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ABSTRACT

This original qualitative study identifies the theories and techniques therapists have found supportive in their work with Transgender and Gender Non-Conforming clients. Twelve clinicians currently in practice in the New York City area and one clinician from Virginia who had experience working with Transgender and Gender Non-Conforming clients were interviewed. The questions posed to them were intended to guide them to reflect on their practice considering what theories arose as themes in their work and what techniques or approaches arose as supportive in their work with this population. Their responses were in line with the current body of literature reflecting an ongoing struggle to apply developmental theory to gender development where some clinicians find use in these theories while others do not. Other major findings indicate the use of empathy, validation, and acceptance for this population may do more therapeutic than just developing a working alliance but also provide a reparative experience for members of this population who may have had little to no empathy, validation and acceptance from their families of origin, surrounding communities, and society at large. Overall this study indicates that clinicians in the field draw upon their training and continuing education to select the specific theory and skills to meet the needs of each individual client as those needs present themselves. The findings also indicate that in general, clinicians feel that treatment approaches that work for most clients will also work for most TGNC clients. Lastly, this study contains

implications for the education of theory and practice in social work settings regarding the treatment of Transgender and Gender Non-Conforming clients.

**THEORIES AND INTERVENTIONS WITH TRANSGENDER AND GENDER NON-
CONFORMING CLIENTS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work

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Massachusetts 2015

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The questions posed in this study would not have occurred to me without the support from my faculty at Smith who encouraged me to question and understand what theories were guiding my interventions and techniques. They provided me the guiding principle that whatever we do or say or refrain from or neglect is rooted in an underlying theory of who we are and what is going on, and that it is our responsibility to understand why we do the things we do for our clients and for ourselves. To my participants, I am honored by the candor and thoughtfulness from my participants. They represent a narrow geographical area but a wide range of practice, political analysis, and philosophies. This study has been enriched by their experiences as I have been.

No project like this could be done in isolation and I am ever indebted to the love and support from my community of thinkers, feelers, and doers. Namely Maya, Arianne, and Frank helped keep me buoyed when I felt alone and adrift throughout this year. They provided the reflection I needed to know I was not alone and the encouragement that we can accomplish this task together. I am deeply grateful to Arianna for helping me with my data analysis and for her mentorship that helped me understanding the importance and power of qualitative research. I am always indebted to my good friend Mykhil for providing amazing editing skills and inspiration for my writing.

Lastly, it is to my dear husband without whom I could not have managed the emotional impact this process had on me. He was the calm reassurance that I could accomplish this task and contributed to my understanding of what care means for TGNC folks. He was also the comfort I needed when I felt overwhelmed and made small by the task at hand.

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CHAPTER I

Introduction

Trans* and gender non-conforming clients are seeking support from mental health practitioners for a myriad of reasons. This study is concerned with the practice of psychotherapy with TGNC clients from the clinicians' experience. What theories and techniques have they found to be helpful in their support for TGNC clients? Many theories of development and theories of the psyche have been used to pathologize those who do not conform to their assigned gender. Without theories that make room for non-binary gender experiences or experiences of transition how are clinicians providing therapeutic support?

Many TGNC clients will seek support for transition from the gender assigned at birth to the gender they most identify with, which includes in many cases the provision of a diagnosis of Gender Identity Disorder (GID) as per the Diagnostic Statistical Manual (DSM) to attain gender confirming treatments such as hormones or surgeries.

In addition to transition as a reason for seeking treatment, many trans* and gender non-conforming people also suffer from anxiety and depression at a much higher rate than the general public. The stressors experienced by this population as a gender minority may lead to the increase in susceptibility to depression and anxiety (Budge, Adelson, & Howard, 2013). The minority stressor model can be used to explain many of these symptoms as rooted in experiences of oppression of their gender non-conformity as children and throughout childhood from peers, authority figures, and even parents (Mallon & DeCrescenzo, 2006), in developing a positive or authentic self-presentation (Levitt & Ippolito, 2014), and especially considering the process of

socialization into gender begins when a child is born and continues to develop thereafter (Menvielle, 2009, p. 294).

There is an abundance of literature addressing “best practices” when working with TGNC clients, promoting trans-affirming approaches and frames of reference for supporting clients through transition in medical, legal, and social fronts. This work appears to be in direct response to the previous pathologizing understandings of *transsexualism* and the field of social work as being a gatekeeper to transition related medical support.

While academics and theorists develop origin stories for gender in the human psyche or brain and national organizations such as WPATH develop standards of care to direct clients through a labyrinth of clinicians on their journey to gender confirmation, there is a dearth of literature on the specific mechanics and interventions that have been useful for working with trans* and gender non-conforming clients. What exists are case studies to describe the clinical work between one clinician and one or only a few clients (Ehrensaft, 2009) (Winograd, 2014) and a few exploring specific approaches such as interpersonal psychotherapy (Budge S. , 2013).

Clearly all the topics that have been explored in the literature should be expounded upon. What is left to discuss then is our attention to interventions in clinical practice and the theoretical grounds for them. This study aims to provide some information to fill this gap in the literature describing what is going on in the clinical setting to answer these questions: How do clinicians conceptualize the identity development of their trans* and gender non-conforming clients? How do clinicians understand their clients’ gender identity as separate from their clients’ sexual identity? What interventions have they found fruitful in exploring these topics? The exploration of these questions will aid current and future social workers in how they learn and apply these techniques with consideration to the Transgender and Gender Non-Conforming clients.

Furthermore, when discussing the transgender and gender non-conforming population, particularly as a cisgender writer, we must be aware that terms are constantly evolving to reflect the complex ways that gender can be expressed and experienced. For the purposes of this paper the following terms will be used to reflect this writer's current understanding of the most respectful terms the trans* and gender non-conforming (TGNC) community utilizes in reference to themselves. Transgender, trans, or trans* refers to individuals who identify their gender as other than that which was assigned at birth and marked on their birth certificate. Where appropriate, certain terms have been used to reflect the history of the evolution of the language around TGNC people. In different eras different terms have prevailed to describe the diverse TGNC community and is still evolving to best represent the current diversity of the population. Transsexual is used in this paper only in places where it was historically used to best describe the population under examination. Currently, this term has largely been replaced with the term transgender. However, there is no group consensus and much diversity within the TGNC community regarding how individuals feel and think about different terms that have been used to describe them by both other transgender and cisgender people. Cisgender refers to individuals who identify their gender with the gender assigned to them at birth. Gender non-conforming refers to individuals who identify their gender outside of the gender binary of male and female (Budge, 2013).

When reading, or using, these terms it is important to ask ourselves, *who* is doing the identification? In many cases it was the cisgender clinicians, heterosexual and homosexual alike, that were doing the identification for purposes of diagnosis and not the trans* community themselves. It is also important to keep in mind how a term is being used, such as in the case of a diagnosis versus a personal identity.

