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Jeannette Sheerin
Transgender Individuals'
Experiences in Therapy and
Perception of the Treatment
Experience

ABSTRACT

This study was undertaken in order to examine transgender individuals' experiences in therapy and the impact that clinicians' affirmative behaviors and their heteronormative and gender normative biases may have on the treatment experience. Despite an extensive history in the mental health field of pathologizing alternative gender identities and the well-researched detrimental impact that experiences of discrimination have on one's mental health, there has been no research on experiences of bias and discrimination in mental health treatment settings. Similarly, there has been a great deal of research on the role of affirmative therapy techniques relating to gay, lesbian, and bisexual persons, and it has been theorized to be beneficial for transgender persons, but there has been no definitive research addressing the impact of affirmative therapy techniques in treatment with this population. The purpose of this quantitative survey of 46 transgender persons who have had at least one experience in mental health treatment was to evaluate the treatment experience and impact of therapist behaviors from the client's perspective. Findings include a confirmation that affirmative therapy techniques are significantly related to positive working alliance with the therapist and reports of treatment satisfaction. Similarly, discriminatory therapist behaviors were found to be significantly related to lower working alliance and lower treatment satisfaction.

TRANSGENDER INDIVIDUALS' EXPERIENCES IN THERAPY AND
PERCEPTION OF THE TREATMENT EXPERIENCE

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

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2009

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CHAPTER I

INTRODUCTION

The research presented in this paper is designed to look at transgender individuals' experiences in therapy and the impact that clinicians' affirmative behaviors and their heteronormative and gender normative biases may have on satisfaction with treatment. Heteronormative bias is the implicit assumption that heterosexual orientation is the normative and preferred one (Tolley & Ranzijn, 2006). Gender normative bias is the implicit assumption that gender identification matches the biological sex assignment given at birth and that self-identification and physical presentation as one of two possible genders – male or female – is normative and preferable. It is assumed in this study that even well-intending and well-informed clinicians may exhibit heteronormativity and gender normativity in treatment due to the constant reinforcement of these attitudes in our society. Such bias could negatively impact a transgender person's experience in therapy. This issue is directly relevant to the field of social work, given the profession's commitment to serving marginalized and diverse populations with culturally competent and appropriate practices.

Much of the literature available on transgender and gender identity issues maintains a gender normative stance, presenting theories and research based on the assumption that any gender identification that does not correspond with a person's physical anatomy and the gender assigned at birth creates inherent internal distress for the individual. It has only been with the fairly recent development of queer theory and

gender theory, and with contributions to the field by trans-identified authors, that researchers have begun taking into consideration the possibility that the distress exhibited by some transgender and gender non-conforming individuals is in fact a reaction to external factors, particularly society's rigid maintenance of the gender binary, with any identity outside of "male" and "female" being considered deviant and wrong (Butler, 2006; Newman, 2002; Wilson, Griffin & Wren, 2002). There are some expanding theories and exploratory studies on strategies and attitudes that may be most helpful to trans individuals in treatment for gender distress and transitioning issues (Embaye, 2006; Newman; Nuttbrock, Rosenblum & Blumenstein, 2002; Rachlin, 2002; Raj, 2002). However, the experiences of transgender persons in therapy remain under-represented in the literature. Even more under-represented in the literature is research on the role of discrimination in treatment, such as heteronormative and gender normative clinician bias, and its impact on the trans person in treatment.

Transgender individuals seek therapy for a variety of both general and gender-specific reasons, including self-exploration, help with specific mental health symptoms, coping with life stressors, gender distress, and support in transitioning to one's self-identified gender (Rachlin, 2002). Psychotherapy is also frequently a requirement for those seeking medical treatment such as hormone therapy or sexual reassignment surgery (SRS) as a part of transitioning (Bockting, Robinson, Benner & Scheltema, 2004; Meyer, et al., 2001; Rachlin, 2002). It has been controversial that mental health professionals serve as gatekeepers for transgender persons to medically transition to their appropriate gender, as this can prevent the development of trust required in an effective treatment relationship, particularly given the ethical standard in the mental health field of a client's

right to self-determination (Raj, 2002). Both in the transgender community and in the clinical community, some people have identified this requirement as pathologizing of transgender persons and inappropriate, and others identify it as essential to successful transition (Bockting et al., 2004; Rachlin, 2002; Raj, 2002).

