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## Psychotherapists' Approaches to Transgender Affirmative Psychotherapy

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A thesis submitted in partial fulfillment of the requirements for the Master of Arts degree in  
Education

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## **Abstract**

This qualitative research study investigated how psychotherapists understand trans-affirmative psychotherapies and apply them to transgender and gender non-conforming (TGNC) populations in their practice. Additionally, this study aimed to gain a better understanding of how psychotherapists who work with these populations work with microaggressions should they occur in session with a TGNC client. Five Canadian psychotherapists were interviewed in-depth about their experiences and a qualitative content analysis revealed 5 themes: (1) the person-centered nature of trans-affirmative psychotherapy, (2) accessing the ability to repair the therapeutic relationship post-microaggression, (3) the role of shame, (4) the universality of trans-affirmative therapy, and (5) therapist self-education. How trans-affirmative psychotherapy can be understood as a specific therapeutic modality is discussed, along with how therapists can work specifically with microaggressions is discussed. Implications for how graduate schools can best educate training psychotherapists in these areas is discussed.

**Keywords:** Trans-Affirmative Psychotherapy, Trans-Positive Psychotherapy, microaggressions

### **Lay Audience Summary**

This qualitative study investigated how therapists incorporate trans-affirmative psychotherapy with clients who are transgender and gender non-conforming (TGNC). Additionally, this study aimed to understand how therapists work with microaggressions when they occur in therapy with the TGNC population. From interviews with 5 Canadian psychotherapists emerged a variety of themes about both trans-affirmative psychotherapy and the role of microaggressions with this population including: (1) how trans-affirmative psychotherapy is influenced by humanistic psychotherapy, (2) how important it is for therapists to assess their ability to repair a relationship with a client should a microaggression occur in their work together, (3) how understanding shame plays a key role in the delivery of trans-affirmative psychotherapy, (4) how trans-affirmative psychotherapy should be a universal approach used even for clients who are not TGNC, and (5) the role that therapists play in educating themselves in trans-affirmative psychotherapy. How these findings can be incorporated into the understanding of how to work with TGNC clients in psychotherapy is discussed, along with how graduate programs that train psychotherapists can better educate their students to feel more prepared to work with this population.

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## Contents

<b>Abstract.....</b>	<b>I</b>
<b>Lay Audience Summary .....</b>	<b>II</b>
<b>Acknowledgments .....</b>	<b>III</b>
<b>Chapter 1: Introduction .....</b>	<b>1</b>
<b>Chapter 2: Literature Review.....</b>	<b>6</b>
<b>History of Psychology’s Approach to Transgender and Gender Non-Conforming     People .....</b>	<b>7</b>
<b>Cultural Context .....</b>	<b>12</b>
<b>Transgender Affirmative Therapy .....</b>	<b>14</b>
<b>Microaggressions.....</b>	<b>17</b>
<b>Affirmative Therapy meets Microaggressions .....</b>	<b>21</b>
<b>Summary.....</b>	<b>21</b>
<b>Chapter 3: Research Methodology.....</b>	<b>23</b>
<b>Research Design .....</b>	<b>25</b>
<b>Participants.....</b>	<b>26</b>
<b>Procedure .....</b>	<b>27</b>
<b>Data Analysis .....</b>	<b>28</b>
<b>Conclusion.....</b>	<b>29</b>
<b>Chapter 4: Results .....</b>	<b>29</b>
<b>Case 1: Natalya.....</b>	<b>29</b>
<b>Case 2: Trish.....</b>	<b>31</b>
<b>Case 3: Dwayne .....</b>	<b>33</b>
<b>Case 4: Peyton .....</b>	<b>34</b>

<b>Case 5: Victoria .....</b>	<b>35</b>
<b>Conclusion.....</b>	<b>37</b>
<b>Chapter 5: Discussion .....</b>	<b>38</b>
<b>Main Themes .....</b>	<b>38</b>
<b>Chapter 6: Conclusion.....</b>	<b>52</b>
<b>Summary of Study .....</b>	<b>53</b>
<b>Key Findings.....</b>	<b>54</b>
<b>Implications .....</b>	<b>57</b>
<b>Limitations and Future Research.....</b>	<b>61</b>
<b>Concluding Remarks .....</b>	<b>62</b>
<b>References.....</b>	<b>63</b>
<b>Appendix A – Recruitment Letter.....</b>	<b>86</b>
<b>Appendix B – Letter of Information .....</b>	<b>87</b>
<b>Appendix C – Interview Guide.....</b>	<b>90</b>
<b>Appendix D – Debriefing Form .....</b>	<b>93</b>
<b>Appendix F – Ethics Approval .....</b>	<b>94</b>
<b>Curriculum Vitae.....</b>	<b>95</b>

## Chapter 1: Introduction

Transgender and gender non-conforming (TGNC) individuals are people whose gender identity is not aligned with the gender and sex they were assigned at birth (American Psychological Association, 2015; Ansara, 2010). An explosion of research within the past 20 years on TGNC people has yielded multiple trans-affirmative and trans-positive approaches to care for TGNC people in a variety of health disciplines (American Psychological Association, 2015). Psychotherapy has not been an exception to this. However, understanding what research psychotherapists use and how they incorporate it into their work with TGNC clients is poorly understood. This study aims to gain a better understand of how psychotherapists practice trans-affirmative therapy.

Transgender and gender non-conforming people have many needs in regard to their mental health. However, many of the issues TGNC people face are similar to the issues *cisgender*, those whose gender identity is aligned with their assigned sex and gender, people seek in therapy. Depression, anxiety, substance issues, and challenging relationships are common presenting problems in this population (Meier & Labuski, 2013; Shipherd, Green & Abramovitz, 2010). However, such issues are more likely to occur in this population. For example, TGNC people have increased levels of depression (Fredriksen-Golden et al., 2014) anxiety (Bouman et al., 2017) substance use (James et al., 2016) and suicidality compared to the rest of the population (Clements-Noelle, Marx, Katz, 2006; Haas, Rodgers, & Herman, 2014). As a result, TGNC individuals often seek out the help of psychotherapists and counsellors at a higher rate compared to cisgender people (King, Semlyen, Killaspy, Nazareth, & Osborn, 2007). For example, Grant, Motter, and Tanis (2011) found that 75% of transgender people have been in or

currently are in psychotherapy. While only 3% of the general population uses psychotherapy (Olfson & Marcus, 2010).

TGNC people also have unique issues that they bring to psychotherapy. Such as exploration around their gender, affirmation of their gender process, familial adjustment and workplace adjustment as it relates to their transition (Bockting, Robinson, Benner, & Scheltema, 2004; Rachlin, 2002). TGNC people also experience high levels of familial rejection, harassment, discrimination, poverty, and social isolation in the workplace (Bockting, Knudson, & Goldberg, 2006; Haas, Rodgers, & Herman, 2014; Stotzer, 2009). These are also common themes in therapy for this population.

Despite many of these issues being well known, this knowledge has not translated to effective psychotherapy for TGNC clients (Mizock & Lundquist, 2016). Historically, TGNC people have viewed psychotherapy as deeply painful since being transgender or gender non-conforming was considered something to be pathologized by mental health professionals (Applegarth & Nuttall, 2016; Sennott, 2010). Research on transgender people has postulated that they are suffering from psychopathy (Olkon & Sherman, 1944), a sexual fetish (Blanchard, 1989), an overabundance of homosexuality (Lawrence, 2017), being overly enmeshed with their mother (or father with trans men) (Zucker & Bradley, 1995), not being close enough to their father (Zucker & Bradley, 1995), or it is a result of social contagion (Littman, 2018) As a result, treatments historically focused on ‘fixing’ or ‘curing’ gender deviance. Methods of curing have ranged from psychoanalysis to aversion and electroshock therapy, and administering assigned sex consistent hormones (Serano, 2009).

In modern times, the ‘curing’ approach has mostly fallen out of favour for more affirmative approaches. However, treating TGNC people has not been without controversy. A



common issue has been therapists and other mental health experts' roles as gatekeepers to transition services/treatments, and thus holding the power to establish the validity of a TGNC person's identity (Budge, 2015; MacKinnon, Grace, Ng, Sicchia, & Ross, 2020). Many countries adhere to some variant of The World Association for Transgender Health (WPATH) Standards of Care (SOC) for health and mental health professionals. Previous SOCs had required at least 3 months of psychotherapy for a TGNC person seeking hormone treatment. In addition, the person had to spend 1 year living as their desired gender to see if they were a fit for hormone treatment (Budge, 2015). Mental health practitioners have often been the ones making the decision about if the client was a good fit for hormone replacement therapy (Budge, 2015). This resulted in many challenges in their therapy dynamic, particularly the power imbalance, and clients feeling the need to lie to clinicians since they often had narrow definition of how a TGNC person should be (Benson, 2013; Budge & Moradi, 2018; MacKinnon et al., 2020). While this is no longer in the current SOC, it does highly recommend that people seek psychological help from mental health professionals, and the somewhat hostile dynamic still remains (Budge, 2015; MacKinnon et al., 2020; Pitts-Taylor, 2020).

Despite structural issues like gatekeeping practices and the overemphasis on pathology being the commonly reported issues TGNC people have found with psychotherapy, it has been more common to address clinician's attitudes towards transgender people and their knowledge of transgender issues as the source for TGNC people's lack of trust in psychotherapy. This presumably stems from research in health care fields showing that negative attitudes toward transgender people (Sanchez, Rabatin, Sanchez, Hubbard, & Kalet, 2006) and lack of knowledge about transgender issues (Dowshen et al., 2014) are a major barrier to competent care. Naturally, researchers have investigated if such a phenomenon existed in mental health care.

Counsellors/psychotherapists have been shown to have more positive attitudes towards transgender people than both healthcare professionals and the general public (Kanamori & Cornelius-White, 2017). Despite this, current research has shown that TGNC clients still experience a myriad of difficulties in therapy, such as being judged or pathologized by therapists, feeling as though gender issues are over or under-emphasized in therapy, and feeling as though their gender identity is being invalidated (Brown et al., 2020; Israel, Gorcheva, Burnes & Walther, 2008; Morris, Lindley, & Galupo, 2020; Rachlin, 2002). It has been proposed that negative experiences in therapy can be incredibly harmful to TGNC people (Mikalson, Pardo & Green, 2012; Morris et al., 2020). These experiences are often harmful enough that TGNC clients proceed to avoid treatment in the future (James et al., 2016).

Research on TGNC people having negative experiences in therapy has generally placed the blame for the negative experiences on clinician's lack of understanding gender and transgender related issues (Israel et al., 2008; Rachlin, 2002). For example, less than 30% of mental health professionals report being familiar with transgender clients' needs (Singh & Dickey, 2016). While the lack of understanding of transgender specific issues is commonly cited as therapists' shortcoming, research has also shown that a lack of a solid therapeutic relationship renders one's knowledge of gender and transgender issues ineffective (Hunt, 2016). This suggests that improved education alone may not be enough to improve treatment of transgender clients. In order for treatment to improve, clinicians should not only be more aware of transgender specific issues but also how they express it may be crucial to fostering an effective therapeutic alliance.

There has been a multitude of issues for the TGNC population when it comes to getting appropriate mental health care. A review of the literature reveals that this population is overly

represented in psychotherapy, but that the majority of clinicians feel unprepared to work with this group. It has not helped that the historical relationship between mental health professionals and the TGNC population has one been one where the clients have been viewed thru a pathological lens and forced to meet strict cis-normative and hetero-normative expectations in order to get adequate treatment. Despite that, research has begun to look at less pathologizing ways to work with this population and such approaches are explored in the next chapter.

## Chapter 2: Literature Review

This literature review focuses on historical approaches to how the scientific and psychological communities have viewed those who are transgender and gender non-conforming. The literature reveals a highly pathologized view of gender non-conformity, and thus amelioration of mental health difficulties has focused on ‘fixing’ or ‘curing’ gender deviance, with more recent affirmative approaches appearing as well. The literature reveals this pathologizing lens appears to stem from beliefs on the importance of a rigid gender binary and a belief in compulsory heterosexuality. In addition to the historical views of TGNC people and how that may influence poor outcomes for them in psychotherapy, this literature review also explores current trends within Canada that may facilitate further negative views of this group. Valorization of those critical of gender non-conformity within Canadian media and lack of government intervention to protect TGNC people are key themes that emerged.

The review then focuses on the development of trans-affirmative psychotherapy as an offshoot of affirmative therapies for the lesbian, gay and bisexual communities. The review highlights how many different trans-affirmative or trans-positive approaches to psychotherapy have popped up in the past 15 years. The literature reveals that these approaches are seldom taught in graduate programs and there is minimal research as to how clinicians consume and implement these approaches, necessitating this study’s first research question.

The review then focuses on microaggressions, their development in general and the research that pertains to microaggressions with TGNC populations. The literature reveals research about microaggressions with this population in the context of therapy, however this is predominantly from the perspective of the client, thus leading to this study’s second research question.

