lore m. dickey
Jae A. Puckett

Advances in Psychotherapy –
Evidence-Based Practice

Affirmative Counseling for Transgender and Gender Diverse Clients

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Affirmative Counseling for Transgender and Gender Diverse Clients

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1

Description

Although transgender and nonbinary individuals are in the minority, being trans is not so uncommon as to be invisible. Trans people have existed throughout history, and being trans is not a new phenomenon. It has been estimated that there are 1.4 million trans people in the US (Flores et al., 2016). Flores and colleagues suggest that the number of trans people in the US could be as high as 2.3 million and as low as 845,000, given statistically credible intervals.

There may be as many as 2.3 million trans people in the United States (ca. 0.95% of the population)

This means that there are as many trans people in the US as there are inhabitants of some cities such as Indianapolis (population 864,447 in 2019), Honolulu (population 348,985 in 2019), Phoenix (population 1.6 million in 2019), Philadelphia (population 1.6 million in 2019), or Houston (population 2.3 million in 2019). Trans people are a subpopulation in the US, and they are often disregarded or turned away from services and care.

In the field of psychology, discussions of the needs of trans people have often been addressed in courses such as abnormal psychology, behavioral pathology, or human sexuality. In each of these course offerings, trans people are typically conceptualized from a deficit perspective, and many of the textbooks used have inaccurate or offensive descriptions of the experiences of trans people. This means that those who are trained to work in clinical settings may only learn about the diagnostic nomenclature found in the *Diagnostic and Statistical Manual of Mental Disorders,* fifth edition (DSM-5; American Psychiatric Association, 2013). There are times when it is appropriate to view trans people's experiences through the lens of the DSM. This might include referrals for medical care, where the provider or the insurance company requires a diagnosis. But medical care is *not* a goal for some trans people, and there are many other reasons a trans person might seek mental health care. If a provider is only viewing their work with a trans person from a medicalized approach, they are at best likely to miss important clinical concerns, and at worst, to alienate and pathologize them.

Deficit models and conceptualizations are harmful to trans people

1.1 Terminology

Transgender, nonbinary, and gender diverse people may use a variety of terms to describe their gender identity. In this volume, we will use the term "trans" as we describe the ways to work with these communities. We acknowledge that the term "trans" may not fit for some people under these broader umbrellas; however, it is the most inclusive term being used as this volume is being written.

"Trans" is used by some people whose gender identity differs from what was assigned at birth

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We describe the lives of trans people below using terms that are commonly used. The list of terms below, in Section 1.2: Definitions, is far from being exhaustive, and psychologists are encouraged to be mindful of the need to talk with their clients about the terms that best describe their identity. Trans people may use terms that shift over time. The ability to be flexible with your clients is vital. Inflexibility is likely to lead to a fracture in the clinical relationship. The result could be catastrophic for your trans clients.

Affirmative language is critical when addressing trans clients

The terms listed below (Section 1.2: Definitions) are relatively common in trans communities. It should be noted that there are many others that are less commonly used. These include "birl," "pangender," "hybrid," and "aggressive" (Harrison et al., 2012). Harrison and colleagues (2012) noted that over 850 different terms were used in the study they were reporting from. Given that the terms for which definitions are provided below are limited to some of the more commonly used, providers will benefit their clients by taking on the responsibility to learn about terms or identities that clients hold, outside of those listed below, as they come up in their clinical practices. Although it is helpful to learn the basic terms provided here, providers will need to seek out new education as they work with trans clients to broaden their knowledge and to continue to grow this awareness as terminology continues to evolve and change over time.

Some trans people eschew labels, others have self-affirmed terms used to describe their gender

1.2 Definitions

For readers' convenience, the terms are listed in alphabetical order.

Agender is a term used to by people who do not identify with a gender, those who identify as having a neutral gender, those who choose not to label their gender, those who feel detached from their gender, and those with other types of experiences in which a person does not identify with a specific gender. Like other categories, agender individuals may or may not seek medical means to affirm their gender. Making a medical transition is an individual decision, regardless of identity.

Some people do not identify with any gender

Bigender relates to people who feel as though two genders (not necessarily male and female or as a man or woman) are consistent with their felt identity. This is different from having an identity as third gender.