Chapter II

Literature Review

The medicalization of gender through research and surgical experimentation began as early as the 1920's. Though general opinion was that transvestism, the desire to live as the opposite sex, and homosexuality, the desire for romantic relations with the same sex, went hand in hand. In 1923 Magnus Hirschfeld first made the distinction between one's sexual desires—*sexuality*—from their gender identity that we begin to see gender identity as a deeper psychic structure (Drescher, *Transsexualism, Gender Identity Disorder and the DSM*, 2010, p. 111). During this time Harry Benjamin offered hormonal treatments to trans* individuals and held a biological essentialist view of transsexualism believing that transsexuals' brains were "feminized" in utero (Drescher, *Transsexualism, Gender Identity Disorder and the DSM*, 2010, p. 114). In contrast to Benjamin's views, Robert Stoller provided an environmental perspective to psychiatry and psychoanalysis in the 1960's. Stoller viewed transsexualism as being the product of over attachment with the mother and mother's body and lack of differentiation from the mother because of a lack of a father's presence (Drescher, *Transsexualism, Gender Identity Disorder and the DSM*, 2010, p. 112). A view that became a popular understanding for both homosexuality and trans* experience for the rest of the twentieth century.

In the 1950's through 1970's most physicians, psychiatrists, and psychoanalysts were critical of sex reassignment surgery (SRS) as a treatment for "gender dysphoric" individuals. However, many of those same critics were surveyed and found to be

proponents for individuals who had gone through SRS to assimilate into the larger society as their new gender including any changes to documentation reflecting gender identity (Drescher, Transsexualism, Gender Identity Disorder and the DSM, 2010, pp. 111-112).

The majority of the physicians and psychotherapists seemed to think that one *could not* transgress gender. Although, *if* someone accomplishes this impossible task the response shifts into expecting that individuals *could* be and *should* be assimilated into the gender binary. This debate is clearly rooted in the “nature versus nurture debate.” It was impossible for those early clinicians to view gender as anything other than natural and unquestionable, but when pushed to posit a plan for how to work with transsexual people they became proponents of training someone to present a gender incongruent with their birth assignment. Maintenance of the status quo seemed to be forefront in their thinking. This debate led us into the 1980’s where the DSM III abandoned psychodynamic theories to inform diagnosis and adopt what Drescher (2010) calls a “neo-Kraepelian, descriptive, symptom-based framework.” In this new framework, symptom maps and symptom constellations are privileged in diagnosis over dynamic perspectives, which *could* have viewed gender and sexuality as deep psychic structures as opposed to pathology. In the DSM-III, and the transitional edition, the diagnostic category for Gender Dysphoria would develop from two to three then back down to one category. Additionally, in the DSM IV, the American Psychiatric Association (APA) struggled to define transsexualism as a mental disorder in adults, adolescents, and children with separate and distinct diagnostic criteria. Concluding with the DSM V one Gender Identity Dysphoria (GID) diagnosis was created with separate criteria for adults (with and without transsexualism)

and children (Drescher citing Zucker and Spitzer (2005) p. 112). There needs to be a transition (no pun intended, heheh) sentence between these two paragraphs.

While physicians were grappling with physical transitions the psychotherapists were grappling with the mental/emotional aspects of gender and sexuality. Freud first posited the idea that at our earliest stages of development we are essentially bisexual, and that through successful transition through the Oedipal complex we come through to the other side fully formed heterosexuals (Hansell, 2011, pp. 55-56). However, many found it hard to not pathologize women in general with Freud's early work (Berzoff, *Psychodynamic Theory and Gender*, 2011) applying these theories to trans* experience becomes just as difficult. With infant bisexuality, penis envy, and the Oedipal complex, theorists endeavored to make sense of the lives of non-heterosexual people and trans* people. From Freud through to the modern age we find psychodynamic theory struggling to understand gender as a psychosexual developmental stage, to something purely socially constructed, and then finally, with some clinicians settling into a more *both/and* approach recognizing gender as a deep psychic structure that has influences found in family life and the culture a child finds him/her/hirself/theirselves in (Whitehead, Thomoas, Forkner, & LaMonica, 2012) (Berzoff, *Psychodynamic Theory and Gender*, 2011) (Mitchell, 2002) (Hansell, 2011).

Our understanding of gender will always be as flexible or inflexible as our basic understanding of the world we live in. Culturally, as we develop a more fluid and nuanced understanding of what gender means—how it develops, what influences it, and what aspects of our being belong to it—our perception for other characteristics deepens. Elements of our identity, such as our sexuality, must also become less rigid and more

nanced. Today just as our understanding of gender and sexuality are influenced by postmodern thought, early psychodynamic ideas of gender and sexuality were rooted in a essentialist and biological views dominant at the time. Gender was viewed as containing two very discrete and mutually exclusive categories, often tinged with Victorian mores (Mitchell, 2002) (Bertilsdotter Rosqvist, Norlund, & Kaiser, 2014) (Hansell, 2011).

Perhaps in reaction to today's postmodern world where everyone is responsible for self-creation, we look to medical based science to resolve all of our questions about who we are, how we think, and how we behave. Just as at the turn of the previous century, we continue to find ourselves looking in vain for a singular determiner for gender and sexuality, such as a gene or the timely release of a hormone through a prenatal child's brain. This pursuit only leaves us with more questions (Winograd, 2014) (Whitehead, Thomoas, Forkner, & LaMonica, 2012).

In response to the medical model's view of gender non-conformity being an issue of the brain and its development in utero, and to some extent the perspective of the environment, developmental psychology attempts to make sense of our lives and experiences as linear stages frequently inline with the psychosexual development process of psychodynamic theory. This school of study has lent its own expertise to understanding how gender and sexuality are developed and focus on aspects of a person's maturity and authenticity as Bertilsdotter Rosqvist, Nordlund, and Kaiser (2014) have found. They also contend that developmental psychology can provide a wider range of understanding of the transgender, and by extension, gender non-conforming experience through deconstructing the dichotomy of male and female (Bertilsdotter Rosqvist, Norlund, & Kaiser, 2014).

Trans* and gender non-conforming clients seek the support of mental health practitioners for a myriad of reasons. Particularly salient for this population is support for transition from the gender assigned at birth to the gender they most identify with, which includes in many cases the provision of a diagnosis of Gender Identity Disorder (GID) as per the Diagnostic Statistical Manual (DSM) to attain gender confirming treatments such as hormones or surgeries. Budge (2013) has laid out a broad yet concise three phase description of *transition* that is helpful to keep in mind for many trans* and gender non-conforming clients,

...(a) pretransitioning, most often indicated through an individual suppressing thoughts and feelings about their gender identity, (b) during transition, where individuals begin coming out to others and actively making changes to fulfill being true to their gender identity, and (c) after transition, whereby gender identity may remain important and often becomes integrated fully into a way of being (p. 357).

Therapists stand as gatekeepers in the achievement of these goals for TGNC people as more and more medical providers adopt the standards of care (SOC) set out by the World Professional Association for Transgender Health (WPATH). As gatekeepers, therapists have a great deal of power and few sources of research to support the strategies and interventions they may be employing (Whitehead, Thomoas, Forkner, & LaMonica, 2012).