## **History of Psychology's Approach to Transgender and Gender Non-Conforming People**

Despite appearing like a relatively new phenomenon to the 'western world', gender variant people have existed throughout history in places and cultures such as: ancient Egypt (*transgendered*), Ethiopia (*the ashtime*), Bantu (*inkotshane*), Navajo (*Dine*), Zuni (*Ihamana*), Zapotec (*Muxes*), Ancient Assyria (*Gala, Kurgarru, assinu*), Ancient Arabia (Khanith), Ancient Japan (*Kabuki*), Ancient India (*Hijras*), Thailand (*Kathoeyes*), Brazil (*Transvesti*), Indonesia (*Waria*), Philippines (*Bakla*), Samoa (*Fa'afine*), Tonga (*Fakaleti*), Fiji (*Vakasalewalewa*), Turtle Island and many other indigenous North American groups (*Two-spirit*) (Meyercook & Labelle, 2004; Reis, 2004). While some of these groups still exist and are even celebrated in their respective cultures, the widespread effect of colonisation and eurocentrism led to many of these concepts being completely removed or severely limited in historical discussion of gender non-conformity (Greensmith & Giwa, 2013).

Knowledge of TGNC people in the 'western world' began mostly with the pioneering work of Richard von Krafft-Ebing in his magnum opus *Psychopathia Sexualis* (1893). It is perhaps this work that led to long term speculations that gender variance is a sexual issue, a misguided assumption that still persists to this day in psychology (De Block & Adriaens, 2013). Krafft-Ebing's book focused on paraphilias (unconventional sexual arousal), but Krafft-Ebing's book positioned men dressing as women as a sexual paraphilia, whether men crossdressed for sexual pleasure or not (De Block & Adriaens, 2013). While Krafft-Ebing's perspective was highly pathologizing, German physician and sexologist Magnus Hirschfeld and British physician Havelock Ellis moved the field in a progressive direction and are among the first medical professionals to be highly supportive of transgender people's autonomy and rights (Sutton, 2012). Ellis was supportive of trans people, but espoused Freudian etiological beliefs,

that persist to this day, that it may result from one being too close to the mother (for trans women in particular), but he was also ahead of his time in thinking gender variance could potentially be a hormone issue (Ellis, 1936). Hirschfeld found tremendous growth in the area of transgender research upon establishing the Institut für Sexualwissenschaft (Institute of Sexual Research). This institute was responsible for progressing the advancement of LGBT+ groups in Weimar Germany through their research (De Block & Adriaens, 2013; Sutton, 2012). Unfortunately, just months after Hitler's appointment as chancellor in 1932, the Nazis ransacked the institute, burning all of the literature and closing the institute forever (De Block & Adriaens, 2013).

Across the Atlantic, American researchers began investigating the transgender phenomenon, but from a much more deficit-based focus than Ellis and Hirschfeld. Olkon and Sherman (1944) did this with a case study of an assigned male at birth patient, Patient M.M., who desired to live as a woman. Olkon and Sherman (1944) describe/diagnose M.M. as both narcissistic and psychopathic, due to a complete disregard for society's notion of proper masculine behaviour. A caption of a photo of M.M. in female clothing states, "He manifested no concern of bystanders' opinions of his change to female attire, denoting emotional stunting" (Olkon & Sherman, 1944, p. 161). While this may seem like simple historical nitpicking, prejudiced notions such as these fueled much of the later research in psychiatry, psychology and psychotherapy.

The Olkon and Sherman perspective was dominant until the 60's when physician Harry Benjamin took keen interest in a much more empathic perspective (Ihlenfeld, 2004). Benjamin was responsible for assisting many transgender individuals with their ability to transition by popularizing hormone treatment and gender reassignment surgery as effective treatments for such people (Benjamin, 1967; Ihlenfeld, 2004). A downfall of Benjamin's work was that he

placed a lot of energy trying to classify who truly was transgender based on sexual orientation, reflecting hetero-normative and cis-normative expectations, and primacy of sexuality in gender issues (Ekins, 2005).

This primacy of one's sexuality determining one's gender identity continued to emerge at Toronto's Clarke Institute, where Ray Blanchard and other researchers noticed a common trend amongst transgender women. One group was predominantly androphilic (attracted to men), transitioned early in life, were rather effeminate as children, and experienced no arousal at the thought of being a woman (Blanchard, 2005). Another major cluster of the trans women that were studied were gynophilic (attracted to women), transitioned later in life, had outwardly masculine childhoods, and did express sexual arousal at the thought of being female (Blanchard, 2005). From this information Blanchard (1989) heavily emphasized the sexual aspects and laid down the tenets of his highly controversial Autogynephilia Theory. This theory posits that there are two types of transgender women: 'homosexual transsexuals' (HTs), the androphilic group which consist of gay men who realize that their dating life would be easier if they became women and had access to straight men instead of just gay men (Blanchard, 1989). The second group, the autogynephiles (AGPs), are men with a sexual paraphilia, in that they are sexually aroused by the idea of being a woman, and thus their motivation to transition is that becoming a woman is the ultimate sexual fantasy (Blanchard, 1989). Later research attempted to establish a similar trend amongst transgender men but found little success in supporting the notion (Coleman, Bockting & Gooren, 1993). This theory became accepted by a number of clinicians working in the area of gender identity (Moser, 2010). However, this theory has been widely criticized for its methodological issues (Serano, 2009), insistence on its universality despite lacking the research to support such a claim (Banks & Roney, 2021; Veale, 2014), research

showing autogynephilia also exists in cisgender women (Moser, 2009), and the notion that the theory itself may be unfalsifiable (Winters, 2008).

This theory led to intense marginalization of transgender people when seeking medical assistance, as autogynephilia theory essentially favoured homosexual transsexuals as more ‘real’ trans people and the autogynephiles as fetishists (Bollin, 1988; Namaste, 2000). Criteria used often have had no grounding in science or research, but simply sexist notions of what it means to be a man or woman (Bollin, 1988; Namaste, 2000). For example, at times, to be taken seriously trans women needed to be seen as sexually attractive (Kessler & Mckenna 1985, Serano, 2009) needed to dress in a very feminine manner (Bollin, 1988; Namaste, 2000), not be engaged in sex work and should ensure their new name is not androgynous in any way (Namaste, 2000). Similar restrictive beliefs and expectations regarding sexuality and gender have been placed upon transgender men and non-binary individuals (Darwin, 2020; Johnson, 2016). These notions reflect what is referred to as *trans-normativity*, the concept that TGNC experience is legitimized via medical and psychological standards (Johnson, 2016).

However, research has not solely looked at sexual orientation as a means to assess who is ‘truly’ transgender. Research has encouraged other gatekeeping type practices that focus on ‘curing’ or ‘fixing’ transgender people, particularly youth, and only providing affirmative care if they cannot be fixed beyond their childhood. This is reflected by Dr. Richard Green’s work in the 1980’s where his approach to feminine boys was that they have ‘Sissy Boy Syndrome’ and simply needed behavioural interventions directed at their feminine qualities to be cured (Green, 1987; Kuhl & Martino, 2018). The 1990’s saw a heavy emphasis on interrogation of the parents’ role in their child becoming transgender or gender variant. Dr. Kenneth Zucker’s research at the Centre for Addiction and Mental Health Gender Identity Clinic for Children posited that parent’s



passivity in intervening in a child's cross-gender behaviour played a role in the child's development of a variant gender identity (Zucker & Bradley, 1995). This approach has been routinely criticized and viewed as indistinguishable from reparative therapy (Winters et al., 2018). Currently, it is not uncommon for mental health professionals to take on a reparative perspective. James et al. (2016) found nearly 20% of trans people who discuss their gender identity with a mental health professional reported that the professional attempted to stop them from being transgender, this is despite research showing that such an experience increases their likelihood of attempting suicide by 149%.

What may perhaps be most harmful about this research is the lack of TGNC people's voices represented in this research. Despite many TGNC people espousing rejection of simplistic and pathologizing models like Blanchard's or Zucker's to explain their existence (Neri, Faccio, & Ludici, 2020; Tosh, 2011; Veale, Clark & Lomax, 2012; Winters et al., 2018), such claims have often dismissed trans people who disagree as 'liars' and 'deceptive' (Lawrence, 2017). This approach to TGNC people would represent an example of *epistemological violence*.

*Epistemological violence* is when interpretations of data have negative consequences for marginalized groups, and these interpretations are selected despite existing alternatives that are equally and possibly even more appropriate interpretations of the data (Teo, 2010). For example, Autogynephilia theory is an example of epistemological violence as there are many other plausible interpretations of TGNC people's reasons for transition and interpretation of women's sexual behaviour that do not reinforce their marginalization (Banks & Roney, 2021; Moser, 2009; Serano, 2009; Veale, Clarke & Lomax, 2014). What is alarming is that these examples of epistemological violence towards TGNC people is not just from theories stemming from the 1980's and 1990's, but new examples are popping up currently.

Even more recent research has continued to view TGNC people in a highly pathologized lens. For example, researchers have politicized the new pseudo-diagnostic term *rapid-onset gender dysphoria* (ROGD) (Littman, 2018). ROGD posits that transgender youth who come out ‘suddenly’ after having exposure to transgender communities amounts to a social contagion issue rather than a gender identity issue (Littman, 2018). Researchers who believe in the validity of ROGD argue that medical transition for young people in this group is dangerous, despite the mounting empirical support showing the benefits of youth who transition (Durwood, McLaughlin, & Olson, 2017; Lopez, Marinkovic, Eimicke, Rosenthal & Olshan, 2017; Turban, Beckwith, Resiner, & Keuroghlian, 2020). Interestingly, the voices of those who are considered to have ROGD are not represented in this research (Ashley, 2020).

### **Cultural Context**

With various epistemological beliefs about TGNC people’s existence being that they have a sexual fetish, a poor relationship with a parental figure, or are suffering from a social contagion, it shouldn’t come as a surprise that psychotherapy with this population has often been traumatizing for this group (Mizock & Lundquist, 2016; Morris et al., 2020). However, psychological research itself is not the only thing that may play a role in poor mental health treatment for TGNC. It has been shown that clinicians attitudes play a role in their ability to provide competent care to TGNC people (Brown, Kucharska, Marczak, 2018; Riggs & Sion, 2017). These attitudes do not exist in a vacuum and come from our interpretation of various factors including cultural context (Norton, 1997; Riggs & Sion, 2017; Schilt & Westbrook, 2009).

Canada itself is a great example of how the cultural mythos of TGNC people as dangerous and deviant, supported by questionable research, may have played a role in poor

mental health support for TGNC people. Ray Blanchard's work took place in Toronto, in fact in the same building that would become Zucker's Gender Identity Clinic for Children. Despite Zucker's work with gender variant children seen as indistinguishable from reparative therapy the clinic was not shut down until 2015 (Kuhl, 2019; Wright, Candy, & King, 2018). Perhaps that is not surprising since Canada only federally outlawed conversion therapy at the federal level in 2020 (Kinitz et al., 2021).

The culture of valorization of those who challenge the legitimacy of TGNC people's existence and rights is not uncommon in Canada either. This may be best demonstrated by the rise of Dr. Jordan Peterson, a relatively unknown neo-Jungian University of Toronto professor of Clinical Psychology whose strong opposition to Canada's Bill C-16 (a bill making gender expression and gender identity protected grounds to the Canadian Human Rights Act) took Peterson from obscurity to stardom (Burston, 2019; Cossman, 2018). The psychologist went from the middling success of his first book *Maps of Meaning* to an international best-selling author after his opposition to Bill C-16 and publication of his book *12 Rules to Life* (Burston, 2019). A key role in that may have been an op-ed he was allowed to write for one of Canada's national newspapers *The National Post*. Since 2011 the paper has published 131 articles about transgender and gender nonconforming people, with 94% of those articles opposing acceptance of TGNC people (McArdle, 2019). It's not uncommon in one of Canada's largest papers to give voice to those critical of transgender people's existence and be described as champions of free speech and common sense, whilst the acceptance of TGNC people is routinely described as 'Orwellian' (McArdle, 2019). Additionally, this same paper allowed writer Barbara Kay to write 29 articles that opposed TNGC people's autonomy, such articles have supported conversion therapy, positioned trans youth as corrupted and valorized ROGD (McArdle, 2019).

Knowing that we cannot untangle cultural interpretation of things like rigid gender norms, compulsory heterosexuality from how mental health professionals view TGNC people, it is not surprising that therapies that are affirmative for this group have been few and far between. However, with the emergence of affirmative therapies for other persecuted groups it has been a natural shift for researchers to try to implement these with TGNC people.

### **Transgender Affirmative Therapy**

With the history in understanding TGNC people and the aetiology of TGNC people being mixed with plenty of pathologization and some supportive interpretations sprinkled in it is not surprising that a systemic approach to affirmative counselling with this group has not been established until more recently. While there have been case studies and the occasional journal article about being supportive in therapy with this population it was not until affirmative therapies began to spring up for the lesbian, gay and bisexual (LGB) communities did research into how this may be applicable to TGNC people begin.