Given the intersecting roles that mental health professionals play in the trans community, it is important that clinicians are not only culturally competent about the transgender community and appropriately knowledgeable about effective treatment strategies, but also aware of potential oppressive factors in the therapeutic dynamic. What requires further research, and what this study will address, is the experience of transgender individuals in therapy and how affirmative behaviors and oppressive or discriminatory behaviors and attitudes from the clinician impact a transgender person's experience.

CHAPTER II

LITERATURE REVIEW

This thesis is a quantitative exploration of the experiences of transgender individuals in therapy and their satisfaction with treatment and will evaluate both affirmative therapist behaviors and discriminatory therapist behaviors, examining the relationship of reported therapist behaviors to the client's reported satisfaction with treatment experience and working alliance with the therapist. This chapter provides an overview of the literature on transgender individuals in therapy, transgender individuals' experiences of discrimination, and the overlap between these two topics. The discussion will therefore address the gender binary and the inherent problems with the binary construct, and will also examine how this construct is tied to a host of experiences of discrimination, including heteronormative and gender normative biases. Included will be a discussion on the impact of discrimination on the mental health of those targeted. The historical perception of transgender identities in the mental health field will be briefly reviewed as it pertains to the complexities of the present-day role of mental health professionals in treatment with transgender persons. Finally, this chapter offers scrutiny of the presence of gender discrimination in the mental health field and a summary of affirmative therapy as the recommended model of treatment with transgender clients.

The Construct of the Gender Binary

In order to understand the complexity and extent of discrimination, oppression and challenges to identity and self-expression faced by transgender individuals, one must

consider the concept of the gender binary, its role in our society and its impact on each of us. The system of gender in Western culture is largely taken for granted; it is only when gender norms are violated or challenged through presentation or interaction that the rigid structure of the gender binary becomes apparent (Gagné & Tewksbury, 1998). In fact, gender is rigorously policed through social interactions beginning when we are born, socializing us quickly and consistently to the accepted rules for gender presentation and expression embedded in our culture (Gagné & Tewksbury, 1998; Wilchins, 2004). We quickly learn that the world is organized into two genders – male and female – that these genders correlate to the biological sex assigned at birth, and that there are stringent rules about how the two genders groom, dress, behave, and relate to one another. Young boys are ostracized by peers for playing with dolls, throwing a ball like a girl, or liking the color pink, while girls are teased for having “boyish” hairstyles or being too much of a tomboy (Wilchins).

These socialized gender norms persevere into adulthood with policing every bit as stringent as in childhood. We check one of two boxes on demographic data forms to denote our biological sex, which is assumed to correlate directly to gender, and we choose which restroom is appropriate for us often based on which featureless drawing, nearly indistinguishable save for the slim flare of a skirt on one of them, looks more like us. It continues to influence every aspect of how we groom, dress, behave and relate to one another. It is expected in Western culture that a simple glance at a person should be sufficient to categorize a person as their appropriate gender. We are well trained to look for the gender markers that place others in their correct position on the binary, and if this cannot be done quickly, many people react with confusion and discomfort (Gagné &

Tewksbury, 1998; Wilchins, 2004). Those who challenge the binary system, including androgynous individuals and those who cross gender boundaries such as masculine women and feminine men, are likely to experience stigmatization or be labeled as mentally ill (Gagné & Tewksbury). After all, gender is considered to be as basic as toilet training, and therefore when we do not perform gender as expected, it is usually seen as personal failing, both by others and by ourselves. Wilchins summarized the internal experience each of us has likely had when we have failed to live up to gender norms: “...[W]e assumed the problem was *us*, not the gender system. We kept it to ourselves and we felt shamed. Because gender expression has never been framed differently, that it ought to be a civil right, never occurred to us” (p. 19).

Framing gender expression in an alternative way, as Wilchins (2004) suggested, brings to light the complexity of the issue: that gender is both the social institution described above, and that it is also a deeply personal, internalized sense of self. In contrast to Western society’s presumption that gender should match with biological sex and should fit within the binary, many people have an internalized sense of gender that does neither (Gagné & Tewksbury, 1998). Transgenderism is an expression of self-determined gender identity that does not match sex assigned at birth and does not necessarily fit within the gender binary (Currah, 2006; Gagné & Tewksbury; Wilchins). This makes the transgender community a complex and highly heterogeneous group pulled into one umbrella category. The term includes male-to-female (MTF) and female-to-male (FTM) transsexuals, masculine-identified women and feminine-identified men who have no intention of altering their bodies, those who identify as genderqueer (being neither or both genders), as well as heterosexual cross-dressers, and many others (Currah;