In addition to transition as a reason for seeking treatment, many trans* and gender non-conforming people also suffer from anxiety and depression at a much higher rate than the general public. The stressors experienced by this population as a gender minority may lead to the increase in susceptibility to depression and anxiety (Budge, Adelson, & Howard, 2013). The minority stressor model can be used to explain many of these symptoms as rooted in experiences of oppression of their gender non-conformity as

children and throughout childhood from peers, authority figures, and even parents (Mallon & DeCrescenzo, 2006), in developing a positive or authentic self-presentation (Levitt & Ippolito, 2014), and especially considering the process of socialization into gender begins when a child is born and continues to develop thereafter (Menvielle, 2009, p. 294).

There are some problems to consider when working with trans* and gender non-conforming clients such as terminology, use of diagnosis, and diversity of trans experience. As stated in the note on terminology, what language is used and by whom is important in understanding the distinctions between descriptions used to define identities that represent a particular set of experiences and descriptions used to categorize those experiences or justify some kind of treatment. The terms largely used by the medical and mental health worlds have been developed by non-trans* people to describe conditions, symptoms constellations, and a diagnoses. Still being a small field of study, further work needs to be completed in order to best represent a very diverse community. Wiseman and Davidson (2011) argue that the DSM-IV diagnosis of Gender Identity Disorder and Gender Dysphoria in the DSM V confine the discourses between clinicians and their clients, privileging a narrow narrative of the transgender experience at the expense of other narratives (p. 529). Currently with the DSM V the room for diversity in gender expression for a gender non-conforming person to qualify for GID is quite narrow and often used by TGNC clients to achieve their desired transition related goals regardless of their lived experiences (Whitehead, Thomoas, Forkner, & LaMonica, 2012). For example, in this context experiences of gender transgression are medicalized and only validated if “clinically significant distress” is present. Any expression of a trans

experience that does not include this clinically significant distress may not fit the dominant discourse and those individuals may not receive the physical transition support desired.

There is an abundance of literature addressing “best practices” when working with TGNC clients, promoting trans-affirming approaches and frames of reference for supporting clients through transition in medical, legal, and social fronts. This work appears to be in direct response to the previous pathologizing understandings of *transsexualism* and the field of social work as being a gatekeeper to transition related medical support.

While academics and theorists develop origin stories for gender in the human psyche or brain, national organizations such as WPATH develop standards of care to direct clients through a labyrinth of clinicians on their journey to gender confirmation; there is a dearth of literature on the specific mechanics and interventions that have been useful for working with trans* and gender non-conforming clients. What exists are case studies to describe the clinical work between one clinician and one or only a few clients (Ehrensaft, 2009) (Winograd, 2014) and a few exploring specific approaches such as interpersonal psychotherapy (Budge S. , 2013).

The best practices approach, as outlined by Mallon and DeCrescenzo (2006) for children and Collazo, Aiden, Austen, Ashely, and Craig’s (2013) recommendations for adults, supports utilizing a therapist in addressing TGNC clients’ needs for transition. This includes: describing trans-affirmative assessment, addressing sexuality, and assessing for potential body dysmorphia in transgender clients, and includes the role of transphobia in their lives (pp. 229-232)

Ehrensaft's (2009) work utilizing Winnicott's developmental theory may be the best direction yet for clinicians looking to ground their work in psychodynamic theory. However, Winnicott left little room for how society plays into human development. To add onto his work, and fill in this gap, we may keep in mind the minority stressor model (Mallon & DeCrescenzo, 2006) to explain many symptoms of depression and anxiety, as they are responses to systemic oppression.

Specific research regarding trans* and gender non-conforming children and youth reflect the positive response "health literacy" approaches have had as they focus on the education of cisgender parents of transgender children on how to be trans* affirming parents (Riley, Clemson, Sitharthan, & Diamond, 2013) and an ecological approach that takes into consideration a child's position in his/her/hir society when assessing the sources of their symptoms of depression and anxiety (Mallon & DeCrescenzo, 2006) to name a few.

Clearly all the topics that have been explored in the literature should be expounded upon. What is left to discuss then is our attention to interventions in clinical practice and the theoretical grounds for them. This study aims to provide some information to fill this gap in the literature describing what is going on in the clinical setting to answer these questions: How do clinicians conceptualize the identity development of their trans* and gender non-conforming clients? How do clinicians understand their clients' gender identity as separate from their clients' sexual identity? What interventions have they found fruitful in exploring these topics?

CHAPTER III

Methodology

This qualitative research study explores the interventions, approaches, and theories that therapists have found to be supportive in their work with TGNC clients. This study asks, “What have we learned from nearly 100 years of theory on gender development?” and “What has been helpful for work with trans* and gender non-conforming clients?” The purpose of this study is to add information on the specific techniques/interventions and theories that have supported the gender identity of TGNC clients to the growing body of literature on best practices for TGNC clients.

To investigate the current practices and theories I developed a qualitative study which allowed me to provide a rich description of practice in the field through a guided interview while also allowing enough room for participants to provide information that I could not anticipate. The structured interview provided space for participants to provide their opinions, which may lead to recommendations and future research possibilities. By taking an inductive approach I can examine first what is being practiced in the field by clinicians and examine their sense of efficacy with what they have practiced (Engel & Schutt, 2013). From there, potentially in this work but definitely in future research, a theory may be derived from the data to explain why these interventions may be helpful to TGNC clients.

To gain a picture of the practices from the field, and the theories that support them, I first turned to clinicians who have been working with trans* and gender non-

conforming clients. They provided descriptions of the interventions they used as well as their observations on the efficacy of those interventions. To round out the discussion on efficacy of practice it would have been germane to also interview their clients, however, that work is beyond the scope of this study and that aspect of the discussion has been left to other researchers.

A screening questionnaire was distributed to potential subjects at two clinics in New York City, clinics that serve the LGBTQ and gender non-conforming population. The screening questionnaire asked the following two simple questions:

- Do you hold a master's or doctoral degree in one of the following disciplines: social work, marriage and family therapy, mental health counseling, or psychology?
- Have you practiced for at least one year with trans* and or gender non-conforming clients?

Subjects who answer yes to both questions were informed that they qualified for the study and an interview time was scheduled with each subject.

Prior to recruitment of participants for this research, approval for the study and all safeguards to ensure ethical standards were obtained from the Smith College School for Social Work Human Subjects Review (HSR) Committee. The recruitment for this study included nonprobability-sampling procedures including convenience and snowball sampling methods. I first recruited subjects from the pool of clinicians at the Institute for Human Identity, my field placement at the time. Each eligible subject was asked to forward information about this study along to his or her colleagues.

