF composite,  $p < .0005$ ; SEQ session depth,  $p < .0005$ ; SEQ session smoothness,  $p < .0005$ ; and SEQ participant's positivity,  $p < .0005$ ). There was also a significant difference between the non-binary affirming video condition and the non-affirming videos (CRF composite,  $p = .0005$ ; SEQ session depth,  $p = .0005$ ; SEQ session smoothness,  $p = .0005$ ; and SEQ participant's positivity,  $p = .0005$ ). Tukey's post-hoc test indicated that there were no significant differences between the two affirming conditions (transition affirming and non-binary affirming) and all the dependent variables (CRF composite,  $p = .661$ ; SEQ session depth,  $p = .921$ ; SEQ session smoothness,  $p = .937$ ; and

SEQ participant's positivity,  $p = .915$ ). These findings support the hypothesis that there is a main effect of therapeutic focus on the dependent variables.

Additional analyses were conducted to understand the role of the video condition and plan to transition on participant's willingness to seek professional psychological help and the SEQ arousal subscale. A two-way analysis of variance (ANOVA) was conducted to test these two dependent measures that were not used in the main analysis, including the SEQ arousal subscale and the Attitudes Toward Seeking Professional Psychological Help (ATSPPH). Results indicate that there was a significant effect of video condition on SEQ arousal ( $p = .023$ ), but no significant effect of plan to transition on SEQ arousal ( $p = .479$ ). The ATSPPH was not statistically significant for video condition ( $p = .33$ ) or plan to transition ( $p = .58$ ). These findings suggest that the video condition does have an effect on the participant's arousal, but their plan to transition or not to transition does not affect this reaction. It also shows that neither the video condition nor one's plan about transitioning affects their overall attitudes toward seeking professional psychological support.

***Hypothesis II:*** *There will be an interaction between the therapist response (i.e., transition affirming or non-binary affirming) and the participant's transition plan (i.e., have transitioned/plan to transition or no plan to transition) such that the therapeutic relationship will be rated higher when there is a match between the therapist approach and the participant's plan (i.e., transition affirming response matches plan to transition and non-binary affirming response matches no plan to transition).*

The second hypothesis was tested to examine the possibility of an interaction effect between the video condition and the participant's transition plan. It was hypothesized that participants who had transitioned, were in the process of transitioning, or wanted to transition would rate the transition affirming videos more favorably than the non-binary affirming video and that those who had no plan to transition would rate the non-binary affirming video more favorably than the transition affirming video.

This analysis utilized the interaction results from the previous MANOVA with the same therapeutic relationship variables: counselor ratings, session depth, session smoothness, and positivity. Results indicated that there was no significant difference in the perception of the therapist and session based on the interaction between the video condition and the participants' transition plan, with a small effect size,  $F(8, 404) = 1.097, p = .364$ ; Wilk's  $\Lambda = 0.958$ , partial  $\eta^2 = .021$ . Although not significant, there was an apparent trend for those who were not interested in transitioning to rate the non-binary affirming video more favorably than the transition affirming video for the Counselor Rating Form (see figure 1), which was not pronounced enough for meaningful interpretation for the SEQ subscales (see figures 2-4). Further, there was also an interesting trend for some of the measures for the non-affirming video condition. Participants who reported no plan to transition rated the non-affirming video condition lower than those who were interested in transitioning or already had transitioned, except for the SEQ depth measure, which showed the opposite trend. Though these trends are interesting and worth noting, the findings are not significant and do not support the hypothesis that there was an interaction effect between the video conditions and the participant's transition plan.