Gagné & Tewksbury; Wilchins). This is the group of people onto whom many would like to project and confine all gender issues; it is much easier to say that “gender issues” are what a group of visibly different people have rather than acknowledging the host of gender stereotypes and restrictions on gender expression that each of us faces regardless of how we identify our gender (Wilchins). Society encourages that we each buy into the institution of the gender binary as the best way of understanding the world; gender is continued to be seen as a given rather than a right. However, “Making gender a rights issue gives people permission to own how each of us is punished for not conforming to gender roles and stereotypes. You give them permission to be all that they are, regardless of whether other people consider them gender-acceptable” (Wilchins, p. 19).

Gender is related to other ongoing civil rights issues, particularly the continuation of oppression through sexism and heterosexism. Despite what might seem like an obvious link between gender and historically unequal rights for women in Western culture, gender rights are not actually a focus for the feminist movement. Feminism focused on winning the same rights for women that men had regarding equal pay, opportunity, and acknowledgement of capability, “but not the right to masculinity itself” (Wilchins, 2004, p. 7). However, can sexism be conquered without addressing the continuation of gender stereotypes and the perpetuating misogyny in our culture evidenced therein? For example, the Equal Rights Amendment of 1972, a seemingly commonsensical proposition which would have established equality between men and women in the Constitution and which has been reintroduced at every Congress since 1982, did not pass. In large part, this was due to bizarre yet highly effective arguments that the establishment of gender equality would lead to the disintegration of the entire

social system of recognized gender differences and mandate the establishment of things such as unisex bathrooms (Wilchins). Thus was a significant legislation for women's rights lost due to a fear of anything outside the construct of the gender binary: genderphobia.

Gender rights are closely tied to gay rights as well, given that drag queens and transgender people of color provided the impetus for the gay rights movement during the riots at Stonewall Inn in 1969. Initially, this leadership in the movement of those who were "visibly queer," people who were identified by others as gay or lesbian because of gender non-conforming markers in their behavior or presentation, provided a moral imperative to include the conversation on gender stereotypes in the political fight for gay civil rights (Wilchins, 2004). However, as it became clear that the general public was gaining no further sense of comfort with identities outside of the gender binary, the gay rights movement began to disown gender from its political agenda, pulling masculine lesbians and feminine gay men out of roles of public representation, and seeking acceptance in the dominant, heterosexual culture with a new social construction of homosexuality that embraced straight-looking gay men and lesbians adhering to traditional gender presentations (Denny, 2006; Wilchins). Transgender people began facing discrimination from within the LGB population as well as from the dominant culture. "Some gay men and lesbians have argued that gender-variant people are embarrassments to the movement, holding it back, that transsexuals have no commonalities with the gay and lesbian community, or, conversely, that they are gay men or lesbians in denial, or are tools of the patriarchy" (Denny, 2006, p. 174). Today, the LGB population has exhibited increased acceptance of the transgender community by

adopting trans-inclusive mission statements and services (Denny). However, gender rights continue to be a distant, secondary struggle to gay rights in the LGB community. Wilchins stated, “Whatever interest exists [in either the gay rights or women’s rights movements to fight gender intolerance] is carefully confined to transgender people, as if gender only affected the small minority of people who want to change their bodies or genders” (p. 19). Despite the attempts of mainstream society to distance itself from the gender dilemma, however, its impact continues to be felt by all.

This section has been a brief and simplified introduction to the concept of the gender binary, its rigid construction in Western society, and the problems this creates not only for those who self-identify outside of the binary, but also for those whose gender lies firmly within the binary. Regardless of how we each identify and express our gender, we are impacted by the binary in every aspect of our lives. However, the binary becomes most problematic in that upholding this system serves to oppress and discriminate against those who do not fit the model. It is this discrimination against transgender people which will now be addressed.