This was not a random sample and therefore not a representative sample of the total population of clinicians who are working with TGNC clients on a national level. However, nonprobability methods are sufficiently adequate for this type of exploratory study (Engel & Schutt, 2013). The clinics my subjects were found at are ones that serve the LGBTQ community. Convenience sampling with these clinicians allowed me to focus on clinicians who were more likely to have worked with TGNC clients and therefore qualify for my study. A random sampling procedure would not be as successful for yielding a high number of subjects who qualify for my study. The second clinic I attempted recruitment from was the Callen-Lorde Community Health Center, a health center with mental health services for the LGBTQ community in New York City. Unfortunately I received no responses from this site for participation.

Once subjects were screened into my study I began the interview process. The format of the interview included a few open-ended questions regarding their experiences and opinions. Through these interviews I gathered data pertaining to techniques or interventions used as well as qualitative information from my subjects as they provided their observations and opinions regarding the efficacy of those techniques or interventions.

Due to the nature of the interviews subject anonymity to myself as the researcher/interviewer was impossible. To ensure subject confidentiality I assigned a number ID to each participant for identification purposes. This number was used to label the audio recordings of the interviews as well as the transcripts of the recordings. The recordings were saved as encrypted files on my computer and any hard copy transcripts were stored in a locked file cabinet to ensure their security.

I informed all of my subjects on the limits to confidentiality and all of my procedures to ensure their confidentiality to the best of my ability and I provided consent forms for all subjects informing them in writing of the benefits of participation, the confidentiality procedures, and the risks. The interviews themselves were conducted in a confidential space and I asked that the subjects refrain from providing any identifying information during the interviews to ensure anonymity. I expected the subjects to be discussing interventions they have used; as such I asked them to refrain from providing any identifying information about their clients to ensure their anonymity.

Because I asked clinicians to reflect on their practice there was a risk that subjects could feel uncomfortable while sharing with me, or other negative emotions. These risks were kept minimal since I asked them to speak mainly to their strengths and successes, which mitigated any negative reaction. They also could benefit from this time to reflect on their practice in such a way as to gain a better understanding of their practice and theoretical underpinnings. This study also added to the existing literature on best practices and theory in work with TGNC clients, which benefits the community as a whole.

The interviews took place in a private office at the IHI clinic where I interned. The room with one door and no windows was equipped with a sound dampening device to minimize the ability for anyone outside the room to overhear the interview. The interviews were audio recorded on my password-protected computer. The audio files were transcribed and analyzed for themes by myself. The initial two categories are interventions/techniques and the second will be theories used. Within these categories I searched for themes as they emerged.

Chapter IV

Findings

Introduction

This chapter presents findings from the analysis of 11 interviews with clinicians working in private practice and agency settings who have worked with TGNC clients for at least one year. The interview guide was sent to participants at least two days in advance to give them a chance to reflect on their work and collect their thoughts. All of the participants were eager to provide their reflections on their work, while only two questioned the relevance of their experience. Each requested to view the final paper and a few were explicitly encouraging of this research project and suggested it be made available to all the clinicians at one of the clinics from which I recruited participants (n=2). The purpose of this study is to explore the theories and techniques clinicians have found helpful in their work with Trans* and Gender Non-Conforming clients.

Participant Demographic Data

I interviewed 11 clinicians both from agencies and in private practice in the New York City area save for one participant who I interviewed from Virginia. They primarily self-identify as “white” or “Caucasian” (n=9), one participant self-identified as Asian/Korean, and one participant identified as Indian-American/South Asian-American. Five participants identified as male, four identified as female, with two of the female identified participants identifying specifically as “cis-female or cisgender female”, one person identified as “fluid” and another as “genderqueer/butch dyke.”

My interview questions were divided into two major areas of inquiry, one regarding theory and one regarding technique. Within those two categories I posed a question regarding general case conceptualization and a question regarding gender identity development. The open-ended nature of my questions and the wording of the questions led to participants providing responses that bridged one question into the other. More often than not participants spoke to more than one question at a time. I have organized their responses along the two major categories of theory and technique along with several sub-categories.

Original training.

All of the participants (n=11) reported bringing what they learned from their training into their work with all of their clients, not just their TGNC clients. One subject described how her education impacts her work this way, “I went to Teachers College for my clinical work and that was object relations theory, so object relations theory influences the way that I work with people in general.” Three explicitly stated their work was no different when working with TGNC clients. This same clinician clearly explained it this way, “TGNC people are the same as anybody else so any developmental theory that applies to them, anything that is helpful in therapy, is going to be the same as would be useful to anyone else. And I also think that having general skills as a clinician is going to apply to working with TGNC people.” Though all participants seemed to imply this idea, none stated it so succinctly. In fact one participant went on to describe his fears of the impact TGNC specific theories might have, “...it just seems to me to be...suspicious

to wonder what made you this way, because there's an implication behind it that if we can find out what made you this way perhaps we can fix it.”

Developmental theory.

Only three participants mentioned developmental theory, however, each had a different take on the topic and how it impacts their work. One participant had this to say, “So developmental theory, I think, is really big as well, particularly when working with younger people around gender.” While another participant had this counter experience, “In graduate school I studied, you know, we had a developmental course or two and we talked about gender identity development, but it's not something I think about a lot in my work.” An unexpected response came from this participant who described how she developed her own model of development after finding that the established theories had failed her:

So there is no theory, usually, other than something like this six stage model which I can describe, which is a loose framework. But most of the theories are actually causal. They will apply to somebody, they're going to definitely apply to somebody because there's such a tremendously diverse group of people that anything we come up with is going to apply to somebody and not apply to other people...

While their original training may have been useful, many reported the need to take what worked from their education and leave behind what did not work for their TGNC clients (n=4). One respondent had this to say, “...I think that some of the psychodynamic theory has fallen away from me because it doesn't really fit how I work with people around gender and how to think about gender.”

Additional training.

Additional training such as in cognitive behavioral therapy and hypnosis were cited as supportive in their work with all of their clients including TGNC folks. This respondent

described it best when describing his work with one TGNC client in particular he said, “I’ve become more eclectic in the theory that I rely on...so I use all of those techniques and theories behind them and I don’t think, for this patient...I think any differently...”

Outside mental health.

Finding support from outside the fields of mental health, some participants referenced anthropology (n=1), sociology (n=6), and postmodern theory (n=2), either by name or through identifying key concepts from these fields. One respondent was quick to state, “...postmodern theory has been really the most helpful, for me in how I work with clients. How I see them and how I work with them. Sometimes in how they see themselves.”

Technique.

While my participants may have been originally trained from psychodynamic perspectives they all identified learning “along the way.” A variety of perspectives, modalities, and techniques have aided their work with TGNC clients. Three participants found the techniques within Cognitive Behavioral Therapy to support exploration of rigid thinking such as the respondent who reported this, “CBT stuff is great, really exploring do they have absolute thinking, black and white thinking, are they saying ‘no one’s going to accept me ever?’” However, a small minority of participants reported techniques such as hypnotherapy (n=1) and creative visualization (n=1) to aid with “changes to the unconscious without really making them conscious” and to support “confidence and relaxation” respectively. Another two participants reported utilizing narrative therapy to reframe the stories their TGNC clients told themselves and about their identities. One of these clinicians had this to say, “...narrative therapy is helpful for some of the youth I

work with...kind of re-telling their story a little bit and reframing how they see themselves...”