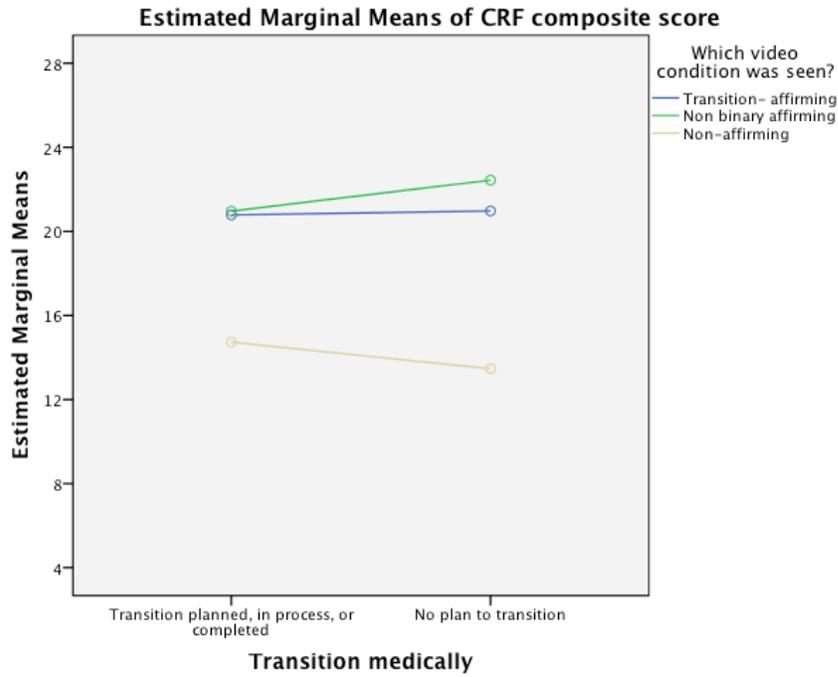


Figure 1. Estimated marginal means of composite Counselor Rating Form.

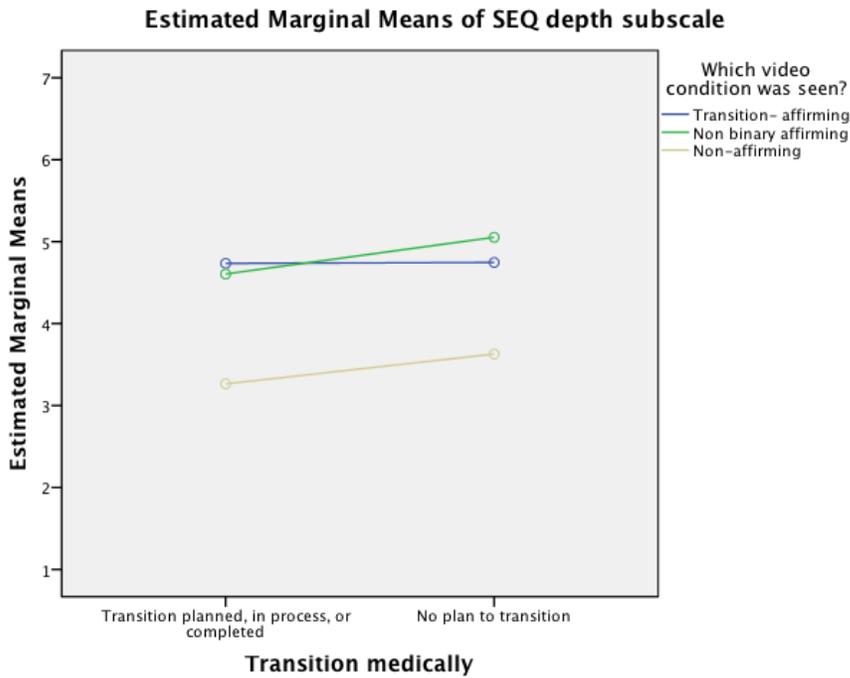


Figure 2. Estimated marginal means of SEQ depth subscale.