Transgender Experiences of Discrimination

With the construct of the gender binary so ingrained in our society, every interaction is saturated with the evaluation of gender (Gagné & Tewksbury, 1998; Wilchins, 2004). For people who fit into the socially acceptable norms of masculine or feminine gender identity, also called passing (Gagné & Tewksbury), the experience of gender evaluation can be relatively innocuous and often goes unnoticed. However, if a person does not readily pass as male or female, the experience of gender normative bias becomes much more pronounced. Discrimination against gender non-conformity remains

pervasive (Clements-Nolle, Marx, & Katz, 2006; Kenagy, 2005; Lombardi, Wilchins, Priesing, & Malouf, 2001; Raj, 2002; Sperber, Landers, & Lawrence, 2005). In fact, there is no legislation against such discrimination, perhaps increasing the likelihood of its occurrence. Indeed, civil rights laws in the United States do not offer protection from harassment to trans individuals, federal hate crimes legislation does not include gender or gender identity, and few states offer protections based on gender (Lombardi et al.; Wolff & Cokely, 2007).

Many transgender individuals experience a vast array of discriminatory incidents in their lives, including verbal and/or physical victimization, harassment and discrimination based on gender identity or presentation (Lombardi et al., 2001), and barriers to health care (Kenagy, 2005). In a study designed to determine the independent predictors of attempted suicide among transgender persons, Clements-Nolle et al. (2006) interviewed 515 trans-identified individuals (392 MTF and 123 FTM) using a structured format. Along with screening for factors such as history of depression and substance abuse, they asked about experiences of gender discrimination and victimization. Clements-Nolle et al. reported that 83% of their study population experienced verbal gender victimization, 36% experienced physical gender victimization, and 59% had experienced sexual abuse or rape (the researchers did not assess for the percentage of sexual victimization that was due to gender discrimination or other reasons). Kenagy (2005) found similarly high rates of violence in her analysis of two needs assessment surveys of transgender people in Philadelphia. The total sample size between the two surveys was 182 people (113 MTF and 69 FTM), and data was gathered through structured interviews and written surveys distributed by mail or in person. Kenagy found

that of the 78 respondents who answered the question, 53.8% reported having been forced to have sex, and of 80 respondents, 56.3% reported that they had experienced violence in their homes. However, as in Clements-Nolle et al., Kenagy's study did not differentiate between violence due to discrimination versus violence due to other reasons.

Transgender individuals reported difficulty finding and maintaining jobs if they were unable to clearly pass as either male or female or if their employment history or documents differed from current gender presentation, and many reported experiences of being fired or pressured to quit if they began to transition while on the job (Broadus, 2006; Gagné & Tewksbury, 1998). Verbal harassment and physical abuse in school settings have contributed to high drop-out rates among gender nonconforming teens, and fears about having to apply to schools with documents containing information that would expose their transgender status have inhibited some trans-identified people from pursuing higher education (Spade, 2006). Some transgendered persons report trying to hide their gender identity from their family and acquaintances due to fear of rejection (Gagné & Tewksbury); this fear seems justifiable, considering the location of assault most frequently reported by transgender victims is the victim's home, and many reported assaults are perpetrated by co-workers, acquaintances, or family members (Wolff & Cokely, 2007). Even those who express support for trans friends, family, employees or clients may still exhibit discriminatory behavior, including expressing discomfort with a trans person's appearance or presentation, or pressuring the person to transition fully into an accepted gender role of male or female rather than accepting the person in an alternative gender identity and regardless of the person's desire or readiness to transition to a dichotomous gender role (Gagné & Tewksbury).

Transgender persons have also reported rampant discrimination at the hands of healthcare providers (Kenagy, 2005; Sperber et al., 2005). Sperber et al. conducted four focus groups with 34 transgender persons – both adults and youth – in Boston to gather information regarding health needs of the trans community as well their experiences in the current health care system. “In all groups, participants said they had encountered humiliating treatment from providers and outright refusal to provide services” (p. 85). Participants reported experiences of ethically egregious behavior from medical providers, such as being told to go to a veterinarian because “a medical doctor was ‘a doctor for people’” (p. 86), or even being turned away from an emergency room because the doctor stated that “he did not treat people like [that]” (p. 84). Similarly, Kenagy reported that 26% of study participants had been denied medical services because of their transgender status. Trans individuals in Sperber et al.’s study also reported unnecessary attention to their trans identity as a part of treatment as well as invasions of privacy such as having their transgender status recorded in medical charts regardless of whether it was relevant to treatment with medical providers stating that people deserve to know as the reason for documenting it. These numerous experiences of discrimination in medical settings have caused some transgender individuals to feel unsafe in seeking healthcare, and many in the study reported that they avoid seeking treatment unless it is undeniably necessary (Sperber et al.).