The framework that bests directs clinicians to not only be informed about specific groups, but to integrate that with their own personal beliefs in order to develop an effective working alliance is *affirmative therapy*. Affirmative therapy originally emerged as an approach to treating lesbian, gay, and bisexual (LGB) clients (Davies, 1996). This kind of therapy posits that clinicians should engage with LGB clients in manner that is affirming and inclusive of their sexual identity, but also works to minimize the effects of oppression that LBG people experience (Langdridge, 2007). This approach has been effective for LGB clients and has received much expansion in recent years (O'Shaughnessy, Tiffany, & Speir, 2018). As a result, it has been applied to a variety of areas such as: disability (Orkin, 2009), consensual non-monogamy

(Barker & Langdrige, 2010), sex workers (Bloomquist & Sprankle, 2019) and the most expansive new area is affirmative therapy for transgender people (American Psychological Association, 2015; Chang, Singh, Dickey, 2018; Edwards-Leeper, Leibowitz & Sangganjanavanich, 2016; Korell & Lorah, 2007).

Perez (2007) describes the more wholistic LGBT affirmative therapy as:

“the integration of knowledge and awareness by the therapist of the unique developmental cultural aspects of LGBT individuals, the therapist’s own self-knowledge, and the translation of this knowledge and awareness into effective and helpful therapy skills at all stages of the therapeutic process” (p. 408).

In addition, Perez (2007) states that there are three core conditions to be met for LGBT affirmative therapy: (a) therapist competence, (b) affirmation of LGBT culture, and (c) the therapist is open to sexual orientation and gender identity issues.

While empirical studies on LGBT affirmative therapy are still rare, research supports the need for these types of competencies in counsellors. LGB clients have more confidence in and are more likely to return to counsellors whose language is free of heterosexist biases (Dorland & Fischer, 2001). Pachankis et al. (2015) found support for their ESTEEM model which was one of the first empirical assessments of gay affirmative therapy model. Multiple studies have found support for adapting pre-existing evidence-based approaches to substance abuse with a gay affirmative framework for gay clients (Shoptaw et al., 2005; Reback & Shoptaw, 2014). There are many other areas where adapting existing validated approaches with LGBT affirmative elements is helpful for LGBT clients, such as acceptance and commitment therapy (Yadavaia &

Hayes, 2012), attachment-based family therapy (Diamond et al., 2013), and cognitive behavioural therapy (Walsh & Hope, 2010). Trans-Affirmative therapy blended with a cognitive behavioural approach has been found to be helpful TGNC clients (Austin & Craig, 2015; Austin, Craig, D'Souza, 2018). A pilot study looking at the effectiveness of trans-affirmative psychotherapy found that it was effective for clients and further research with larger samples is warranted (Budge, Sinnard, & Hoyt, 2020).

Looking specifically at transgender affirmative therapy, it is built upon a similar framework as other affirmative therapies, but because of its infancy different research on the subject offers different advice for psychotherapists. Almost all research suggests counsellors have a self-awareness about how their views on gender may affect a transgender client, a recognition of institutional barriers that harm transgender people, understanding of how discrimination is detrimental to trans people's mental health, and the differences between gender identity and sexual orientation (American Psychological Association, 2015; Chang et al., 2018; Edwards-Leeper et al., 2016). Another common tenet is attempts by the therapist to repair the damage done by a heterosexist and transphobic society (Austin & Craig, 2015). However, differences can be seen in how some guidelines place a large emphasis on correct usage of pronouns as a central tenant, while other articles treat that as a prerequisite skill (American Psychological Association, 2015). Additionally, others see a large emphasis on deconstruction of the gender binary while others do not and may reinforce the notion of there being only two genders (Benson, 2013). The reflection of different tenets may be reflective of how trans-affirmative psychotherapy is often ground in a large variety of other therapeutic modalities. For example, Chang et al. (2018) state that trans-affirmative psychotherapy includes the following psychotherapeutic frameworks: client centered, multicultural, psychodynamic/attachment theory,

family systems, feminist, trauma informed, cognitive behavioural, dialectical behavioural, acceptance and commitment, and developmental amongst others.

The variance in the literature is compounded by the fact that training counsellors often receive very little education in affirmative therapy to begin with (Grzanka & Miles, 2016). Additionally, knowing how understandings of affirmative therapies may play out within a therapeutic encounter and interact with a therapist's beliefs is not well understood (Grzanka & Miles, 2016). Therefore, knowing how much, and what training therapists have taken is difficult to determine. As a result, it becomes imperative to understand what psychotherapists are using as a guide, if any, when it comes to working with a TGNC client. Along with how they conceptualize trans-affirmative psychotherapy in terms of incorporated therapeutic frameworks. This leads to this study's first research question: *How do psychotherapists approach affirmative psychotherapy towards TGNC clients?* (e.g. How were they educated on the subject? What sources do they use? What commonalities appear amongst this group of clinicians?).

### **Microaggressions**

Microaggressions are defined as, 'everyday exchanges that send denigrating messages to people of colour because they belong to a racial minority group (Sue et al., 2007, p. 273). While the initial works on microaggressions, such as Sue et al.'s (2007) work, focused on racial microaggressions, future research began to include other groups, such as gender and sexual minorities (Sue, 2010; Vaccaro & Koob, 2019). Research in this area posits that microaggressions can be experienced both environmentally and interpersonally (Sue, 2010). Environmental microaggressions are considered "demeaning and threatening social, educational, political or economic cues that are communicated individually or societally" (Sue, 2010, p.25). Sue et al. (2007) broke down interpersonal microaggressions into three different types:

microassaults, microinsults, and microinvalidations. Microassaults are considered conscious actions that are meant to hurt people from minority groups, that can include threats, bullying, name calling, and exclusion (Sue, 2010). Conversely, microinvalidations and microinsults are not committed consciously. Microinsults are insensitive or rude comments that express negative messages about one's minority identity (Sue, 2010). Microinvalidations include cues, 'that exclude, negate or nullify the psychological thoughts, feelings, or experiential reality of certain groups' (Sue, 2010, p. 37).

Some scholars have criticized microaggressions for lacking sufficient operationalization, over reliance on subjective reports, and that they don't reflect actual racist intentions (Haidt, 2017; Lilenfield, 2017). However, most criticism of microaggressions operationalization have failed to take into account how microaggressions are context dependent, thus leading to misinterpretations (Vaccaro & Koob, 2019). In regard to measurement issues, scholars researching microaggressions do use self-reporting measures, such as the Racial Microaggression Scale (Torres-Harding, Andrade, Diaz, & Crist, 2012) and the Sexual Orientation Microaggression Inventory (Swann, Minshew, Newcomb & Mustanski, 2016) which have good psychometric properties (Vaccaro & Koob, 2019). In terms of intentions behind microaggressions, research has found that microaggressive behaviours are in fact rooted in racist beliefs (Kanter et al., 2017; Vaccaro & Koob, 2019).

Nadal, Rivera, Corpus, & Sue (2010) brought light to how microaggressions can impact those who are gender and sexual minorities. From the dearth of research into LGBT microaggressions, many researchers focused solely on how microaggressions impact, and are experienced by TGNC people (Chang & Chung, 2015; Pulice-Farrow, Brown, & Galupo, 2017; Pulice-Farrow, Clements, & Galupo, 2017; Woodford, Joslin, Pitcher, & Renn, 2017).



Nadal, Skolnik, and Wong (2012) found that there are 12 different types of microaggressions that pertain to TGNC people. The first of which is *use of transphobic language*, such as derogatory terms like ‘tranny’, or misgendering someone, as in calling a male identified person ‘she’. The second microaggression is the *assumption of a universal transgender experience*. This is manifested as the belief that all TGNC people experience their gender in a similar manner. It may also refer to negative stereotypes that people, falsely, believe pertain to all transgender people, such as the belief that all trans women engage in prostitution. The third microaggression is *exoticization*, where TGNC people are objectified, this is often seen in tokenism. The fourth microaggression is *discomfort/disapproval of the transgender experience*, which is often expressed as disgust at the discovery that one is transgender. The fifth microaggression is *endorsement of gender normative or binary culture*, which is manifested in endorsement of gender norms, especially as they relate to a TGNC person’s assigned birth sex instead of their gender identity. For example, some might express surprise at a trans woman’s makeup skills, because people assigned male at birth are often not skilled in makeup application.

The sixth microaggression Nadal et al. (2012) found was *the denial of transphobia*, which occurs when one minimizes trans peoples struggles against society’s cis-normative and hetero-normative biases. The seventh microaggression, *denial of individual transphobia*, is closely related. This occurs when a person denies that they may possibly hold transphobic beliefs, instilled in them through socialization. The eighth microaggression found was the *assumption of sexual pathology*, such that being transgender is a sexual or psychological disorder, or the belief that all trans men and women are hypersexual. The ninth microaggression is *physical threat or harassment* towards TGNC people. The tenth is the *denial of bodily privacy*, where people assume they can ask TGNC people invasive questions about their genitalia. The

final two microaggressions are familial microaggressions and environmental and systemic microaggressions.

While the research on microaggressions has been conducted with TGNC people in general (Nadal et al., 2010), along within the context of relationships (Pulice-Farrow, Brown & Galupo, 2017) and friendships (Galupo, Henise, & Davis, 2014), they have also been looked at in the context of therapy (Nadal et al., 2012). Research has found that all the varying microaggressions previously mentioned may all be topics of discussion in therapy with a TGNC client. However, many of them are microaggressions that the therapist themselves may commit towards the client (Johnson, 2014; Morris, Lindley, & Galupo, 2020; Nadal et al., 2012; Smith, Shin, & Officer, 2012).

Johnson (2014) found that TGNC people experiencing microaggressions in therapy was significantly related to a negative therapeutic relationship and early termination of therapy. These experiences lead to self-doubt in clients about their ability to respond to prejudice and discrimination and self-doubt in regard to their gender identity. Interestingly Johnson (2014) found that therapists addressing microaggressions in therapy was helpful in minimizing the damage to the therapeutic alliance, but this only happened 11% of the time microaggressions occurred. How microaggression occur and how they are addressed in therapy is important in understanding how to improve the therapeutic relationship when working with TGNC clients. Especially considering Anzani, Morris, and Galupo's (2019) findings that TGNC tend to conceive success in therapy not by positive experiences they have, but by the lack of negative ones (i.e., microaggressions) that they experience.

### **Affirmative Therapy meets Microaggressions**

Johnson (2014) looked at 255 TGNC people's experiences of microaggressions in therapy. More than half the sample experienced at least one microaggression while in therapy. However, comparing this research to commonalities seen in various affirmative therapy guidelines is fascinating as it could potentially relate to the mitigation of microaggressions in therapy. For example, almost all TGNC-affirmative guidelines encourage understanding of transphobia and its effects, and not one person in Johnson's (2014) study indicated a microaggression in regard to denial of transphobia. Which is surprising considering it has been a common issue in previous research (Nadal et al., 2012). Conversely, less common tenets seen in affirmative TGNC therapy, like importance of seeing gender as non-binary routinely came up as an issue in Johnson's (2014) study. For example, one of the most common microaggressions experienced in Johnson's (2014) study was psychotherapists assumption and comfort with *binary transition norms* (that trans people transition from one gender [e.g., male] to an assumed opposite gender [e.g., female] and expressed confusion and invalidation towards transition to other genders [e.g., genderqueer or non-binary]). This isn't surprising as research on non-binary transition is lagging behind understanding of binary transgender people's transitions (Matsuno & Budge, 2014). But what is suggested here is that perhaps trans-affirmative approaches may potentially have impact in mitigating microaggressions in therapy and thus improving therapeutic relationships.

### **Summary**

While there is plenty of research on transgender affirmative therapy, little is known about how psychotherapists acquire this knowledge and implement it into their practice with TGNC clients. Therefore, gaining a better understanding of what psychotherapists use to guide their

work with TGNC clients and how these sources are implemented is important in improving therapeutic experiences for these clients.

Research has shown that limiting microaggressions in therapy with TGNC clients is an ideal step in reducing the negative experiences that lead to the termination of therapy by these clients. However, research has not yet looked at the therapist's perspective on occurrences of microaggressions in therapy with TGNC clients. Understanding how therapists interpret these events and how they deal with them, if at all, is vital in determining how therapists can best minimize microaggressions and properly mitigate the negative effects should they occur in therapy. This leads to the second research question of this study: *How do psychotherapists go about avoiding microaggressions with this population and how do they address microaggressions if/when they are committed?*

### Chapter 3: Research Methodology

I am a transgender woman. I transitioned at 27 years old despite coming out to my parents at 22 years old and having many thoughts about wanting to be a girl as a child and teenager. But along the road many encounters with epistemological violence delayed my transition. I can recall one of my braver moments as a teen deciding to research transsexuals (the more common vernacular for people like me in the mid-2000s) and everything I saw was about being ‘true transsexuals’, ‘pseudo-transsexuals’ and ‘autogynephiles’. Needless to say, I left that internet exploration session feeling horrible about myself, thinking perhaps I’m just some sexual deviant. I am far from the last person to be harmed by such epistemological violence (see Veale et al., 2012). I didn’t really accept myself till 22 when I stumbled across a young trans woman documenting her transition on Youtube, which was not quite the cultural powerhouse it is now, littered with thousands of LBGTQ+ bloggers. That was the first time I ever really thought I might actually be transgender. It did not come from academic literature or a mental health professional, but my first exposure to a depiction of a transgender woman that was not a sexual deviant or malevolent and devious sex worker (ala *Silence of The Lambs*, *The 40 Year Old Virgin*, *The Hangover Part II* etc.) or deeply mentally disturbed (ala *Ace Ventura: Pet Detective* and *Silence of The Lambs* again). While that depiction of the real trans woman helped me come closer to accepting myself I was already dripping in internalized transphobia and rigid beliefs about gender norms and compulsory heterosexuality. This may be best reflected by the fact that I came out to my mom by saying I wanted to be a girl, while telling my dad I had a sexual fetish to crossdressing that I needed to resolve. I was obviously in a confused state and was encouraged by my mother to seek mental health support to get to a better place.