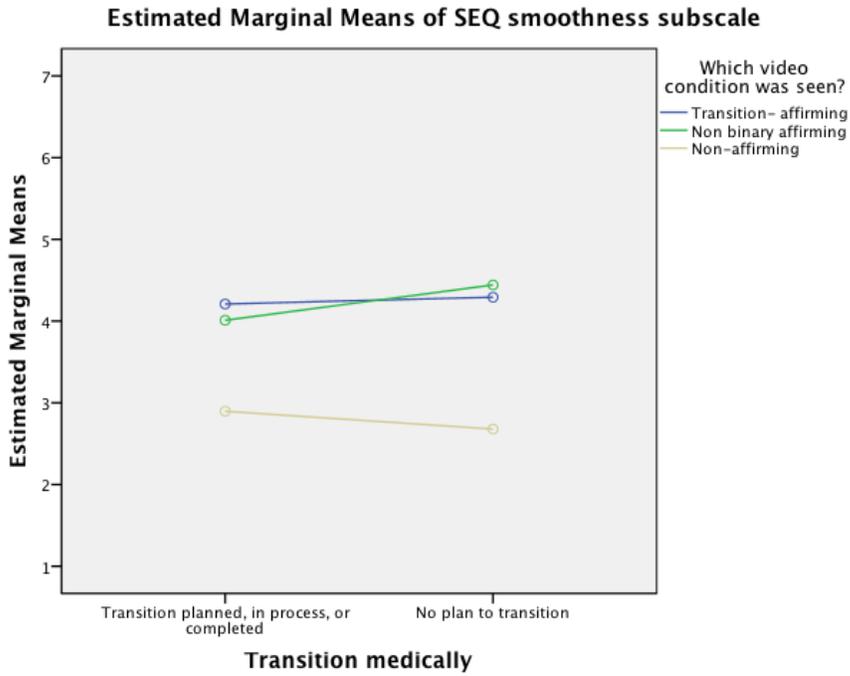


Figure 3. Estimated marginal means of SEQ smoothness subscale.

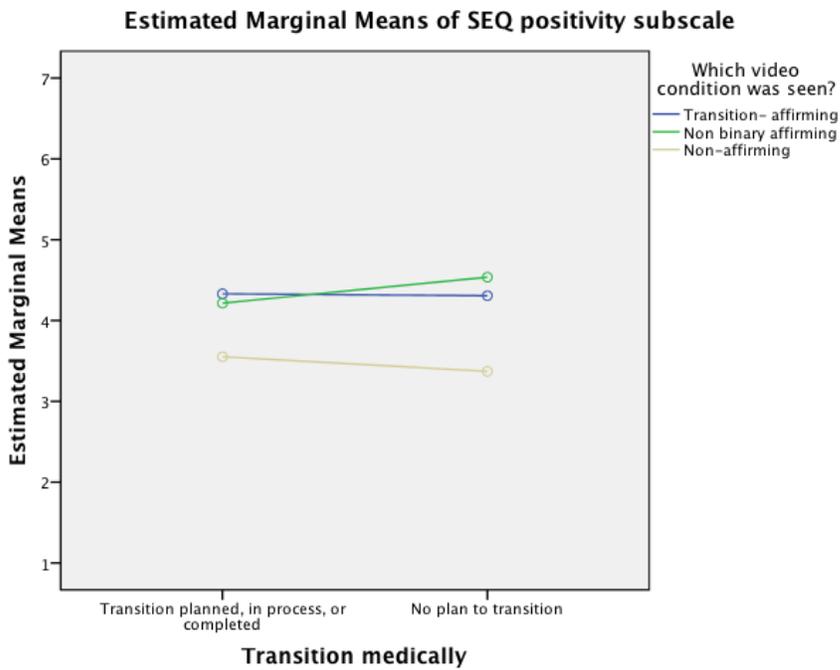


Figure 4. Estimate marginal means for SEQ positivity subscale

**Hypothesis III:** *There will be a significant difference between un-matched groups (i.e., transition affirming condition does not match participants plan not to transition AND non-binary condition does not match with participants plan to transition) such that those in the*

*transition affirming condition who do not plan to transition will rate the therapeutic relationship less favorably than those in the non-binary affirming condition who are planning to transition or have already transitioned.*

The third hypothesis was tested to examine the possibility that there would be a difference in therapist and session ratings between unmatched groups. It was hypothesized that participants who had no plan to transition would rate the transition affirming video condition more negatively than those participants who viewed the non-binary affirming condition and had transitioned, planned to transition, or were in the process of transitioning.