Bottom surgery includes the various genital surgeries. For a person assigned male at birth (AMAB), this includes an orchiectomy and a vaginoplasty. For a person assigned female at birth (AFAB), it includes a hysterectomy with or without oophorectomy, metoidioplasty, or phalloplasty (with or without a urethral extension), and a scrotoplasty. For many people, the cost of these procedures prohibits their ability to access care.

Surgeries can be prohibitively expensive for many trans people

Cisgender is a label that applies to any person whose gender is consistent or congruent with the sex they were assigned at birth. Another way of thinking about cisgender is that a cisgender person does not have a trans identity. Rather than referring to people in this group as not being transgender, it is important to specifically use the term "cisgender." Individuals who are in the dominant and majority group often have their identity treated as the norm and as such are not called on to have labels for their identities. Using the term "cisgender"

Cisgender people make up the majority of those in society – they have their own experience of gender

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2

Theories and Models

It is important to honor a trans client's right to autonomy

At the core of affirming mental health services with trans clients is respect for the autonomy of trans individuals and their varied life and gender experiences (American Psychological Association [APA], 2015; Chang et al., 2018). Providers who adhere to these principles understand that there is no singular narrative for what it means to be trans and that trans people vary in their desires for socially, legally, or medically affirming their gender.

There are many ways for a trans person to affirm their gender

Furthermore, not all trans people socially, legally, or medically affirm their gender, for a variety of other reasons, such as safety concerns or difficulties accessing such services. In terms of clinical practice, there are three main treatment contexts in which providers serve trans clients: general mental health services, therapy related to supporting a person's gender exploration and affirmation, and clinical services targeted toward supporting clients in their medical gender affirmation process (e.g., providing letters of support, conducting evaluations for treatment [if needed], helping to address mental health challenges). These are not mutually exclusive and may overlap depending on the client.

The clinical concern for some trans clients may have nothing to do with their gender identity

In mental health services, clients may be seeking therapy due to any form of distress they are experiencing, such as depression or anxiety, as well as other life challenges (e.g., loss of employment, relationship concerns). Trans clients may be seeking therapy for reasons that are more closely connected to their experiences as trans individuals, such as managing stress around coming out and disclosing a trans identity, coping with social stigma, developing strategies for managing rejection from family, and other life challenges. More specifics about implementing an affirmative therapy approach are available in Section 4.2.1: Affirmative Practice.

Here we describe the basic strategies that providers can implement to integrate a gender-affirming approach into their overall therapy services with trans clients given that many people may seek care unrelated to their gender experience. For starters, providers must understand that gender is a nonbinary construct, although most people have been socialized in a way that encourages binary thinking about gender and enforces this via policies, practices, gender norms, and physical manifestations of the gender binary (e.g., gendered restrooms, limited forms addressing sex/gender in applications; APA, 2015; Budge et al., 2014; Chang et al., 2018). Taking on this understanding of gender means that psychologists will need to unpack their own internalized understanding of gender and work through their assumptions of their own and others' gender experiences in order to provide an open space for clients to express and explore their gender without having psychologist-imposed expectations (Chang et al., 2018). This will influence the dialogue between psychologists

Providers need to reflect on their own internalized understandings of gender

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Before Client Contact

- Make sure your practice, setting, forms, and policies are affirming
- Review the full experience of clients to identify areas for improvement
- Engage in critical self-reflection to unpack your own biases and assumptions about gender
- Make clear on your advertisement materials/website your qualifications and training
- Make transparent your general policies and fees related to letter writing for gender-affirming medical care

Intake

- Introduce self with pronouns and be transparent about experience level
- Avoid assumptions about gender experiences of clients
- Explore experiences of gender, marginalization, and strengths so that these can be integrated into case conceptualization
- Do not overemphasize gender – follow the client's lead in how central this is to their experience
- Assess for mental health concerns as would be done with any client
- Explore gender dysphoria if relevant to the client
- Inquire about purpose of services – is the client seeking therapy or are they seeking a letter of support for gender-affirming medical care?
- If missteps occur, address them right away with brief apologies, moving on, and doing better in the future

Ongoing Therapy (if applicable)

- Understand that there can be fluidity in a client's gender experience over time
- Avoid making assumptions or having expectations about the client's gender affirmation process (including pushing clients to pursue any of the social, medical, or legal ways that they may affirm their gender)
- Recognize that transition or gender affirmation is unique to a given client; follow the client's lead about what is relevant regarding their own process over the course of working together
- Be responsive to ongoing or new experiences of marginalization and respond as clinically appropriate
- Integrate interventions that promote resilience and positive self-views to manage social oppression
- Use appropriate progress monitoring tools and be thoughtful about reliability, validity, and interpretation if not developed for trans people
- If missteps occur, address them right away with brief apologies, moving on, and doing better in the future

Figure 1
Improving inclusion across the course of therapy.