Many negative experiences with mental health professionals (admittedly it was predominantly psychiatrists) after coming out to my family left me feeling that I was not legitimately transgender. One incident with a psychiatrist at the London Health Science Center stuck with me in particular. He suggested that my poor relationship with my father was the reason that I desired to be girl/woman. This hypothesis was offered to me *before* I was even asked about my relationship to my parents, or if I even had parents. In hindsight, I can laugh about the foolish Zucker-esque interpretation without evidence. Alas, I was not the person I am today with a graduate level education in psychology to guide my understanding of my own gender. I was a confused 22-year-old with no post-secondary education on the specifics of gender. A description fitting of many of the TGNC people that seek help from mental health professionals to better understand themselves and seek amelioration. I do not think it is coincidence that I eventually shifted my career goals to become a psychotherapist, nor do I think that it is a coincidence and that I was relatively ruthless in both my undergraduate and graduate programs to find an advisor who would allow me to do a thesis looking at TGNC people's sexuality from a perspective critical of common psychological interpretations (see Banks & Roney, 2021) or about TGNC people's experience with psychotherapy and microaggressions that may occur during them.

My personal background has brought many strengths in my ability to understand this topic and to conduct in-depth interviews with these psychotherapists. I found as the interviews went on, I was able to engage on the various topics that affect TGNC people with ease. This however presented a challenge as it was important to make sure the conversation didn't stray too far from the therapy room into systemic issues. That's not to say that we need to overlook systemic issues, far from it. But that this study wanted to look at how clinicians work with such

issues in the present one on one context of therapy. I did notice a trend in the interviewees to shift toward wanting to talk about the systemic issues devoid of how it would be applied in the session itself occasionally, which was a great insight for me, not so much as a researcher, but as a clinician knowing it is probably easier to talk about systemic issues than sit with its impacts on a client in a therapy room.

My interviews and perceptions of the topic in general became more cynical as they went on, as all the interviewees mentioned challenges in regard to the lack of education that they received in school. I could empathize with their position, having similar feelings with my own graduate education. Knowing that many a study's conclusion discusses the importance of furthering education in this area for psychotherapists (Bidell, 2013; 2016; Fraser, 2009; Fraser & Knudson, 2019; Mizock & Lundquist, 2016; Weir & Piquette, 2018). My sense of distress over this was reciprocated by the interviewees as they were not only frustrated by the lack preparedness they felt about their work with this population, but also the lack of resources in their respective communities to assist with TGNC individuals. I put a large onus on myself to not 'throw out the baby with the bathwater' as they say, as these therapists had tremendous insights as to what was important in working with TGNC clients and how to work with microaggressions. These insights were valuable and cannot be overshadowed by the lack of implementation of trans-affirmative techniques at a systemic level.

### **Research Design**

This study aimed to better understand how clinicians consume knowledge about trans-affirmative psychotherapy and apply it to this population. Additionally, this study explored how psychotherapists work with microaggressions that may occur in therapy with this population, and how they would handle such an occurrence. This study took a qualitative approach to the

research as not only was a rich amount of data desired, but also a desire to better understand the subjective nature of experience of how therapists approach both trans-affirmative psychotherapy and handling the occurrence of microaggressions when working with this population. In addition, Maxwell (2008) notes that qualitative research designs are useful for understanding meaning for participants in the study. This study aimed to understand the actions those interviewed take, but how they make sense of these actions and what particular contexts may influence such actions (*e.g., how does a clinician make sense of what works as a trans-affirmative approach*). Maxwell (2008) also noted the importance of qualitative research in helping to understand unanticipated and novel phenomenon. While some research has investigated therapist's work with trans-positive or trans-affirmative approaches, understanding how therapists work specifically with microaggressions and how clinicians feel about the steps to take in order to mitigate potential negative effects of them is particularly novel.

### **Participants**

Participants were recruited from the Social Justice Chapter of the Canadian Counselling and Psychotherapy Association (CCPA), which has approximately 200 members. All members were invited to participate in the study via email advertisement [Appendix A]. This sample was unique in that the knowledge they have of working with TGNC clients was relatively unknown. This however provides a new perspective to the existing literature, as previous research has only looked at psychotherapists who specialize with transgender clients and their approach to trans-affirmative care (Ali, 2014). Often times it is difficult for TGNC clients to be able to access psychotherapists who have specialized training with transgender people (Hunt, 2014). As a result, understanding how psychotherapists who may not be specialized in this area approach working with these clients is useful and novel information.



## Procedure

Individuals who participated were emailed consent forms/letters of information describing the nature of the study [Appendix B]. They were asked to give consent to participate and a time to conduct an interview over the phone. Upon interview time, participants were contacted via phone for the interview by a master's student in counselling psychology. Participants were reminded they could withdraw from the study at any time before beginning. Participants were asked demographic information and interview questions about providing trans affirmative care and dealing with microaggressions with TGNC clients [see Appendix C]. In addition to stand alone questions, questions were also asked in response to vignettes that display common scenarios involving TGNC clients [see Appendix C]. The first vignette shows a client who is struggling with gender identity issues, allowing for general questions about how to approach the client from a trans-affirmative perspective. The vignette is as follows:

During your second session with your client Lindsay they expresses to you that they would like to be addressed as Jack and uses he/him pronouns. Jack is uncomfortable discussing much in therapy around his transgender status because of past rejection from others for being different. Jack experiences many mood swings and would like to discuss how to work thru some of the shame he experiences for being transgender.

The second vignette displays a situation where a trans client addresses a microaggression committed by the therapist, allowing for questions to interviewees about how to handle such a situation. The Vignette is as follows:

In your last session with your client Sarah she expressed her frustrations with how people treat her for being trans. You reassured her that things will probably get

better once she completes her vocal training and gets her upcoming facial feminization surgery. Sarah starts this session by pointing out that she felt very upset in the last session because you gave her no viable options to deal with the stress in the moment and the notion that trans women need to ‘pass’ as more feminine can be very harmful.

Vignettes were based on actual cases discussed in the literature on psychotherapy with transgender clients (Johnson, 2014). This was done to help with applicability in ensuring they are real world scenarios and to help prompt participants who may have less personal experience with TGNC clients. The interviews were semi-structured, allowing for follow up questions which helped clarify the participants responses for maximum accuracy. Upon completion of the interview, participants were emailed a debriefing form [Appendix D], which included an email address to contact the researcher if they were interested in learning about the results of the study.

### **Data Analysis**

A qualitative content analysis was conducted as the analytic process to understand themes that emerged from the interviews. This process of analyzing qualitative data involves interpretations of transcriptions, or in this case notes of interviews, in order to develop answers to the specific research questions (Creswell, 2013). A qualitative content analysis is suitable for this purpose as a content analysis, “attempts to characterize the meanings in a given body of discourse in a *systematic* and *quantitative* fashion” (Franzosi, 2008).

The analysis followed Creswell’s (2002) approach to interpreting qualitative data. This process involves 6 key steps: gathering data, prepping the data, reading the data, coding data, identifying themes from the coded data, and effectively describing the themes (Creswell, 2002). After collecting data from the various interviews (notes from each interview), the data was

reread and notes from the interviews were segmented into various segments, with segments eventually being labeled with codes. Initially 27 codes emerged, ranging from types of therapeutic modalities (e.g., trauma-informed approach), emotions (e.g., shame), to actions (e.g., making referrals). From that initial list of codes emerged 5 major themes based on the aggregate of similar codes into an overarching theme (e.g., ‘client-led’, ‘person-centered’ and ‘empathy’ become the theme ‘person-centered approach’).

### **Conclusion**

This chapter reviewed the choice of a qualitative design for this study. Additionally, the chapter reviewed the participants and how they were recruited, the procedure for interviews, how the data collected was analysed via Creswell’s (2002) approach to interpreting qualitative data, along with positioning the researcher in the context of this work.

## **Chapter 4: Results**

Each of the cases are presented according to the responses of the interviewees under the headings of view of trans-affirmative therapy and the role of microaggressions as well as response to vignettes.

### **Case 1: Natalya**

Natalya has been practicing for 15 years. Natalya specializes in trauma, assessment, couples work and counsellor education. Natalya identifies as a cis-woman and uses she/her pronouns. On a scale of 1-10, she rated her experience of working with trans clients as a 5, while her training in the area as a 7 out of 10.

### **View of trans-affirmative therapy and role of microaggressions.**

Natalya expressed how trans affirmative therapy is something for all clients no matter their gender identity. She expressed the importance of having more than just binary gender information on intake forms as to normalize the variance in gender identity. Creating a welcoming and safe space was of utmost importance to Natalya and expressing the universality of gender identity was vital for a therapist as it helps to ensure no one is alienated.

Natalya stated that work in this area needs to be client led, and clinicians need to bring a beginner's mind and minimize assumptions. While exploration of gender issues may be important for the client, Natalya stressed that a therapist must not be a gatekeeper of one's gender. While gender may be important for a client to explore in therapy, Natalya also felt that one needs to proceed with caution, and not assume that a trans or non-binary client is in therapy solely for gender issues. Natalya encouraged self-identification, while she herself is not transgender she felt that it was important to disclose that she was cisgender and how she may be educated in the area but is lacking in lived experience.

Natalya felt that a clinician needs to prepare for the chance of microaggressions at the outset of therapy with this population. This happens by encouraging the client to 'call you out' if they feel that you have said anything that is bothersome to them. Should a microaggression occur, Natalya felt that being humble is important, but also being willing to ask the client if they feel the relationship can be repaired based on what occurred. If the rupture can be overcome Natalya stated that it does create some areas of discussion. Particularly around notions that may have been internalized by the client and how your error may have played into that and how to rectify it. Natalya described microaggressions as 'death by a thousand cuts'. The occurrence of a microaggression in therapy can create space for learning how to heal those wounds.

### **Response to vignettes.**

The first thing Natalya felt was important with Jack was to express gratitude to Jack for the trust that he was placing in him. Natalya felt that it was important for her to take on a role of advocacy for Jack, but not to slip into the role of a ‘rescuer’. Natalya felt that trying to make resources available that might be helpful for Jack. When asked what she would like to know more about with Jack she said she would want to know what he needs in order to feel less shame.

In regard to the Sarah vignette, Natalya pointed out that she would first apologize to Sarah, and that it was important to have humility in this interaction. Natalya would offer the opportunity to reexplore the situation if Sarah wanted to. She wanted to gain an understanding of the impact of the microaggression on Sarah. She wanted to highlight strengths wherever possible, but also acknowledge that she may have to have a discussion about if another clinician may be better for Sarah.

### **Case 2: Trish**

Trish specializes in trauma and addictions. Trish identifies as a cis woman and uses she/her pronouns. On a scale of 1-10, Trish rated her experience of working with trans clients as a 3, while her formal training in the area was a ‘0’. While she said her self-teaching in the area would be a 7 out of 10. Trish said that herself learning came from reading, interpersonal experience within the LGBTQ+ community, workshops, and following trans and gender non-conforming people on social media.

### **View of trans-affirmative therapy and role of microaggressions.**

Similar to Natalya, Trish expressed the universal application of being trans-affirmative. Since this is an approach that affirms one’s identity it can be similar to many other issues. Trish drew an analogy to weight loss, in how you can play the role of attempting to help someone

realize key goals while also being mindful of how some may establish goals that would be unethical to help with (e.g., extreme/unhealthy weight loss or ‘curing’ one’s transgender identity). Trish also expressed how this is an approach that affirms transgender people’s human rights, and affirmation of marginalized groups’ human rights should be a goal for all clinicians.

Referring to the occurrence of microaggressions, Trish noted that therapists should begin with an apology. She said that this is a ‘super opportunity’ to attempt to break down the therapist/client power structure. By acknowledging one’s mistake and taking ownership of it you can create a more egalitarian space. This is a time to see if this therapeutic rupture can be repaired and if the client does not feel that this is the case you need to respect their rights and refer them to someone else.