Person centered psychology.

The work of Carl Rogers, either by name (n=2) or through describing key components of his person centered psychology (n=6), was listed by participants as central techniques they found valuable in working with TGNC clients, and two participants noted Winnicott and his idea of the “holding environment” as a major theme in their work with TGNC clients. One participant who frequently described this idea had this to say:

What has been important to me is creating the space so, with disclosure for instance, that would fall into this area for me, the more someone is able to disclose to...people who are supportive in their life...the more they are able to identify with their new gender.

Transference/countertransference.

Clinicians reported reflecting on their own struggles with coming out as lesbian, gay, or queer people (n=3) as supportive in understanding their clients’ struggles. One participant described it best this way:

I think it helps me see their own struggles. Because, the struggle, the homophobia that one deals with...in clients, internalized homophobia...and how difficult that is to come out...adapting that to what a transgender [person] internally is feeling and what they may do about it, I think there is some similarity because the being different in not conforming to societal standards and modes is very similar for the gay person.

Other clinicians (n=3) found how their clients’ and their own sense of difference aided the work such as this participant regarding their own gender identity, “For the most part though they don’t ask. It doesn’t come up, yet they know, and they come in and at times they’ll talk about, ‘well these people just don’t get it’ and they’ll stop and say, ‘wait, do you get it?’ and I have to be honest, it’s not my story, it’s not my experience...what’s

important is that we are here for the experience.” Participants also reported working specifically from a relational perspective (n=3) and half of my participants (n=5) reflected on how they used their own countertransference with their clients to support their work.

Time/society/possibilities.

One unexpected finding was that most participants (n=7) described societal acceptance of gender non-conformity as playing a major role in shaping what clinical work looks like with TGNC clients. One clinician used this concept to help place the issue within society and not within his client. He describes it best this way, “...because, what it said was the problem isn’t in here [referring to his client], the problem is out there [in society].” While other participants (n=4) were able to map the experience of gay and lesbians historically onto the experience of their TGNC clients. This clinician described that best, “remembering the gay men I knew a generation or two older than me so much of the content of [his client’s] anxiety and [their] unhappiness is so much the same of what a gay man from fifty years ago would say.” These clinicians also described how they expect society to be more embracing in the future of non-gender normative expressions and identities. One clinician described it this way:

...people grow up knowing there are other models for sexuality than being heterosexual. But it’s going to take some more time, I think it’s starting to happen, but it’ll take more time for people who are growing up now to grow up with models of gender to be non-binary and fluid and changing as opposed to essentialist and fixed.

Summary

This chapter is the presentation of the responses from 11 participants who currently work as clinicians in agency settings and/or in private practice with TGNC

clients. The participants regularly responded to more than one question with their answers. In attempts to explain why they do what they do (theory), clinicians often responded with what they actually do (technique). In fact all participants were quick to identify and describe specific techniques such as CBT or role-playing, but fewer were as likely to assign a theoretical framework to that technique. There were some general points of similarity in theory and technique, but where clinicians seemed to diverge was in how they used a technique or why they worked from a particular theoretical framework. While all of the participants brought their training into their work with clients they also largely had to adapt what they had previously learned and “pick up along the way” theories and techniques to work with a growing number of clients. Every clinician expressed many of the ideas from Carl Rogers’ person centered psychology while a few named him specifically, but each identified a unique offering they brought from outside of their original training. The specifics of the similarities and differences will be explored in further detail in the discussion chapter.

Chapter V

Discussion

The Purpose of This Study

The purpose of this study has been to explore what theories and techniques clinicians are finding supportive in their work with Trans* and Gender Non-Conforming clients. I interviewed eleven clinicians who held masters or doctoral level degrees in social work, mental health, or psychology in the New York City area, and one clinician in Virginia. Participants ranged in clinical practice from 3-30 years and 2.5-29 years of clinical practice specifically with TGNC clients. After analyzing the findings that came out of the interviews I found that there is clear overlap with findings from current literature, specifically exploring biological and social influences for gender identity development and expression, which will be discussed further below. Where these data diverge from the current body of literature is in exploring how clinicians a) start from their original training, b) then adapt those ideas to fit their clients' needs, and c) also gather additional knowledge from a variety of disciplines as they see fit.

The most consistent finding, however, has been that the techniques and theories of empathy and acceptance, as exemplified by the client-centered thinking of Carl Rogers, are the foundation for any therapeutic work. Additionally the techniques and theories of introspection, self-awareness, and behavioral/impulse control, and emotional regulation are helpful in the work of therapy with all clients, not just the cisgender majority of clients. While there are specific stressors that Trans* and Gender Non-Conforming

clients may face, what remains the same are the skills of coping and building a sense of self.

Key Findings

The clinicians I interviewed all displayed and discussed a strong sense of empathy for their clients. This was clearly a bedrock skill introduced to them in their training in which their work was grounded and further honed through their work with clients. The role of empathy became a theme of its own throughout each interview. Each practitioner utilized their countertransference to develop and use empathy in different ways or for a different goal.

Empathy as key to working alliance with all clients.

Empathy is employed to develop a working alliance with clients and a way to understand clients on an emotional level. Greenson (1990) defines empathy as, “a means to share, to experience the feelings of another person.” He goes on to describe its function: “This sharing of feeling is temporary. One partakes of the quality and not the degree of the feelings, the kind and not the quantity. It is primarily a preconscious phenomenon. The main motive of empathy is to achieve an understanding of the patient.” To put a finer point on this definition I would only change the language around the clinician feeling the “same” emotion to feeling a similar or resonant emotion. All of the participants displayed a similar understanding of empathy. They expressed using empathy, validation, acceptance with all of their clients and likely were able to build a therapeutic alliance with each of their clients facilitated by their capacity for empathy, acceptance, and skills in validation.

Generally speaking the empathy employed, while it is supportive in work with all clients, may be of particular use for TGNC clients. The TGNC population is marginalized based on the identification and expression of their gender (Budge, Adelson, & Howard, 2013). A clinician's acceptance and empathy for their TGNC client may not only build a therapeutic alliance with their client but also meet the need of providing visibility for clients who may not experience that in other parts of their lives. The experience of visibility without violence may be new for a client. Providing that space may do more than create a relationship between a therapist and her client and may begin to undo some of the trauma experienced by many TGNC people.

There may be further reparative work occurring between cisgender clinicians and TGNC clients within these empathic experiences. The act of acceptance, validation, and empathic understanding on the part of a cisgender person in authority may begin the healing work for a client who has experienced harm at the hands of cisgender family members, community members, and authority figures.