Introduce yourself with your pronouns and invite clients to share their pronouns as well

are deeply linked to gender. For instance, one could say "Hello, I'm Dr. Jae Puckett and my pronouns are they/them." This simple act can be a source of relief for your client as they enter a clinical relationship with you and provides an opening for clients to share their pronouns with you with less fear about broaching the topic. We recommend that you introduce yourself with your pronouns to all clients, not just those you know to be trans or who you think could be. If you go the latter route, you may be making inaccurate assumptions about your new clients. We do not know another person's pronouns until they share them with us.

Pronouns are very personal, and asking your client about the pronouns they use can help to build the foundation of trust in the clinical relationship. Like

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3

Assessment and Treatment Indications

Intakes with new clients generally include an assessment of their presenting concerns, learning about identity-related experiences, and understanding the contextual factors that influence a client's day-to-day life. Generally speaking, evidence-based practice should be followed in the assessment and treatment planning process, but we recognize that few such resources exist that were designed for trans people. Given that there has been minimal research about the effectiveness and validity of various assessment tools with trans clients, psychologists should be aware of this and how it may influence their interpretations of a client's responses. In this section, we detail various screening and assessment tools, as well as progress-monitoring tools that may be useful with trans clients, and concerns that may arise.

3.1 Assessment

One aspect of a psychologist's work portfolio is the ability to administer, score, and interpret psychological assessments. Although screening tools are often used by professionals with less training, the most complex personality and cognitive assessments are employed by psychologists or under the direction of a psychologist. We will devote considerable time here to the understanding of the various measures that have been developed for use with trans clients.

Assessment is the work activity that distinguishes psychologists from other mental health providers

3.1.1 Screening Tools

Screening tools are used in clinical practice, as they have the ability to paint a picture of what is happening in the client's life. Screening tools and other measures should not be the only source of information, as they do not replace the knowledge that can be obtained with a quality intake interview and do not provide sufficient information to make a diagnosis. As such, they are only part of the data gathering and not the sole source of information.

Sheldrick and colleagues (2015) describe the required aspects of an effective screening tool. They start with the concept of *sensitivity* which refers to the screening tool being able to accurately predict the clinical concern. Next, they address *specificity,* which relates to the number of people who receive a negative result, where the clinical concern is not present. Finally, they refer to *positive* and *negative predictive values*. These values relate to the proportion of people who correctly receive a positive or negative result (Sheldrick et al.,

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this, outcome measures that reflect treatment progress and the quality of the clinical relationship and alliance may be useful.

3.1.3 Critique of Personality Assessment Tools

Personality assessment tools such as the MMPI-2 (the MMPI-3 was recently published), the Personality Assessment Inventory (PAI), the Millon Clinical Multiaxial Inventory–IV (MCMI-IV), or the 16 Personality Factors (16PF) are often used in clinical practice for the purpose of determining the clinical concern a client is experiencing. Like screening tools, personality assessments have not been normed for use with trans people. The challenge for psychologists is how to select an assessment tool that will lead to accurate results for their trans clients, without pathologizing their lived experience.

One concern a psychologist must attend to is how to assign a gender (or sex) to clients which may be required for scoring purposes with some assessments. For example, if you have a client who was AFAB who has been living as a trans masculine person, how would you assign their gender? In justifying the assignment of female, there is the reality that the trans masculine person may have been primarily socialized as a female. However, some trans people know from a young age (as young as the age of 3) that their gender is different from the sex they were assigned at birth. Is using female norms appropriate for this client? Or should the instrument be scored for a male client?

Keo-Meier and Fitzgerald (2017) provided a landmark critical review of neurocognitive and personality assessment. Keo-Meier and Fitzgerald begin by describing the need for more than basic training in psychosocial assessment. Without this, the psychologist may make an inaccurate decision about the clinical needs of the client. Should this happen, the harm incurred by a trans person may be significant. Given the history of the use of personality assessments in making a determination of a client's readiness to transition, psychologists must be thoughtful about the selection and use of assessments.