### **Response to vignettes.**

Trish expressed letting Jack lead in therapy. This is because Trish wanted to make sure to establish a safe and accepting therapeutic alliance. Trish noted that you have to watch the common trap of making therapy all about Jack’s trans identity, as it is possible that this may be an important thing for Jack but may not be what therapy is going to be about moving forward. In terms of what Trish would like to know more about Jack, she cited how his attachment style may play a role in his relationships across his transition. She also wanted to know what he uses as safe spaces, what resources he has at his disposal and how he manages his mood.

In the Sarah vignette, Trish wanted to start by taking responsibility for what occurred. She wanted to acknowledge that she made an assumption about Sarah and that that was wrong. She wanted to thank Sarah for bringing up how this bothered her, and Trish wanted to know what effect this had on her.

### **Case 3: Dwayne**

Dwayne identifies as a cis-man and uses he/him pronouns. On a scale of 1-10, Dwayne rated his experience of working with trans clients as a 2 as a therapist, while he rated his experience with trans clients in his previous work in youth justice as a 7. His formal therapist training with trans clients was a 1, while he rated his personal training as a 7 out of 10.

#### **View of trans-affirmative therapy and role of microaggressions.**

Dwayne stressed the importance of making no assumptions and bringing curiosity to your interactions. Dwayne felt a key component of trans-affirmative therapy was acknowledging that there is no way you as a therapist can truly understand another person's experience. Dwayne noted that in order to practice from this framework one needs to have the ability to talk about gender in a way that is not pathologizing. Dwayne further stressed that clinicians need to be willing to educate themselves as many do not receive a large amount of formal training.

Similar to Trish, Dwayne felt that you need to lay the groundwork at the outset of therapy for how to approach a potential microaggression. At the start of therapy, you need to establish that you are someone who is going to be open to feedback from clients about gender related issues. Dwayne said that you need to believe what the person has to say and not to get defensive. As a therapist you need to be mindful that the anger that a client may express is not because you are the first person to commit a microaggression against them, but that they have had a cumulative effect.

#### **Response to vignettes.**

Dwayne said it was important to start with stating Jack's pronouns and name to help establish a place of safety in this relationship. At this point Dwayne wanted to allow the client to

lead the session. Things Dwayne expressed wanting to know included any trauma that may have resulted from keeping this secret, how Jack connects with peers, if they desire to medically transition, and the role shame plays in Jack's ability to be authentic.

Dwayne felt that responding to Sarah was all about humility. Dwayne noted that this was probably a mistake that he would not make in an actual therapy situation but noted that he could see there being a different situation where he makes an equally foolish mistake. In that case, being willing to listen to where you erred is extremely important. While you may want to repair the therapeutic relationship, you need to be willing to accept that referral may be the outcome.

#### **Case 4: Peyton**

Peyton identifies as non-binary and uses they/them pronouns. On a scale of 1-10, Peyton rated their experience of working with trans clients as a '8 or 9', while their training in school was a 2 out of 10, with their own personal learning/training rated as an '8 or 9 as well'. Peyton noted that their personal learning came from readings, workshops, and their experience working in a clinic for the trans population.

#### **View of trans-affirmative therapy and role of microaggressions.**

Peyton defined trans affirmative therapy as an approach that, 'centers someone's experience of their gender'. Peyton stressed the importance of not making any assumptions working with this population. Additionally, it involves therapists taking the time to educate themselves with the resources they have at their disposal.

Peyton felt that clinicians should not be doing therapy if they do not have much understanding or training about how to approach microaggressions or how common they are with this population. They stressed that graduate schools should place more emphasis on



microaggressions as part of their curriculum. Part of this reasoning came from the number of clients they have had in this population that have had microaggression issues with other psychotherapists, psychologists, psychiatrists and doctors.

### **Response to vignettes.**

Peyton wanted to convey to Jack that there is plenty of time and that they don't want to rush Jack. They wanted to allow things to build slowly and organically in the therapeutic relationship. In terms of what Peyton would like to know more about in regard to Jack, they expressed wanting to know more about Jack's support system, how open they can be in their day-to-day life, their openness to seeking out peer groups, and if they are seeking medical care.

In regard to Sarah, Peyton wanted to know what it was Sarah would have needed in that moment. How they could make amends, what needs to be done to move past this and possibly if a referral would be suitable. Peyton also wanted to know at what level Sarah internalized what occurred. Peyton reflected that in their experience of working with many clients where this had occurred, they had a tendency to deeply internalize such comments because it was coming from supposed professionals.

### **Case 5: Victoria**

Victoria identifies as non-binary and uses she/her pronouns. On a scale of 1-10, she rated her experience of working with trans clients as a 7, while her formal school training in the area as a 2.5 out of 10, with her personal learning as a 9 out of 10. Victoria described her personal training as lived experience, a capstone project on the subject in graduate school, and her consumption of various media touching on the subject (e.g., blogs, documentaries, music, podcasts).

**View of trans-affirmative therapy and role of microaggressions.**

Victoria felt that trans-affirmative therapy is an approach that stresses not making assumptions. Victoria felt that clinicians from this perspective need to be aware that some of their assumptions will creep in and you need to be willing to 'own what's yours' and acknowledge some of your internalized notions of gender. Similar to others, Victoria felt that therapists need to educate themselves as much as possible and allow the client to take the lead in session.

Victoria described the occurrence of a microaggression with a TGNC client as a 'make or break moment'. Victoria felt that it is therapists' job to be accountable in these situations. Therapists need to directly address these situations and make amends. Victoria felt that when this is not done it often leaves clients in this population with the belief that counselling is not safe.

**Response to vignettes.**

Victoria wanted to get across to Jack that he could pass on any questions he felt uncertain about, as she wanted to keep a low amount of pressure on Jack in terms of disclosures. She wanted to validate any bad experiences that he may have had and wanted to call 'bullshit' on society as a means to offer support. In terms of more things that Victoria would like to know about Jack, she expressed knowing more about what shame looks like for him.

Victoria wanted to respond to Sarah by apologizing and acknowledge this as an opener. Victoria wanted to thank Sarah for her willingness to express her concerns. Victoria would like to know what Sarah is looking for in that scenario.

**Conclusion**

Review of these case studies indicate that these clinicians are aligned with what is recommended in the literature on Trans-Affirmative Psychotherapy (Chang et al., 2018). Therapists discussed their beliefs about how they can respond to microaggressions with TGNC clients in addition to what they felt made up trans-affirmative psychotherapy. In addition, these case studies note the therapist's responses to both the Jack and Sarah vignettes.

## **Chapter 5: Discussion**

This cross-case analysis focuses on similarities across the cases from the previous chapter. From content analysis the following themes emerged: Person-centered approach, The ability to repair the therapeutic relationship post microaggression, The role of shame, Universality of trans-affirmative therapy, and Self-education.

### **Main Themes**

#### **Person centered approach.**

All five interviewees at some point expressed the importance of the client taking the lead in session and avoiding assumptions. While this may seem like simple person-centered tenets that many therapists follow, it has commonly been a challenge for therapists to translate these skills to their work with the TGNC population (Knutson & Koch, 2018). This is despite the fact that many trans affirmative guidelines are explicitly grounded in a person-centered approach (Brammer & Ginicola, 2017). Researchers looking at the TGNC population have noted that person-centered approach would be ideal for this group, Knutson & Koch (2018) note, “as society continues to grapple with transgender issues (exemplified, e.g., in current conflicts over bathroom access), a method that allows for less dependence on others for approval, by inspiring self-affirmation for example, may pair nicely with calls for affirmative and empowering forms of therapy”. Carl Rogers himself noted that person-centered approaches are suitable for groups seen as ‘different’ from societal norms (Raskin & Rogers, 2005). A person-centered perspective has also been found in similar qualitative research on psychotherapists approach to trans-affirmative perspectives (Ali, 2014, p. 69).

Multiple interviewees noted trying to gain an understanding of the role that discrimination plays in the lives of transgender clients. Raskin and Rogers (2005) noted that a

person can easily restructure themselves based on evaluation interactions with others, they stated, “Over time, the individual introjects the values of others, but these expectations become distorted as they are “incongruent with the structure of the self” (p. 142). Knutson and Koch (2018) applied this to TGNC people with how the rigidity of societal gender norms can have this impact on TGNC people. Interviewees felt that establishing a safe relationship and strong therapeutic alliance would allow for more authenticity in that setting, allowing clients to become more acquainted with their true selves as opposed to who they feel they need to be, or have been in the past because of societal norms or fear of loss. Interestingly, Knutson and Koch (2018) address such as double bind, as was often discussed in this study, where TGNC people may avoid one type of pain (e.g., loss, by staying in the closet), but this can result in another type of pain (e.g., dysphoria, by being in an incongruent body). Interviewees wanted to gain an understanding of role switching that may occur for transgender clients and how they could best be authentic in as many facets of their life as possible. Knutson and Koch (2018) state that person-centered therapy is an ideal modality for ‘providing insight into competing motivations’.

Rogers (1946) viewed the goal of personality development as to have congruence between oneself and their phenomenal field of experience. Finding such a congruity can be difficult for transgender people with challenges like discrimination, minority stress, transphobia, trauma and dysphoria. Knutson and Koch (2018) note that such things are not necessary parts of being transgender, but that in a space where people can remove the layers of societal norms placed upon them, individuals can gain clarity about what is needed to get themselves to a place of more congruence. Chavez-Korell and Johnson (2010) see this as an interpersonal process, wherein the individual is the expert on their identity. This idea is further stated in the literature as it has been noted that gender is based on a subjective sense of oneself (Brammer & Ginicola,

2017). Therefore, clients should be empowered to tell their own story of their gender (Knutson & Koch, 2018). While the therapists interviewed for this study desired to see TGNC clients being their authentic selves, they were also mindful that for a variety of reasons (e.g., safety, job security, relationships, family) they may not be able to be in many areas of their lives. Therapists were not quick to push for such change but accepting of where people are and meeting them there. While research notes that incongruities are not desirable in terms of mental health outcomes, the damage done by well thought out and intentional inauthenticity is less damaging to the TGNC person (Knutson & Koch, 2018).

The therapists interviewed were much more aligned with a person-center approach to trans-affirmative psychotherapy compared to other trans-affirmative modalities like Austin and Craig's (2015) cognitive behavioural approach. The interviewed therapists saw clients' self-perceptions, emotions and environment as core issues opposed to faulty thinking. Instead of challenging negative thoughts interviewees were more concerned with creating a therapeutic environment where clients felt acceptance. While not stated by any of the interviewees, such an environment created by the therapist may led the client to cultivating more similar environments in their day-to-day life (Knutson & Koch, 2018).

Person-centered therapy has historically involved the use of self and requires counsellors to provide as nonbiased an environment as possible (Raskin & Rogers, 2005). Change et al. (2017) noted that counsellors can help create such an environment by exploring their own gender identities. Additionally, counsellors need to be willing to challenge their internalized transphobia in particular (Knutson & Koch, 2018). This concept was reflected by Dwayne, who said he needed, 'to watch the temptation to view things from a cis-male perspective'. Victoria stated that you need to, 'own your shit' in order to be able to do this work. This self-reflection on

clinicians' part is desirable from a person-centered perspective as this modality presumes that as a therapist gains greater congruence in themselves, they can model this for a client (Ehrbar, 2004). The willingness for a clinician to interrogate their own internalized heterosexism and transphobia as a precursor to working with these clients has been previously discussed in the literature (Livingstone, 2008; Ali, 2014). While this insight is great to foster, Brammer and Ginicola (2017) have cautioned therapists that this insight should not be used as a guide for understanding a TGNC client. This concern was reflected in Peyton's discussion of how often there is a temptation for self-disclosure based on their self-reflections as a non-binary individual. This struck a cord with myself as a novice clinician getting to work with the TGNC population, who has similar feelings. However, Peyton noted this needs to be reigned in as this can be more a reflection of the isolation a non-binary person may have and their desire to connect with someone similar. It should also be noted that these approaches involving personal reflection and challenging internalized notions from society are more typical of person-centered approaches with feminist influences (Ehrbar, 2004).

Clinicians desire to create an accepting environment was often discussed in the manner of creating a safe space for TGNC clients. Many interviewees mentioned the importance of clients being able to discuss things at their own pace and not feeling like they have to discuss things they are not yet ready to discuss. The notion of clients leading the session in this manner tied in closely with therapists needing to be mindful how they may fill the role of a gatekeeper. The role of therapists, doctors and psychiatrists as gatekeepers to TGNC's transition has been well documented (Ashley, 2019; Budge, 2015). While it was standard fair before the 2010's for mental health professionals to assume they knew a client's/patient's gender better than the client (Ashley, 2019; Budge, 2015), it has become much more in vogue for psychotherapists to take a

more humanistic approach of allowing self-determination of the client (Darby, Bolland-Hillesheim, Cervantes, & Hitter, 2020; Singh & Burnes, 2010). Additionally, this is viewed as a transition from gatekeeper to that of advocate for social change, as gender is a systemic force that controls and maintains power (Wada, McGroarty, Tomaro, & Amundsen-Dainow, 2019). This again reflects more injection of feminist or social justice tenets being incorporated with person-center beliefs.