One participant described an example of how his empathic understanding supported acceptance as he saw his client build confidence. Confidence was a client issue described by four of the twelve participants. As the clinicians provided validation and expressed their empathic understanding, their clients were able to develop more confidence in their identity and expression. Speaking of one client in particular, a participant described how his client developed more confidence as she developed more self-acceptance. Over time she was able to present and express herself without fear and became more involved politically in her community. This likely was hugely supported by the clinician's modeling acceptance and positive regard.

All the participants expressed empathy for their clients; however, the diversity was expressed in how countertransference informed or each clinician and subsequent interventions

Some clinicians experienced identification in their countertransference with their TGNC clients as they heard similarities in their clients' stories with their own experiences as Lesbian, Gay, or Bisexual (LGB) identified clinicians. This countertransference promoted empathy and acceptance on the part of the clinician for their client. One clinician described this process best in his exploration of his countertransference with a TGNC client in particular. He did not share this experience with his client but shared it as an internal exploration with this writer.

...being older and remembering the gay men I knew a generation or two older than me. So much of the content of [the client's] anxiety and her unhappiness is so much the same of what a gay man from fifty years ago would say.

In attempting to empathize with the TGNC experience, he is reminded of his own experience and the experiences of those he knew. Clinicians are not just bringing their own experiences to bear on the subject of their clients; many also look to literature, exploring the experiences of other identity-based groups as well. Four participants cited LGB and other identity research as sources of affirmative and supportive language and framework for their work with TGNC clients. This respondent concisely stated it this way:

...several theories about identity development specific to LGBTQ folks... the research looking at immigrant identity development and African American identity development tends to be the largest corpus of literature. So, we borrow from that because it's much more developed than the LGBTQ literature.

Then speaking of identity development research within the LGBTQ literature itself he found that, “certainly the gay and lesbian literature is more developed than the trans and gender non-conforming literature.”

Four clinicians remarked on the ways that, when compared to historical record, things have essentially gotten better for the LGB community. Mapping that trajectory onto the TGNC community, each expects things to get better in the future in terms of finding affirmative, knowledgeable mental health and medical services, and in terms of their experience within the mainstream community of cisgender people. These perspectives are reflected in the literature when we look at the fact that the diagnosis for TGNC has gone through many changes, from transsexualism in the early 20th century to gender identity dysphoria today (Drescher, 2010) There was a consensus that with time there will be more and more social acceptance, not just acceptance in the medical and mental health communities. One clinician described this social evolution this way:

I think as we get more used to things being typical such as being gay is so much more typical these days than it was thirty years ago. Who doesn't know someone who is gay or bisexual right now? Back in the 70's hardly anyone knew anyone and the people were much more concerned in the 80's and 90's. Now we don't care as much.

She goes on to explain it this way:

We have a very different attitude about being transgender and gender non-conforming than we do about a sexual orientation that is not heterosexual, and I think that's because we've gotten used to a different range of sexual orientations now than we had been used to.

With time many clinicians believe that our society will be more embracing of other genders than male and female, get more comfortable with a more diverse pronoun vocabulary, and expect more gender fluidity from one other.

Theory adaptation.

Primarily the theoretical underpinnings these participants reported as foundational were those from psychodynamic and psychoanalytic fields. However, each expressed in different ways how the theories they originally learned in graduate school and other training required adaptation to meet the needs of their clients, particularly their TGNC clients. Two participants described how impossible it would be to use Freud's original ideas about women having penis envy in a way that was anything but pathologizing for their clients. It isn't surprising that over a century since Freud developed his original thoughts, psychotherapy looks very different. Paraphrasing what one clinician said, Freud's theories have an internal logic that makes sense if you stop at theory. But when you work with many different people you will find that the logic unravels and find too many exceptions to the theories. This clinician clearly explained the pitfalls of any theory: "They will apply to somebody, they're going to definitely apply to somebody because they're such a tremendously diverse group of people that anything we come up with is going to apply to somebody and not apply to other people."

Clinicians described taking what worked and leaving behind what didn't work for them in their therapeutic approaches, but also discussed how they understood gender themselves. Wachtel tells us that the theories that help us make sense of the world around us are based in how we have experienced the world (Wachtel, 2011, p. 17). In referring to how she has developed her practice this clinician described it this way: "...I think that some of the psychodynamic theory has fallen away from me because it doesn't really fit how I work with people around gender and how I think about gender." What made sense for this clinician is what she brings to her psychotherapy practice. Unfortunately, this

study did not reveal what changes were made. Likewise, another clinician didn't find in literature or formal education the support she required to understand gender and sexuality. She found in "queer community" the understanding of gender that has helped her to support her clients. The ideas of gender development from culture she also describes as temporal, rooted in particular eras. Just like the ever-evolving ideas in psychodynamic literature, the theories within cultures are evolving. She described culture as defining the possibilities for gender. While the mainstream culture defines two possibilities, male and female, she found that the "queer community" expands those to include many more.

Continuing education.

Most of the participants identified bringing other modalities into their practice as need arose and as they learned them through continuing education. Formal education cannot contain all of the skills a clinician will need with every individual they encounter. Furthermore, new or refined techniques are being developed on a regular basis. Often times the decade a clinician went through their original training can dictate what techniques and theories they were exposed to. Again, as Wachtel says about the theories that we choose to rely on, the techniques that we find most useful are chosen based on our experiences of the world.

Cognitive Behavioral Therapy (CBT) and Acceptance and Commitment Therapy (ACT) were frequently and quickly identified by most clinicians as regularly used techniques that they had picked up "along the way." Clinicians described their use in confronting concrete or "black and white" thinking. Dealing with this type of thinking is helpful for all clients, but with TGNC clients clinicians felt that CBT and ACT support

explorations of gender expectations, gender roles, and gender expressions. The skills in developing acceptance found in ACT may be especially helpful for TGNC clients. Many clinicians identified acceptance as a main topic in session. They identified their own acceptance of their TGNC clients, supporting their clients in accepting their own identities, and exploring expectations of family and community members' acceptance of the TGNC clients as being supportive.

Biology versus society.

Clinicians are clearly finding ways to merge ideas of biology with social factors in defining what gender means. Historically some doctors and therapists have attempted to situate gender as a biological phenomenon while others have tried to find the cause for gender in culture and society (Drescher, 2010). Can we find a definitive biological determinant for gender? Or, is gender completely a product of socialization? The literature shows us that early researchers could not find an answer to these questions. The literature clearly reflects a struggle to reconcile the biology with the culture. Current clinicians also seem to be saying both are important factors in how an individual develops their gender, but no one can predict what that might be for a given individual. What clinicians have overwhelmingly found is a huge diversity of identity and expression that cannot fully be explained by biology or society alone. Only through reconciling them both as contributing factors have they been able to understand gender development. One clinician described it best when she said, “you have to look at a lot of factors; the family they grew up in, the socio/cultural influences, the school influences, the friend influences, the disposition.”