An independent samples t-test was conducted to compare the counselor rating form composite score, SEQ depth, SEQ smoothness, SEQ positivity, and SEQ arousal scales for the unmatched non-binary video condition and the unmatched transition affirming video condition. There was no significant difference between the un-matched non-binary affirming (M = 20.9, SD = 5.1) and un-matched transition affirming (M = 20.9, SD = 5.6) video condition for the counselor rating form,  $t(63) = -.006, p = .563$ . For SEQ depth, there was no significant difference between the un-matched non-binary affirming (M = 4.7, SD = 1.2) and un-matched transition affirming (M = 4.35, SD = 1.5) video condition;  $t(142) = 1.57, p = .119$ . For SEQ smoothness there was no significant difference between the un-matched non-binary affirming (M = 4.1, SD = 1.25) and un-matched transition affirming (M = 3.84, SD = 1.3) video condition;  $t(141) = 1.16, p = .248$ . For SEQ positivity, there was no significant difference between the un-matched non-binary affirming (M = 4.17, SD = .79) and un-matched transition affirming (M = 4.07, SD = .8) video condition;  $t(141) = .75, p = .45$ . SEQ arousal shows a similar pattern, as there is no significant difference between un-matched non-binary affirming (M = 3.5, SD = .98) and un-matched transition affirming (M = 3.39, SD = .75) video condition,  $t(142) = .475, p = .64$ . Taken together, these results suggest that there

is no significant difference between those who plan to transition who view a non-binary affirming video condition and those who do not plan to transition and view the transition affirming video condition across counselor and session ratings.

### **Exploratory Analyses**

In addition to the proposed research questions, exploratory analyses were conducted to further understand the relationship between the therapist response, the participant, and the participant's ratings of the therapeutic relationship. For example, transgender-specific measures were included to understand the role of gender-related fears, psychosocial impact of gender status, coping and gender-reorientation efforts, appearance congruence, and gender identity acceptance on the participant's rating of therapeutic relationship. Further, the participants' previous positive or negative experiences in therapy may have impacted their ratings of the therapist response conditions.

The transgender-specific measures included the Transgender Adaptation and Integration Measure (Sjoberg, Walch, Stanny, 2006) and the Transgender Congruence Scale (Kozee, Tylka, Bauerband, 2012). A correlation was conducted between the transgender-specific measures and all the dependent variables and there were no significant correlations between these the measures or subscales. The file was then split based on the participants' plan to transition or not transition. It was posited that a person's plan to transition would change the correlation between transgender-specific items and the dependent variables. However, there were no strong or significant correlations when the file was split based on the participant's plan to transition or not transition. The file was then split based on video condition as the video that was seen might have changed the correlations between the transgender-specific measures and the ratings of the video conditions. Again, there were no

significant correlations between these measures when splitting the file based on the video condition seen. These results suggest that factors such as acceptance of one's gender identity, congruence of identity and appearance, gender related fears, and gender reorientation efforts are not strongly or significantly correlated with viewing the therapist as likable, trustworthy, as an expert or the session as positive or deep.

Participants were asked about their past and current experiences with therapy. 80% of participants indicated they had seen a counselor or therapist at some point in their lives. The results indicated that participants generally had mostly positive (33%) or mixed positive and negative experiences (29%), with few reporting neutral (9%) or mostly negative experiences (7%). It was posited that past positive or negative experiences in therapy might have made the rating of the therapists higher because these participants have learned to trust or distrust the process of therapy, which might influence their overall positive or negative views of therapy. However, past positive experiences might have also made the rating of the therapy videos lower than they might have otherwise been if they were comparing the video to their experience and thinking that the therapist wasn't as good, could have been better, or were otherwise use to the positive relationship they had built with their therapist. However, the data shows that the potential bias of previous positive and/or negative experiences on ratings of the video condition is unlikely. Correlations between past therapy ratings as positive, negative, or mixed were not significantly correlated with ratings of the therapist, including, attractiveness,  $r(156) = .095, p = .236$ ; expertness,  $r(155) = .046, p = .572$ ; trustworthiness,  $r(155) = .077, p = .339$ ; or the session smoothness,  $r(281) = .084, p = .16$ ; or arousal,  $r(280) = -.043, p = .472$ . There were, however, some very small correlations between past experiences in therapy and the ratings of session depth,  $r(282) = .145, p = .015$ , and session

positivity,  $r(280) = .237, p = .0001$ . Thus, it seems that though many participants had previous experiences in therapy, many of which were positive or mixed, there does not seem to be a strong association between their past experiences and their ratings of the therapist in the present study.