“You need to be able to speak about gender in a way that isn’t pathologizing or gatekeepy [sic]”  
– Dwayne

This awareness of how the mental health clinician’s role can be perceived as a gatekeeper, even when not intended is vital in how to approach this population. Some have even suggested that an assessment of the working alliance with the TGNC population should include elements focusing on gatekeeping perceptions because of how important this can be in these relationships (Budge, Israel, & Merrill, 2017). Interviewees were very mindful of how they may be perceived by TGNC clients, Natalya noted that you need to do everything you can to minimize the client/therapist power dynamic as the perception of you may be that of a gatekeeper even when that is not your intention. This perspective taken by the interviewees is a stark contrast to what is seen in the literature and in my own personal experiences described in the methods section. For all my cynicism, having conversations with psychotherapists, majority of whom were cis, having such frank and reflective discussions about straying from the status quo as gatekeeper was very encouraging.

All five interviewees mentioned that it is vital to do your best to avoid making any assumptions with the TGNC population. The idea of assumptions was often discussed in reference to the Sarah vignette, with multiple interviewees citing the microaggression as an



example of the therapist making assumptions about one's gender and how they cope with gender dysphoria. Victoria noted that just based on our upbringing we all have internalized problematic notions of gender and this can lead us to making assumptions about gender. She felt that the more aware we can be of our tendency for our minds to want to make assumptions and then foster a willingness to challenge those assumptions the more effective we can be as therapists. This corresponded to one of Victoria's previous statements about how we need to, 'own what's ours'. In that we need to own what is our own problematic internalizations and not project them onto clients as though they are facts about the world, an all-too-common occurrence in therapy with this population (Johnson, 2014).

#### **Assessing the ability to repair the relationship after a microaggression.**

Majority of the therapists interviewed said that they wanted to try to see how the client felt about the ability to repair the therapeutic relationship after the occurrence of a microaggression. The interviewed therapists wanted to be genuine in apologizing for what occurred but recognized that this could be a 'make or break' point in therapy. All the interviewees acknowledged that this could potentially be what brings the relationship to an end. Knowing this is consistent with the literature on how TGNC people respond to microaggressions in psychotherapy (James et al., 2016; Johnson, 2014). However, it was also acknowledged that this would be an opportunity to further build the relationship, by being genuine in apologizing, and in how they convey their desire to rectify the situation. The notion of a therapeutic rupture being beneficial is well researched. Ruptures can result in a corrective emotional experience, by demonstrating to clients how to handle disagreements in important relationships (Castonguay & Hill, 2012). Additionally, by allowing a client to reengage in a relationship after feeling disconnected with the other party (Larsson, Falkenstrom, Andersson, & Holmquist, 2018).

Natalya said that such an incident is an opportunity for the therapist to breakdown the therapist/client power structure, by acknowledging that as a therapist you're not perfect and are fallible. This is consistent with research that has found humility to help mitigate client's perceptions of a counsellor post microaggression (Hook et al., 2016). She stated that being able to demonstrate a desire to gain a better understanding of how this affected the client and how to improve moving forward may be an example of creating an environment of unconditional positive regard that they may be lacking in their personal lives. Creating such an environment is a common tenet of trans-affirmative psychotherapy (Chang et al., 2018; Riley, Wong, & Sitharthan, 2011).

Natalya also felt that it required some knowledge on how microaggressions can affect someone in order to engage in that conversation. She wanted to explain how often times microaggressions can be 'death by a 1000 cuts' for people and understand what it felt like for the client to see the therapist as one of the people delivering one of those cuts. Trish also felt that understanding the client's perspective of how the microaggression felt would be needed to be able to repair the therapeutic relationship. She expressed that a clinician needs to be willing to truly understand where they went awry without being defensive to allow the client to feel that they can be heard with you. This emphasis on therapeutic presence showed a mindful approach to trans-affirmative therapy in addition to the previously mentioned emphasis on person-centered and feminist techniques.

Peyton was the most adamant that therapists needed a firm understanding of microaggressions with this community in order to work with them. Peyton said that clinicians should not be working with this population if they did not have awareness of these types of issues that TGNC people face, not just in their day to day lives, but often in psychotherapy. I

found myself agreeing with Peyton on such a claim, but we wondered if clinics and the like would make such a commitment. Peyton's statement aligns with Mearns and Cooper's (2005) work on person-centered therapy that stated that therapists must earn the right to work with clients who have been marginalized, particularly when the therapist benefits from the structures that marginalize the client. Additionally, such a sentiment aligns with the concept of microaggressions as an ethical violation (Morris et al., 2020). It is also a valid point because of how therapist's willingness to address microaggressions translates to strengthening the therapeutic alliance (Johnson, 2014). If a therapist can understand how to work with microaggressions they have the ability to make therapy work for a TGNC client, as opposed to a clinician who is less knowledgeable in this area. Additionally, trans-affirmative guidelines have suggested that clinicians should not be working in this area if they are not competent (Chang et al. 2018). This is also consistent with ethics boards stating that clinicians should not be working in areas where they lack competence (Morris et al., 2020).

The interviewed therapists felt that their ability to set up the therapeutic environment as one where a client can feel comfortable with 'calling out' the therapist should they say anything to make them uncomfortable would be beneficial to how rupture and repair would operate. The desire to set up the therapeutic environment initially as a place where the client can feel safe is consistent with the literature on how to navigate microaggressions with TGNC clients. In addition to humility, it has also been found that the state of the working alliance mediates a client's decision to terminate therapy (Johnson, 2014). The therapists interviewed felt that creating a strong working alliance from the start was the best way possible to manage a microaggression should it occur. The literature has shown in other realms that a knowledge of microaggressions and preparation for them has been beneficial in mitigating harm. Looking at

research of social work and psychology educators, they are seldom prepared to address issues like transphobia (Chinell, 2011; Dentato et al., 2016). This can lead to microaggressions going completely ignored, however when those educators had more knowledge of the subject, damage to TGNC people was mitigated (Austin, Craig & McInroy, 2016; Austin, Craig, Dentato, Roseman, & McInroy, 2019). Such research was not surprising to me, as I found similar experiences in my graduate school education in Counselling Psychology. Interviewees felt that psychotherapy would operate in a similar manner.

Victoria felt that handling a microaggression appropriately was something therapists need to be accountable for. She said that even if it is determined that referring to another counsellor may be the appropriate solution, you as a therapist still have work to do to help the client. By attending to the microaggression sensitively and with a genuine desire to minimize harm you can help maintain that therapy is a safe space for TGNC people. Similar to Peyton's comments, this also aligns with viewing microaggressions in the ethical violation realm, that therapists have a responsibility to rectify (Morris et al., 2020).

### **Understanding the role of shame.**

A fascinating theme that emerged when asking therapists what more they would like to know about Jack in the first vignette was that his feelings of, and how he handles, shame. The importance of shame corresponds to what the literature is beginning to report on. Shame is an often-felt emotion for transgender individuals, Bockting et al., (2020) note, "Transgender individuals may internalize gender norms and expectations, and they may develop shame and self-hatred because of their lack of conformity to culturally established definitions of maleness and femaleness, manhood and womanhood, or masculinity and femininity". Such feelings of shame and self-hatred are referred to in the literature as *internalized transphobia*, the discomfort

of one's own TGNC identity as a result of internalizing societal prejudices about trans and gender non-conforming people (Bockting, 2014). Research looking at transgender individuals in psychotherapy has found internalized shame to be a common theme, manifesting in three unique ways (Bockting, Knudson, & Goldberg, 2006). First, TGNC people may experience shame simply about being transgender (Bockting, 2008). Second, shame may be elicited from conformity to binary conceptualizations of gender, as TGNC people may conform to their sex assigned at birth or attempt to pass as a cisgender member of the other sex (Bockting, 2008). Third, TGNC people may avoid association with other TGNC people because they themselves have internalized societal prejudices about this group, or because being proximal to other TGNC people may expose themselves as being gender variant (Bockting et al., 2020).

Interviewees in this study had relatively open-ended inquiries into shame, (e.g., “What does shame look like to Jack?” – Victoria). This corresponds to how shame is discussed in the literature as it is heavily dependent on one's social context and may change over a person's life (Bockting et al., 2020). Interviewees noted that gaining an understanding of how shame affects TGNC clients would help guide the therapist into knowing why they may struggle with authenticity in certain areas of their lives. The situational nature of shame was important for these therapists because they know how clients may have very different issues across differing areas of their life. This discussion resonated with me because of my experience of working with mental health practitioners being engagements that induced shame in myself, something seen in the literature as well (Yarbrough, 2018). A dedication to understanding of what shame looks like and its various contexts for clients struck me, on a personal level, as unfortunately novel.

Working with shame has been found to be beneficial for a psychotherapist as research has found that certain reactions to feelings of shame in TGNC people have helped TGNC people's

mental health. Those who react to the stigma of gender nonconformity with pride in their transgender identity has resulted in buffering the negative effects of stigma on mental health (Barr, Budge, & Adelson, 2016). Natalya made such a connection when discussing the effect that shame may have on clients' ability to be authentic and tied this back into a person-centered perspective as she felt the congruency of the therapist and their unconditional positive regard could foster authenticity in the trans client. Authenticity is more than just a Rogerian talking point when it comes to transgender clients, as research has found that TGNC clients being more authentic, particularly in gender expression, has multiple mental health benefits (Lev, 2013; Levitt & Ippolito, 2014; Martinez, Sawyer, Thoroughgood, Ruggs, & Smith, 2017).

### **Universality of trans-affirmative therapy.**

While trans-affirmative psychotherapy may appear as a niche subject in the field of psychology, many of the clinicians interviewed expressed how trans-affirmative psychotherapy applies to all clients. Interviewees noted the importance of being accessible and equitable for all clients, and as a result that includes working from a theoretical framework that affirms all gender identities. Such a universal approach isn't explicitly reflected in the trans-affirmative counselling literature. Chang et al. (2018) state that trans affirmative counselling is based on theoretical foundations such as social justice, feminism and intersectionality. Similar foundational tenets are mentioned in other formative guidelines (see American Psychological Association, 2015). The grounding in social justice in particular speaks to a universal approach. Natalya and Dwayne both felt that a trans-affirmative approach was beneficial for all clients because they felt that affirming an individual's human rights made the world better for all people. Trish was more explicit pointing out how being affirming of 'typically transgressive gender expressions or

identities' benefits not only transgender people, but also cisgender individuals. Trish noted that the more you are affirming of all gender identities, the better you are at conveying and normalizing the non-binary nature of gender. Trish's comments are reflected in the literature as to how trans-affirmative therapy involves a level of transgression, as affirmations of non-normative gender identity and expression is allowing individuals to resist social norms and define their own lives (Fassinger, 2017).

While the literature on trans-affirmative care is not explicit in its universality, most literature notes the importance of gender being non-binary (American Psychological Association, 2015; Chang et al., 2018; Edwards-Leeper et al., 2016; Korell & Lorah, 2007). Trish's connection to this being a universal tenet drives home how this perspective is beneficial to all clients.

### **Self-education.**

All of the interviewees felt it was extremely important for clinicians to educate themselves as best as possible. This stemmed predominantly from a lack of education that the interviewees received in school. For example, when asked to rate the amount of training they received in the area of TGNC clients in school from 1 to 10 (1 being very little, and 10 being a lot) the interviews average response was 2.5. However, when asked to give the same rating to the amount of education they did on their own the group averaged 7.7. This is not surprising as research routinely finds that clinicians seldom receive basic education on transgender and non-binary people (Chang et al., 2018). Nor was this surprising at a personal level for me, as my graduate program featured portion of a lecture in our cross cultural counselling class that touched on the group. I had fruitful discussion with the non-binary participants as to how their identity may have actually enriched their classmates learning in graduate school if they were open about

their identity. I noted how the discussions of trans issues was most likely highlighted many times throughout my education simply by my lens being provided in discussions. The interviewees agreed and noted how such a theme seemed similar if their class had another student from a marginalized background: black, indigenous, disabled etc. Such a phenomenon would make for informative future research.

The group identified a multitude of different sources they used to further their education: workshops, volunteering, reading clinical literature and textbooks, documentaries, blogs, and social media. Less formal areas of learning such as social media made more and more sense as I continued my practical work with TGNC clients as I routinely found my knowledge of the subculture of TGNC people to be as valuable information as my academic knowledge of TGNC people. Such routes of education are commonly reported in the literature when clinicians report how they learn more about the transgender community (Chang et al., 2018). Clinicians having to rely on self-directed learning is nothing new in this area. Research has found that TGNC populations are scantily covered in graduate counselling programs (O'Hara, Dispenza, Brack, & Blood, 2013). This is a dangerous combination with the overrepresentation of TGNC people seeking psychotherapy (Grant et al., 2011) and how inadequate many clinicians feel about having to work with this population (Chang et al., 2018). The therapists interviewed had found ways to overcome their minimal formal education, but all felt that despite their ability to become more educated in the area, schools should put more focus into transgender and non-binary education for counsellors. This sentiment extended beyond just TGNC specific counselling, as interviewees desired more availability of transgender research in more counselling adjacent topics like career counselling, couples counselling, and family counselling. This was not remotely surprising for me as a practicing clinician, as having to refer TGNC clients for family



therapy in my city was quite challenging when looking for clinicians/clinics that were not only knowledgeable of TGNC people, but were considered a safe space for them. This call for more in-depth research is not new. For example, a meta-analysis found that only 1.6% of transgender counselling research looked at career counselling (Moradi et al., 2016). It has been argued that the oft pathologizing of transgender people in psychology has left ‘normal’ concerns like career development as an afterthought (Wada et al., 2019).