Some clinicians found a biologic perspective on gender to be important. They seemed to apply a biological understanding to sexuality and gender. One clinician who preferred a diversity of genders to a gender binary reflected that any exploration of why a person is a certain way is inherently flawed and she found solace in the possibility that some people are just “born this way.” Another felt that having a biological grounding for his work allowed him to better respect his client’s experience. Grounding explanations in biology, even if we can’t pinpoint the biological mechanism, validates the acceptance clinicians have to offer their TGNC clients.

A biological perspective can be used to normalize a developmental process such as “re-adolescence” or a “second puberty” that may occur when someone begins hormone therapy after a typical adolescence. The emotions that arise in even common developmental phases such as individuation and development of autonomy often re-emerge during this time. Normalizing these processes as temporary and common helps clients to see their experience as part of a normal continuum of experience, not a singularly unique one. This understanding can help to fight isolation and a sense of difference, and seems to support self-acceptance. These findings align with findings from other literature proposing developmental psychology as a supportive lens for work with TGNC clients (Bertilsson Rosqvist, Norlund, & Kaiser, 2014).

Most clinicians also identified social influences as equally important in understanding their clients’ experiences of gender. Some indicated specifically that the culture of their clients was important to consider, while others were influenced by an understanding of gender found in contemporary culture as a way to support their clients in identifying multiple options for genders rather than a simple binary.

Postmodernism enables affirmative therapy.

Narrative therapy was mentioned with only three participants. The clinicians' use of narrative with their clients seemed particularly salient in terms of the identity development of their TGNC clients. One clinician described his use of narrative therapy to help his clients develop a new vision for themselves: "Narrative therapy is helpful for some of the youth I work with, and even the adult person of trans experience, in retelling their story a little bit and reframing how they see themselves."

The youth he had worked with where this was helpful had negative judgments about themselves. They saw themselves as "problems," particularly to their families. He even described one individual who reclaimed his story and reframed himself as an "adventurer" instead of a "victim." We can see here how postmodern theory is informing the technique of narrative therapy in terms of meaning making. Narrative therapy used in an assessment process aided one clinician in identifying whether a child was exploring issues of sexuality or issues of gender identity. There are many reasons to bend or transgress gender norms that do not come from issues of gender identity. A narrative approach seemed to allow room for her clients to express their full experience and also room for the clinician to identify what needed to be addressed. In a classic postmodern style of self-directed meaning making this clinician also spoke of using narrative therapy to help young people re-identify their changing bodies to better align with their gender identity. Often with TGNC young people gender can be more flexible pre-puberty when young people's bodies are not that different from each other. As hormonal shifts happen secondary sex characteristics develop that may conflict with a young person's sense of gender identity.

Many young TGNC people experience distress as their bodies change in puberty when a young person may feel their body betraying them. When halting these changes is not possible due to lack of financial resources or in the case of minors lack of parental consent, she found it helpful to help her clients rename those body parts to align with the young person's view of themselves and the body they want to have.

Whether from a sociological or cultural perspective, clinicians developed an affirmative approach to their therapy that seems to be influenced by postmodernism. One clinician in particular found that the ability to make meaning for oneself is a paramount foundation of both postmodernism and of her work. Many clinicians described society as currently providing more options for gender roles, gender expression, gender presentation, and gender identity than in years past. They all described a social evolution as society grows in acceptance and understanding of gender non-conformity and gender categories. Again, many people identified social acceptance for non-heterosexual identities/experiences as a map example of how society is increasing its acceptance for trans* and gender non-conformity and saw a positive trajectory. As a society we would appear to be getting more comfortable with the idea of gender as being performative and not limited to a binary. The postmodern psychodynamic theorists describe this as resolving gender anxieties when describing why a gender develops (Hansell, 2011). Perhaps that gender anxiety and resolution are experienced on a group level with society as a whole. It would seem that the gender dysphoria is held within the culture and not within the individual.

Summary

The purpose of this study has been to identify what theories and techniques clinicians are using in the field with TGNC clients. The findings of the study indicate that in general, clinicians feel that treatment approaches that work for most clients will also work for most TGNC clients. However, the findings reflect that some interventions may work for different reasons or have additional benefits for TGNC clients than they do for the general cisgender population.

Additionally clinicians feel that while they can rely on their original training in most situations, those original theories are insufficient to meet the needs of the clients they are seeing today. These subjects' clients express a more diverse experience than can be understood by any one theory alone.

The original education and training and the corresponding theoretical underpinnings chosen by clinicians are influenced by the clinicians' own history. Those original theories that clinicians bring into the field need adaptation. They take what works and leave what doesn't work for them generally, not just for TGNC clients. Furthermore, the clinicians' own needs around understanding gender roles, expressions, and identities will influence how they adapt theories they've learned. As clinicians identify additional techniques and skills that will aid them in their work, they again will be influenced by their own histories.

The empathy that provides a foundation for a clinician's work can do more than build a strong working or therapeutic alliance. When working with TGNC clients it may provide reparative work and healing for someone who has not experienced the same empathy from his family or community. This empathy conveys acceptance of clients and

a safe environment for clients to explore their understanding of gender. The therapists' countertransference is hugely valuable in this process for both the process of identification and for identifying biases.

From a biological perspective, clinicians can normalize physical and emotional experiences and ground a respect for human diversity. From a social perspective clinicians can explore the multiple expressions gender can take. Both perspectives can be utilized and integrated to offer a more holistic understanding of any individual.

Limitations and Strengths

This study is qualitative and exploratory in nature. It does not gather information on how many times a clinician used a particular technique or how often a theory was applicable. This exploration is limited to identifying the theories and techniques that are employed in work with TGNC clients. However, clarity on the efficacy of a technique for TGNC clients in relation to their cisgender counterparts is beyond the scope of this investigation. By clinicians' own admission it is likely that the techniques they adopted were a matter of preference rather than being based specifically on their clients' gender identity. The exploration was also too limited in participation to capture whether number of years providing clinical service to the TGNC community played a role in the theories or techniques employed. I also did not gather information on what percentage of each clinician's caseload consisted of TGNC clients, a factor that might influence a therapist's experience with the issues specific to this population.

The open-ended structure of the questions encouraged clinicians to reflect on both the successes in providing support and the impasses they faced with their TGNC clients. This writer provided each subject with the questionnaire at least a few days before the

interview to allow time for this reflection and for clinicians to formulate their responses. The broad questions allowed for the clinicians to provide a fuller and more meaningful description of their experience than a quantitative study would permit. The Strength in qualitative work is in representing the experiences and “voice” of the participants (Engel & Schutt, 2013). We are able to hear in the participants’ own words how they understand the work they are doing as they apply theory and choose techniques.