Advanced training in the use of assessments is required

Keo-Meier and Fitzgerald (2017) discuss the need for psychologists to have training and competency in the use of the *gender affirmative model* (GAM), the gender minority stress model, the ways that hormones may impact the client's mood, and how to score assessments for trans clients (as mentioned above).

The GAM is a conceptual approach to working with trans people. It starts with the belief that having a trans identity is not a disorder. This can be a difficult concept for a psychologist to accept, depending on their training. When psychologists assume there is something wrong with their patient, they may have trouble accepting the positive attributes of their clients. The GAM expects an understanding of the ways intersecting identities influence a person's gender experience (see Section 4.5.1: Intersectionality). Finally, psychologists understand the fluidity of gender and sexuality and that the source of pathology may have much more to do with discriminatory experiences than it does the person's gender.

The gender affirmative model is a conceptual framework for understanding the needs of trans people

Keo-Meier and Fitzgerald (2017) spend considerable time critiquing the use of the MMPI-2. They begin by addressing the ways the assessment has been used and, in some cases, misused. They clearly explain the ways that trans people may be likely to have elevated scores that indicate clinically significant

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4

Treatment

Much more research is needed evaluating evidence-based interventions with trans clients

There has been minimal research about interventions that are effective with trans clients. Much of the existing literature has focused on case studies, summaries of treatment adaptations, and guidance based on clinical experience. Although this is helpful in providing guidance for clinicians and information that can help improve mental health services, there has been minimal empirical evaluation of interventions with trans clients. As such, there is much to be learned about the types of interventions that are effective in addressing the unique experiences that come up for trans clients, such as minority stressors, or about how to adapt treatments for presenting concerns such as depression or PTSD, to make them affirming for trans clients. Overall, there is a great need for research about both intervention development and treatment adaptation to improve the quality of care that trans clients receive.

4.1 Method of Treatment

Counseling is not a requirement for gender affirming medical care

Overall, psychologists must differentiate the method of treatment depending on the client's presenting concerns. An initial consult with a client should include exploring whether a client is seeking counseling or if they are seeking a letter of support for gender-affirming medical care. If the latter, counseling is *not* a requirement, and imposing this expectation on your client is harmful, as it hinders their access to gender-affirming medical care that has been shown to improve mental health and well-being (Keo-Meier et al., 2015).

If, on the other hand, a client is seeking counseling, or it would be useful due to a need to address mental health concerns that are not reasonably well-controlled, psychologists will need to make decisions about the best treatment approach for a given client. This should be based on the specific mental health concern of the client (e.g., depression, anxiety, obsessive-compulsive disorder, or PTSD) and psychologists should utilize evidence-based practices in shaping their treatment choices and approach. In this section, we review the available literature about the efficacy and prognosis of therapy and adaptations that will likely help psychologists to provide more affirming care with trans clients.

4.1.1 Specific Clinical Concerns

It is not uncommon for trans people to have co-occurring mental health concerns (APA, 2015). Reports of substance abuse, depression, anxiety, and

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4.6 Importance of Interrogating Your Gender

Interrogating your gender is a personal and necessary process for those who work with trans people

There have been numerous calls for psychologists to interrogate their gender as part of their preparedness for working with trans clients (APA, 2015; Chang et al., 2018).

Many years ago, Peggy McIntosh (1989) published an article that addressed the ways she was able to walk in the world without there being any restriction based on the color of her skin; or because she had white privilege. In the same light, the first author of the present work developed a similar listing of the ways that cisgender people can walk in the world and not receive mistreatment because of their gender. These are shown in the following list of statements to consider, based on the work of Peggy McIntosh (1989):

- I do not have to worry that someone will tell me that I am in the wrong restroom.
- I do not have to worry about whether I will receive competent care if I am not able to tell a doctor about my gender.
- On first meeting me, no one asks me about my genitals.
- I can usually count on another person using the correct pronoun.
- I do not need to be concerned that others will assume I am unfit to be a parent because of my gender identity.
- I am not excluded from employment or social services because of my gender.
- I do not have to worry that I will be harassed by a police officer because my gender expression is different from the sex listed on my identification.
- I do not have to worry that I will be pulled aside by the US Transportation Security Administration because my X-ray image is not consistent with what was expected.
- I do not have to "out" myself on an employment application when someone asks if I have ever used another name.
- I do not have to worry about whether I can receive health care for the organs that are present in (or absent from) my body.
- I do not fear for my safety when I am in public because my gender might be misunderstood by another.
- I am not afraid to talk to another person about what it means to have a gender identity.