This notion of wanting to be able to have more beyond just transition specific research connected to many of the interviewee’s desires to not make therapy all about gender if that is not what the client desires. Natalya noted there is often a temptation to do so and wanted to ‘check herself’ when she noticed her mind going there. Making therapy purely about gender for transgender clients is one of the common microaggressions committed by therapists against this population (Nadal et al., 2012). This can prove challenging even for those who are educated on the subject. In my practical work I had a slew of clients who entered therapy expressing desire to transition from male to female. However, many suddenly settled on non-binary or genderfluid as their preferred identity. In my experience it wasn’t uncommon to see a slow shift to something more ‘neutral’ before transition to the ‘opposite’ gender. I myself after initially reneging on wanting to be a woman settled on drag queen/crossdresser. Managing such countertransference, but also a genuine understanding of the potential for this to be an incremental process was challenging, but I knew erring on the side of client self-determination was the way to go. Further education on the issues with making gender to sole topic of therapy, along with the process TGNC people undertake in their transition in graduate programs could help limit a too oft made error.

One challenge with lack of educational recourses is that while trans-affirmative guidelines are quite explicit about counsellors gaining a further understanding of TGNC people, along with providing affirmative therapy to them, the existing literature is lacking in system application of these services (Ginicola, Smith & Filmore, 2017; Knutson & Koch, 2018). The therapists interviewed in this study did not shy away from the fact that trans-affirmative therapy is challenging to integrate. Dwayne noted that there never really is a way to truly know what will work for people, and he chalked that up to the fact that he can never truly know someone's experience of their gender and how it plays into their approach to therapy, if it even does at all. Most comments about the challenging nature of trans-affirmative therapy and pinning down precise approaches to it often harkened back to person-centered comments like Dwayne's.

## **Chapter 6: Conclusion**

While research has emerged over the past 20 years looking at trans-affirmative approaches to psychotherapy with transgender and gender non-conforming clients, an understanding of how that is implemented and what tenets of these guidelines are most often used is seldom known. Additionally, the role of mitigating microaggressions, and responding to them when they occur has recently been found to be of utmost importance when practicing with this population. Despite that, little is known about the phenomenological understanding of how therapists' approach and react in a situation where a microaggression has occurred. This study aimed to see not only how clinicians' approach and understand trans-affirmative therapy, but also how they respond to the occurrence of microaggressions in session with a TGNC client. This chapter will review clinical literature, present key findings from analyses, address limitations, and recommend future directions for research.

## Summary of Study

### Literature review.

From the successful implementation of affirmative therapies for lesbian, gay and bisexual individuals, research has begun to apply these modalities towards the transgender community. Tenets of trans-affirmative therapies suggest that therapists need a self-awareness of their own views on gender, and how these views may affect a TGNC client, an ability to recognize institutional barriers that harm TGNC individuals, an understanding of how these barriers and other forms of discrimination are adverse to TGNC people's mental health, along with a firm grasp of the differences between gender identity and sexual orientation (American Psychological Organization, 2015; Chang et al., 2018). However, some of the core tenets of various trans-affirmative approaches are in conflict with one another, such as how some urge a deconstruction of the gender binary, while others appear to reinforce it (Benson, 2013). Research has yet to establish what clinicians tend to use as a guide to trans-affirmative work with this population.

Research has found that there are 12 specific types of microaggressions that pertain to TGNC people (Nadal, Skolnik, & Wong, 2012). These range from the seemingly obvious like *use of transphobic language* to the more subtle that even clinicians who have worked with this population may not even be aware of such as *exoticization*, where a trans person is viewed in a tokenistic manner. Microaggression against this group has been explored in a variety of areas and psychotherapy has been no exception. Research has found that more than half of TGNC people in therapy will experience a microaggression from their therapist (Johnson, 2014). However, it has also been found that therapists who can directly address this in therapy actually are able to improve the therapeutic relationship with their TGNC clients, but it is a small minority of clinicians who are able to do this (Johnson, 2014). An understanding of such a skill may be of

vital importance as research has found that success in therapy with this population may not be characterized by positive experiences so much as the lack of negative ones (Anzani et al., 2019).

## **Key Findings**

### **Person-centered approach.**

One of the key findings of this study was that the most common interpretation of trans-affirmative therapy is that of a person-centered approach. This is not surprising as many guidelines specifically describe trans-affirmative therapy as one that is person or client centered (American Psychological Association, 2015, Chang et al., 2018). The dominance of person-centered techniques at the foundation of trans-affirmative therapy may be one of the reasons trans-affirmative therapy is criticized for its lack of systemic implementation (Ginicola et al., 2017). Person-centered therapy itself is often criticized for its lack of systemic implementation and inconsistency (Kahn, 1999; Quinn, 1993). Quinn (1993) noted that person-centered therapy was in fact too person-centered, that it was overly reliant on concepts such as unconditional positive regard and empathy, while lacking in direct techniques. Such a critique is consistent with some criticisms of trans-affirmative therapy. While trans affirmative texts encourage things like empathy, challenging one's assumptions, and allowing the client to lead the session, they lack description of specific techniques/interventions to help TGNC clients (Ginicola et al., 2017). However, a similar critique of person-centered therapy is that tenets like unconditional positive regard, empathy, and congruence have been diluted into other modalities thus rendering person-centered therapy inadequate (Jones-Smith, 2019). However, research routinely finds that empathy may not be of utmost importance in some modalities or is at least conceptualized differently (Burns & Auerbach, 1996; Thwaites & Bennett-Levy, 2007). Additionally, there is still plenty of times where these supposed core skills all therapists should possess are lacking and

it is detrimental to clients (Moyers & Miller, 2013). Therefore, an assumption that modalities like person-centered therapy or trans-affirmative therapy are just theories reiterating therapy basics and don't help clients directly appears misguided at best. This is further demonstrated by research that looks at the importance of the therapeutic relationship as a catalyst for change in therapy.

The strength of the therapeutic relationship in general (Knox & Cooper, 2014; Lambert & Barley, 2001) and with the TGNC population (Whitman & Han, 2017) has been found to play a large role in client improvement. Research has also found that the strength of the therapeutic relationship is mediated by skills like unconditional positive regard, empathy, and congruence (Frankel, Rachlin, & Yip-Bannicq, 2012; Kolden, Klien, Wang, Austin, 2011). Therefore, it appears that these modalities are vital to helping clients from the TGNC population and critiquing the person-centered aspect of trans-affirmative therapy may be overstated. However, to suggest that trans-affirmative psychotherapy is purely a person-centered approach would be naive. Interviewees were quick to discuss concepts like power, privilege, and positionality more reflective of a feminist or social justice approach. Blending of these concepts appear to be at the heart of many trans-affirmative approaches (see Chang et al., 2018; Wada et al., 2019). It is almost ironic that my interviewing had to involve bringing the therapy room back into play as all interviewees could speak at length about systemic issues and could easily stray from discussion of the scenario presented and perhaps that created a unique aspect of how trans-affirmative psychotherapy operates. Clinicians working from this perspective have the required knowledge from a social justice/systems/feminist perspective to have discussions about power, privilege, and the like, but how they worked with the client in the moment reflected more person-centered basics like empathy and presence. Person-centered therapy has been criticized from a feminist

perspective as overlooking major systems of marginalization as a whole (Ivey, D'Andrea, Ivey, & Simek-Morgan, 2007; Waterhouse, 1993). While more recently it has been critiqued for how its emphasis on non-directiveness may lead therapists to not being aware of some of the power the control and influence they have on their clients (Margolin, 2020). Yet those interviewed for this study were well beyond such issues. Their ability to focus on potential bias and systems larger than themselves reflected an incorporation of those feminist concerns often leveled at a person-centered approach. From this perspective, trans-affirmative therapy may be best encapsulated as an integrative approach.

### **Knowledge of and preparation for microaggressions.**

The interviewed therapists felt that the best way to handle microaggressions was to prepare the therapeutic environment up as one where a client could feel comfortable to address microaggressions with a therapist should they occur. While the complete lack of microaggressions in therapy is ideal, the current literature reflects that minimization of microaggressions is where the field is currently at (Anzani et al., 2019), and that a knowledge of microaggressions and how to work with them is beneficial to minimizing the harm done to the client (Johnson, 2014). It is possible that both the issue of how to approach trans-affirmative therapy and how to work with microaggressions come back to issues with education on these subjects for psychotherapists. This line of thinking also harkened back to how the interviewees were educated, as focus on minimization of harm, which may be a more important direct discussion with this population than others, was not a major area of focus in their respective graduate programs, instead it was assumed to be a prerequisite skill that all therapists should possess. Many of the findings in this study point to further development of how working with TGNC populations is underrepresented in graduate school education.

## **Implications**

### **Academic suggestions.**

While the research looking at TGNC populations has exploded in the past 20 years, with plenty of this looking into how to conduct therapy with this population in particular, therapist's ability to work with this group has lagged behind. Research has routinely found that majority of clinicians feel unprepared to work with this group (Budge, 2015; Chang et al., 2018; Ginicola et al., 2017; Hunt, 2016; Rock, Carlson, McGeorge, 2010). While research has also found that education on these areas in graduate programs is scant at best (Acker, 2017; Rock et al., 2010). Evidence has pointed to an underdevelopment of policy encouraging effective training for the TGNC population (McNeil, Bailey, Ellis, & Regan, 2013). However, this study has shown that an educational background in the area has not been a prerequisite for working with this population, as all of the participants identified their own personal research as what has helped them to be effective with TGNC populations. Research has shown that personal desire to work with this population has been effective in helping in clinicians' competency in this area. For example, O'Hara et al., (2013) found that personal experience with TGNC people was more predictive of competency with this population than those who had clinical training in the area. Further research suggests that clinicians with more personal interest in the subject matter are better able to identify gaps in their own knowledge and were mindful of what was required to fill them in (Noonan et al., 2020). Although, other research has pointed to lack of training as a key issue in providing effective treatment for this population, and often acts as a major barrier to care for TGNC people (Bess & Stabb, 2009; Rachlin, 2002). This is not surprising as research has found that those in helping professions, despite having less transphobia compared to the general population (Kanomori & Corneilus-White, 2017) still tend to have relatively high levels of

transphobia (Acker, 2019). Research has been shown to minimize this through education and attitudinal reflection (Bidell, 2013). As a result, this researcher posits that graduate programs for counsellor education should have more training for students when it comes to TGNC people.

Currently, the most common approach seen for graduate psychotherapy students learning about TGNC people is as part of LGBTQ+ issues which are usually a section a graduate program's multicultural counselling class (Frank & Cannon, 2010; Heather, 2017). This method appears to have inadequately trained clinicians in TGNC groups and the larger LGBTQ+ groups as a whole. For example, Sherry, Whilde and Patton (2005) found that roughly a third of 104 counselling and clinical psychology programs had a multicultural counselling class, with 70% of them discussing LGBTQ+ people. Despite that only 17% of the programs had LGBTQ+ knowledge incorporated into their end of year evaluation of students and, perhaps more alarmingly, only 21% of programs had discussion of the groups in classes other than the multicultural class. Bidell (2014) found that these types of multicultural class do help improve multicultural competency as a whole, but do not have the same effect for competency with gender and sexual minorities. Both Bidell (2013) and Heather (2017) found that inclusions of a full course on LGBTQ+ individuals to be effective for helping clinicians develop their competencies. Other training protocols that have been found to be helpful for education in these areas tends to be more in-depth than part of lecture in a class. For example, Pepping, Lyons, and Morris (2018) found improvement in therapist training with an 8-hour workshop, while de los Reyes and Collicit (2020) used a multi-week course spanning 12 hours of education to see improvements. While some training in this area has consisted of much shorter time periods (e.g., a 3-hour workshop) that has found improvements in clinicians competency, the effects are ephemeral and the methodology is not always sound (Dubin et al., 2018; Heather, 2017).



However, conflict exists over whether improvement to the curriculum would come from an additional class on LGBTQ+ or TGNC issues or if what is required is an inclusion of those topics across all elements of the graduate program (Biaggio et al., 2003; Frank & Cannon, 2010). Specifics of accomplishing integration with the rest of the program have varied. Biaggio et al. (2003) suggested a more general filtering of LGBTQ+ topics throughout courses, Frank and Cannon (2010) suggested grounding a pedagogical shift in queer theory, while Ali (2014) additionally felt that such a shift involved grounding the curriculum in queer theory, but transgender studies and postmodern psychology as well.