Implications for Clinical Social Work Practice

Social work practice in particular will benefit from further exploration of how theory is applied and how clinical work for TGNC clients is evolving in the field. The clinicians who informed this study have developed their knowledge and expertise with the support of clinical supervision and seeking out additional training to work with TGNC clients. What this study shows is that there is a tremendous diversity in care for TGNC clients and very little taught in formal educational settings. The unique stressors experienced by the TGNC population as gender minorities may lead to increased vulnerability to depression and anxiety (Budge, Adelson, & Howard, 2013). Information from the field regarding theories and techniques supportive of TGNC clients and gender exploration outside of a gender binary will aid clinicians who want to work with this population. This information can also provide feedback for educational institutions as they instruct future clinicians in use of theory and practice.

Recommendations for Future Research

This study would benefit from the addition of quantitative methods to gather information on what techniques and theories are more or less successful, more or less used by clinicians who have been working with many TGNC clients over the course of

many years. This study could also be improved by extending recruitment to a national level to correct for sampling errors.

Future research that includes the perspectives of more TGNC clinicians would reflect a wider diversity in respondents. The inclusion of the experiences of TGNC clients would greatly improve the accuracy of the findings. This sort of constructivist research would include all of the stakeholders involved and situate any validity or authenticity in the hands of the participants and not just the researchers (Engel & Schutt, 2013).

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Appendix A
Human Subjects Review Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-
7994

February 17, 2015

Charles Shealy

Dear Charlie,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'E. ...'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Claudia Bepko, Research Advisor

Appendix B
Recruitment Email

Hello,

My name is Charlie Shealy and I am an MSW student at Smith College School for Social Work and a current intern here at IHI. I am seeking participants for my graduate research study. I am interested in exploring what techniques and theories clinicians have found helpful in their work with transgender and gender non-conforming clients. I am looking for participants who hold masters or doctoral degrees in social work, marriage and family therapy, mental health counseling, and or psychology and have worked with transgender and or gender non-conforming clients for at least one year. The in-person interviews will be conducted in the NYC area and only take 30-45 minutes.

If you are interested in participating please email me with your interest to the address below and I will respond to schedule our interview. Additionally, if you know of a clinician who is eligible and might be willing to support this project please forward this email along to them.

Thank you for your time and support,

Charlie Shealy

charlesshealy@gmail.com

Appendix C

Informed Consent Form

**Consent to Participate in a Research Study
Smith College School for Social Work • Northampton, MA**

.....

Title of Study: In the Field with TGNC Clients: Current Techniques and Theories with Trans* and Gender Non-Conforming Clients

Investigator(s): Charles Shealy (XXX) XXX-XXXX

.....

Introduction

- You are being asked to be in a research study to explore the techniques and theories that have been helpful in clinical work with transgender and gender non-conforming clients.
- You were selected as a possible participant because you hold a graduate degree in social work, marriage and family therapy, mental health counseling, and or psychology and have worked with transgender and or gender non-conforming clients for at least one year..
- We ask that you read this form and ask any questions that you may have before agreeing to be in the study.

Purpose of Study

- The purpose of the study is to explore what practices are therapists finding helpful in understanding their trans* and gender non-conforming clients' lives.
- This study is being conducted as a research requirement for my master's in social work degree.
- Ultimately, this research may be published or presented at professional conferences.

Description of the Study Procedures

- If you agree to be in this study, you will be asked to do the following things: You will be provided with this informed consent to keep for your records and sign a copy for my records. Next, I will be ask you a few demographic questions followed by the open ended questions you received in my email. The whole interview will take between 45-55 minutes. Within that time frame you may have as much or as little time as you need to answer each question. This is the only interview you will be asked to participate in.

Risks/Discomforts of Being in this Study

- The study has the following risks. First, you may feel some discomfort in sharing interventions or techniques that were not helpful to your clients; however the focus of the study is on the interventions and techniques that were helpful so this discomfort should be minimal and unlikely.
- There are no reasonable foreseeable (or expected) risks.

Benefits of Being in the Study

- The benefits of participation include gaining insight into your own practice with trans* and gender non-conforming clients and the opportunity to talk about issues that are important to you.
- The benefits to social work/society include: adding to the body of research of clinical work with trans* and gender non-conforming clients.

Confidentiality

- Your participation will be kept confidential. Only the Executive Director and Clinical Coordinator for the Institute for Human Identity know I will be using this office to conduct my research study. No other agency staff will know I am conducting a research study. If you are seen in the waiting room or walking with me to or from my office it will likely appear as though I am conducting regular therapy sessions or some other meeting. These interviews will be audio recorded and heard by my research advisor and me. The audio files and corresponding transcripts will be stripped of any identifying information to protect your confidentiality. All digital files will be encrypted and stored on my password-protected computer. *In addition*, the records of this study will be kept strictly confidential.
- All research materials including recordings, transcriptions, analyses and consent/assent documents will be stored in a secure location for three years according to federal regulations. In the event that materials are needed beyond this period, they will be kept secured until no longer needed, and then destroyed. All electronically stored data will be password protected during the storage period. We will not include any information in any report we may publish that would make it possible to identify you.

Payments/gift

- You will not receive any financial payment for your participation.

Right to Refuse or Withdraw

- The decision to participate in this study is entirely up to you. You may refuse to take part in the study *at any time* (up to the date noted below) without affecting your relationship with the researchers of this study or Smith College. Your decision to refuse will not result in any loss of benefits (including access to services) to which you are otherwise entitled. You have the right not to answer any single question, as well as to withdraw completely up to the point noted below. If you choose to withdraw, I will not use any of your information collected for this study. You must notify me of your decision to withdraw by email or phone by up to one month after the interview. After that date, your information will be part of the thesis, dissertation or final report.

Right to Ask Questions and Report Concerns

- You have the right to ask questions about this research study and to have those questions answered by me before, during or after the research. If you have any further questions about the study, at any time feel free to contact me, Charles Shealy at cshealy@smith.edu or by telephone at (XXX) XXX-XXXX. If you would like a summary of the study results, one will be sent to you once the study is completed. If you have any other concerns about your rights as a research participant, or if you have any problems as a result of your participation, you may contact the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974.

Consent

- Your signature below indicates that you have decided to volunteer as a research participant for this study, and that you have read and understood the information provided above. You will be given a signed and dated copy of this form to keep.

.....

1. I agree to be audio taped for this interview:

Name of Participant (print):

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

2. I agree to be interviewed, but I do not want the interview to be taped:

Name of Participant (print):

Signature of Participant: _____ Date: _____

Signature of Researcher(s): _____ Date: _____

Appendix D
Interview Guide

1. How do you identify your race and or ethnicity?
 2. How do you identify your gender?
 3. How many years have you been in practice?
 4. How many years of your practice have you worked with Trans* or Gender Non-Conforming clients?
-
1. Are there theories in psychodynamic or other literature that have been helpful in generally conceptualizing your work with TGNC clients? If so, which?

 2. Specifically have these theories helped you in understanding or conceptualizing how your client has developed their gender identity? If so, in what ways?

 3. Are there particular techniques or modalities that have been helpful generally in your work with TGNC clients? If so which? What has not been helpful?

 4. Have these techniques or modalities been helpful in supporting how your clients develop their gender identity? If so how? What has not been helpful?