Interrogating your gender should start early in your clinical practice. Whether this happens with supervision when you are a trainee or in a consultation group after you are independently licensed, we must all attend to the biases we have about gender. Our clients deserve to work with psychologists who have made an effort to understand their inherent biases. The goal is not to eliminate biases (although that would be helpful) but rather to understand how our thoughts and beliefs about gender may get in the way of our work with trans clients. For example, if we hold a belief that men are supposed to be strong and hold power in relationships with others; how will we work with a trans woman who is coming out and will need to give up these expressions of male privilege?

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Case Vignettes

Eliza

Eliza, like many trans people, has a significant trauma history

Eliza is a 28-year-old who was AMAB. Eliza completed high school and has about 25 college credits. She identifies as a Black trans woman. Her trauma history is quite significant. She scored 9 out of 10 on the Adverse Childhood Experiences (ACE; Felitti et al., 1998) assessment. Eliza was born in the US, and her parents are first generation US citizens. Their respective parents immigrated to the US from Jamaica.

Until recently, Eliza lived with a cisgender male partner (named Liam) for 2 years. They lived in an apartment together, but the lease was only in his name. When she first moved in, this seemed like an acceptable living situation. That was due in part to Eliza not having had a stable home prior to meeting Liam. Eliza mostly stayed at home and took care of household chores. Liam had not forbidden Eliza from working, but he assured her that he would take responsibility for providing for her.

Stable housing has been a challenge

Eliza was referred by her physician. Eliza had been to see this provider to get a refill on her medication to treat a hepatitis B infection. The physician asked Eliza how things were going for her. The physician had noticed that Eliza's appearance was more disheveled than usual. Eliza admitted that she and her partner had recently broken up, which resulted in her losing a place to live. Eliza stated that she has exhausted the kindness of her friends and has been living on the street for about a month. She does not have a job, and since she has not been in the workforce for over 2 years, she does not believe she has the skills needed to find meaningful work.

Assessing Eliza's Need for Support

An ill-informed provider may believe that they should start with an assessment to determine their client's gender. There are no assessments that can be used to determine whether a person is trans. Deogracias and colleagues (2007) developed an assessment that on face value seems to assess whether or not a person has a trans identity. Their assessment measure, titled the *Gender Identity/Dysphoria Questionnaire for Adolescents and Adults* (GIDYQ-AA), was designed as a means of exploring whether a person was experiencing questions about their gender identity. One problem with the GIDYQ-AA is that it was created as a measure to assess binary conceptualizations of gender. This means that if a trans person has a nonbinary identity, this assessment tool

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Appendix: Tools and Resources

The materials reproduced on the following pages can also be downloaded free of charge from the Hogrefe website after registration.

Appendix 1: Client Case Conceptualization Form
Appendix 2: Sources for Finding Providers
Appendix 3: Training Resources
Appendix 4: Client Reading
Appendix 5: List of Biographical Resources
Appendix 6: Sample Letters
Appendix 7: List of Established Conferences

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Sources for Finding Providers

Finding a provider who works with trans and gender nonconforming people is sometimes challenging. We offer the following online resources but make no guarantee as to the results of a search, meaning that there could be providers who are not affirmative in their work with trans people also listed on such websites. Providers should seek more detailed information about any referrals before taking their expertise and knowledge at face value.

Resource	Web address
Psychology Today	https://www.psychologytoday.com/us
American Psychological Association	https://locator.apa.org/
World Professional Association for Transgender Health (WPATH)	https://wpath.org/provider/search/
Gay Lesbian Medical Association (GLMA)	https://glmaimpak.networkats.com/
OutCare	https://www.outcarehealth.org/
Gender Affirming Letter Access Project	https://thegalap.org/
Association for Behavioral and Cognitive Therapies	https://www.findcbt.org/FAT/

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