This paper leans towards inclusion of a LGBTQ+ specific course based on the results of both Heather's (2017) and Bidell's (2013) work. But also understands the importance of a more holistic approach to work with these groups. This paper does not propose a theoretical or philosophical framework for how to achieve that, instead approaching it from Biaggio et al.'s (2003) general inclusions of topics, but also pulling from research in the medial field on how to better educate clinicians on TGNC health.

Research in medicine has found that most education on TGNC people is a one-time attitude and awareness-based intervention which does show significant improvement for clinicians in the short-term, but the research tends to suffer methodologically (Dubin et al., 2018). Consensus in the medical literature is that their needs to be a pedagogical shift toward longitudinally integrated interventions and development of clinical skills (Dubin et al., 2018; Park & Safer, 2018; Vanderleest & Galper, 2009). Taking recommendations from Dubin et al. (2018), the following recommendations should guide such a shift:

- 1 - Accreditation boards and schools specifically naming TGNC health/mental health a required subject and have expected competencies for clinicians. Institutional leadership should

ensure appropriate allotment of curriculum time to this subject with clear learning goals. It should be recognized that attempting to educate about all aspects of LGBTQ+ people's health/mental health is insufficient with one class/lecture.

2 – Separate transgender and gender non-conforming content from the larger LGBTQ+ umbrella. The distinction between gender identity and sexual orientation is a must in order for clinicians to be able to understand the importance of gender identity issues separate from sexuality ones, and their intersections when appropriate.

3 – Use pedagogical interventions that aim to improve awareness of transgender health and mental health inequalities. While this may be an inadequate intervention if it is the only intervention available it is vital in building comfort with this population.

4 – Pedagogical interventions should provide insight into social and legal barriers that produces health/mental health inequalities for this population. The curriculum content should avoid the pathologizing of TGNC people and the content should acknowledge TGNC people's documented resilience and agency

5 – Pedagogical interventions needs to focus on the development of students' clinical skills via measured outcomes. This may be more challenging for graduate programs in psychotherapy as the students do not receive the clinical experience that medical students do (e.g., multiple clinical rotations). However, many measures do exist to measure psychotherapists clinical competency based on their education (e.g., gender identity competency scale, Bidell, 2005)

### **Limitations and Future Research**

This research was limited by the sample size of only 5 participants. While each interview was in-depth, each case only relies on the subjective self-reports provided by each clinician. Each self-report was guided by each of their unique experiences, and each participant was from vastly different communities across Canada, and those communities and the resources available in each directly effected how each therapist viewed trans-affirmative therapy, microaggressions with this population, and opportunities for further education on TGNC clients. This study was also limited by the lack of transcription for the interviews as a result of following the format of an existing survey with tight timelines for data collection.

This topic has a vast number of options for future research. More research looking at those working in graduate programs for psychotherapists and how they choose to implement trans-affirmative approaches may be of utmost importance based on how common the issues of graduate education came up during interviews. Additionally, each therapist clearly had an interest in working with this population, which made having in-depth conversations about working with TGNC people very rich. However, if research continues to show that majority of clinicians feel they are very unprepared to work with this group and research shows that TGNC people are struggling to find therapy helpful to them, investigation into therapists who know little about this area may be valuable. Research in this area has often focused on what clinicians with interest in the area know, but little is known about what those not interested in TGNC issues do not know, and how we can make sure they leave their graduate programs with more sufficient knowledge in working with this population. Finally, conducting a study as a transgender woman training to be a psychotherapist and featured two TGNC psychotherapists points to more

research on TGNC psychotherapists. At this time there is only one academic article on the topic (Shipman & Martin, 2019).

### **Concluding Remarks**

While research in the field of psychotherapy with TGNC populations has come a long way in recent history, the field is still growing rapidly. Gaining a better understanding of how clinicians who work with this population and incorporate trans-affirmative and trans-positive theories into their practice is valuable information. The understanding of how clinicians are able to work with and understand microaggressions with the population is also important to understand. Especially considering how we are now learning how important mitigating microaggressions are with this population (Anzani et al., 2019). Insights from these experienced clinicians help to gain a better understanding of how to incorporate the role of shame, the universality of a trans-affirmative approach, and a better understanding of the underpinnings of person-centered tenets. While these insights are tremendously valuable, another takeaway is the continued lack of robust education that prepares counsellors/therapists to work with these populations. Hopefully, more evidence pointing towards the importance of more substantive education for training clinicians will help the field move in that direction.

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## Appendix A – Recruitment Letter



### Survey on Social Justice and Trans Affirmative Practice

Jason Brown, Ph.D.

Principal Investigator

The Social Justice Committee Executive are interested in learning about the issues you consider important. We are seeking the views of all CCPA members to inform our Chapter's planning and priority setting.

We are writing now to request your participation in a study. We are recruiting participants for a single telephone interview focusing on 1) the interface between Social Justice and Counselling/Psychotherapy, as well as 2) the practice of Trans Affirmative therapy.

Your views on Social Justice will assist the Chapter Executive with planning and priority setting. Your views on Trans Affirmative practice will form the basis of our RA, Jordyn Banks', Master's Thesis in Counselling Psychology at Western University. Results will be shared with the CCPA membership and appear in scholarly publications.

If you are interested and agree, you would be asked to participate in a telephone interview at a mutually agreeable time to discuss the topics of social justice and trans affirmative therapy. Questions will be provided in advance of the interview. The interview would last approximately 30-60 minutes.

## Appendix B – Letter of Information



### Letter of Information and Consent

**Project Title:** Social Justice and Trans Affirmative Practice

Dr. Jason Brown, Principal Investigator  
1110 Althouse, Faculty of Education,  
1137 Western Road, London, Ontario  
N6G 1G7

Because you are a member of the Canadian Counselling and Psychotherapy Association you are invited to participate in this research study about the intersection of social justice with counselling/psychotherapy and trans affirmative practice.

The purpose of this study is to describe counselling/psychotherapy students' and professionals' perceptions of social justice and trans affirmative practice.

Participation will take approximately 30-60 minutes.

The interviewer will take notes throughout the interview. No audio will be recorded.

Participant quotes will be used in reports and publications. Quotes will be identified only by pseudonym.

If you agree to participate you will be asked to engage in a telephone interview at a mutually agreeable time.

There are no known or anticipated risks or discomforts associated with participating in this study.

The possible benefit to you may be to have your experience reflected in research about social justice and trans affirmative practice. The possible benefit to society may be increased wellbeing for individuals receiving or delivering counselling/psychotherapy services.

You may withdraw from the study and have your data withdrawn at any point.

Representatives of Western University's Non-Medical Research Ethics Board may require access to your study-related records to monitor the conduct of the research.

The researcher will keep any personal information about you in a secure and confidential location for 7 years. A list linking your study number with your name will be kept by the researcher in a secure place, separate from your study file. If the results of the study are published, your name will not be used

You will not be compensated for your participation in this research.

Your participation in this study is voluntary. You may decide not to be in this study. Even if you consent to participate you have the right to not answer individual questions or to withdraw from the study at any time. If you choose not to participate or to leave the study at any time it will have no effect on your professional or employment status. You do not waive any legal right by consenting to this study.

If you have questions about this research study please contact Jason Brown, Principal Investigator.

If you have any questions about your rights as a research participant or the conduct of this study, you may contact The Office of Human Research Ethics. The Research Ethics Board is a group of people who oversee the ethical conduct of research studies. The Non-Medical Research Ethics Board is not part of the study team. Everything that you discuss will be kept confidential.

**A copy of this letter can be emailed to you if you provide an email address for this purpose.**

**Project Title:** Social Justice and Trans Affirmative Practice

Dr. Jason Brown, Principal Investigator

1110 Althouse, Faculty of Education,

1137 Western Road, London, Ontario

N6G 1G7

Have you read the Letter of Information and had the nature of the research explained to you?

Have all of your questions been answered?

Do you agree to participate?

\_\_\_\_\_

Yes

\_\_\_\_\_

No

## Appendix C – Interview Guide



**Project Title:** Social Justice and Trans Affirmative Practice

### Interview Guide

#### Demographic Questions

City/community where you practice:

Populations with whom you practice:

Areas of specialty:

Years practising counselling or psychotherapy:

Years as member of SJ chapter:

Years as member of CCPA:

Regulating body or bodies:

#### Social Location

Age:

Gender:        I identify as male

                  I identify as female

                  I identify as (please specify)

Ethnicity:

Race:

Class:



(dis)Ability:

### Questions about Social Justice

1. What does social justice mean to you?
2. What social justice issues do you feel are particularly important?
3. In what ways could the chapter help you in your social justice work?
4. How can therapists address social disadvantage with clients from socially advantaged groups?
5. How can therapists address social disadvantage with clients from socially disadvantaged groups?

### Trans Affirmative Therapy and Microaggressions

On a scale from 1-10 how would you rate your therapy experience with clients who identify as trans?

On a scale from 1-10 how would you rate your own therapist training with clients who identify as trans?

#### Research question 1:

What do you view as trans affirmative therapy?

#### Consider the following vignette: (Jack)

*During your second session with your client Lindsay they expresses to you that they would like to be addressed as Jack and uses he/him pronouns. Jack is uncomfortable discussing much in therapy around his transgender status because of past rejection from others for being different. Jack experiences many mood swings and would like to discuss how to work thru some of the shame he experiences for being transgender.*

How would you approach helping Jack? What would you want to know about Jack? What would you want to communicate to Jack? How would you approach therapy? What might be different (and similar) about your therapy with Jack relative to therapy with a cis gender client? In what ways might your therapy with Jack take his experience with discrimination into account? How might you attend to the problems he is facing in an unaccepting society?

**Research question 2:**

How can therapists respond to their micro aggressions in therapy with a client who identifies as trans?

**Consider the following vignette: (Sarah)**

*In your last session with your client Sarah she expressed her frustrations with how people treat her for being trans. You reassured her that things will probably get better once she completes her vocal training and gets her upcoming facial feminization surgery. Sarah starts this session by pointing out that she felt very upset in the last session because you gave her no viable options to deal with the stress in the moment and the notion that trans women need to 'pass' as more feminine can be very harmful.*

How would you approach helping Sarah? What would you want to know about Sarah? What would you want to communicate to Sarah? How would you approach therapy with Sarah? What might be different (and similar) about your therapy with Sarah relative to therapy with a cis gender client? In what ways might your therapy with Sarah take her experience with discrimination into account? How might you attend to the problems she is facing in an unaccepting society?

## Appendix D – Debriefing Form



### DEBRIEFING FORM

**Project Title:** Social Justice and Trans Affirmative Practice

**Principal Investigator:** Jason Brown, University of Western Ontario

Thank you for your participation in this study.

We really appreciate the time you have taken to share your insights about the intersections between social justice and counselling/psychotherapy and trans affirmative practice.

The study had two purposes. 1) Description of counsellors' understanding and application of social justice into their practice. 2) Description of counsellors' understanding and application of trans affirmative practice.

Once interviews are complete, the data will be analyzed and summarized.

A summary of the results will be available to all interested participants by the spring of 2021.

## Appendix F – Ethics Approval



Date: 11 March 2020

To: Dr. Jason Brown

Project ID: 115437

Study Title: Social Justice and Trans Affirmative Practice

Short Title: Social Justice and Trans Affirmative Practice

Application Type: NMREB Initial Application

Review Type: Delegated

Full Board Reporting Date: April 3 2020

Date Approval Issued: 11/Mar/2020

REB Approval Expiry Date: 11/Mar/2021

Dear Dr. Jason Brown

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Confirming Ethics Review.

This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
Debriefing Form_CLEAN	Debriefing document		
Email advertisement_CLEAN	Recruitment Materials		
Interview Guide_CLEAN	Interview Guide		
LOI_CLEAN	Verbal Consent/Assent	05/Mar/2020	

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Kelly Patterson, Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

*Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).*

## Curriculum Vitae

**Name:** Jordyn Banks

**Education:**

**Master of the Arts – Counselling Psychology**

*Western University*

London, Ontario, Canada

2019-2021 M.A.

**Bachelor of the Arts – Honours Specialization in Psychology, Minor in Disability Studies**

*Kings University College*

London, Ontario, Canada

2014-2018 BA

**Honours and Awards**

**Western University Entrance Scholarship**

2019

**Kings University College Deans Honor List**

2015, 2016 & 2017

**Kings University College Continuing Scholarship**

2016, 2017 & 2018

**Academic Experience**

**Masters Thesis**

*Psychotherapists' Approach to Trans-Affirmative Psychotherapy*

**Undergraduate Thesis**

*An Examination of Gender Identities Among a Non-cisgender Sample: The Role of Sexual Orientation and Binary Versus Non-binary Identification*

**Related Work Experience**

**Teaching Assistant**

*Kings University College*

2016-Current

**Volunteer Experience**

**Psychotherapy Intern**

*Daya Counselling Center*

2020-Current

**Peer Support Worker**

*Canadian Mental Health Association*

2015-2019