The Impact of Discrimination on Mental Health

The negative impact of experiences of discrimination on mental health is well-documented in many oppressed populations, including groups targeted by racism (Diaz, Ayala, Bein, Henne, & Marin, 2001; Krieger, Smith, Naishdham, Hartman, & Barbeau,

2005) as well as the gay, lesbian, and bisexual (GLB) population (Diaz et al.; DiPlacido, 1998; Hershberger & D'Augelli, 1995; Mays & Cochran, 2001; Ritter & Terndrup, 2002). The constant devaluation of target, or minority, identities by the dominant culture can decrease self-esteem and self-worth, creating the phenomenon of internalized oppression, including internalized homophobia and transphobia (Davies, 1996a; DiPlacido; Maylon, 1982; Mays & Cochran; Ritter & Terndrup). Hershberger and D'Augelli surveyed GLB youth (N=165) through community centers across the country to determine the impact of discrimination such as verbal abuse, threat of attacks, and physical assault on their mental health. In analyzing the relationships between these discrimination experiences and mitigating factors such as family support, positive self-esteem and self-acceptance, results showed that the impact of victimization on the mental health of GLB youth was high even when they had strong positive mediating factors in their lives. Therefore, although there has been comparatively little research on the impact of such victimization on trans individuals, it should come as no surprise that studies of trans individuals thus far show that experiences of discrimination and abuse have a correlation to distress, increased symptoms of depression and anxiety, and the high rate of suicidal behavior among trans individuals (Clements-Nolle et al., 2006; Mathy, Lehmann, & Kerr, 2003).

Transgender Identity and the Mental Health Profession

The transgender community has had a complex and at times contentious and controversial relationship with the mental health profession (Rachlin, 2001; Vitale, 1997). Gender Identity Disorder (GID) remains a diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric

Association, 2000), the benefits and negative consequences of which are heavily debated both in the transgender community and elsewhere (Butler, 2006). The early history of medical and mental health writings on gender dysphoria and GID usually focused on the transgender individual as sick and manipulative (Denny, 2006; Vitale, 1997), and for much of psychotherapy's history, conversion therapies, in which patients were therapized out of believing that their genders did not match their biological sex, were common and recommended practice (Denny). Butler argued that the GID diagnostic category is a vestige of such pathologizing perceptions and remains an instrument of oppression. Many trans-identified persons and allies advocate the abolishment of GID as a diagnostic category, arguing that it is reflective of the current and historical cultural perception that non-conforming gender identity and expression is a mental illness and serves to perpetuate the negative stigma associated with alternative gender identity (Butler), and that it serves to inhibit access for many trans persons to medical services because they do not fit the narrowly defined model of the transgender experience presented in the diagnosis (Denny). Others argue that the diagnosis must be kept, as it facilitates access to medical services for transition, insurance benefits, and legal status that might not otherwise be available to trans persons, and it therefore ultimately serves trans autonomy despite the simultaneous degradation to trans identity (Butler).

The relationship of the mental health profession and trans individuals has been further complicated by the Harry Benjamin Standards of Care for Gender Identity Disorders (Meyer et al., 2001), which outlined recommendations for mental health assessment and treatment prior to a transgender person's receiving body modifying surgery or hormones that constitute medical transition to his or her self-identified gender.

Following these standards of care, many doctors treating transitioning transgender patients require a letter from a mental health professional approving the person of being ready for medical transition. Therapists therefore take on a role of gatekeeper for the portion of the transgender community that desires to medically transition, which may create a dynamic in treatment that is opposed to the very principles of ethical and socially just mental health treatment (Bockting et al., 2004; Butler, 2006; Denny, 2006; Rachlin, 2002; Vitale, 1997).

The development of the Benjamin Standards and the diagnosis of GID provided several quandaries to many transgender persons. One difficulty discussed above is the fact that the diagnosis pathologized alternative gender identities, and yet the diagnosis usually remains a requirement in order for hormones and surgeries to be considered medically necessary and possibly be covered by insurance (Butler, 2006). Additionally, the Benjamin Standards and GID very narrowly defined the transgender experience that would qualify a person for medical treatment, which has historically provided opportunity to exclude many transgender persons from treatment because they did not fit the rigid standards of definition (Butler; Denny, 2006). In order to be diagnosed with GID, the person had to show that the desire to be a different gender had been almost lifelong, which makes the assumption that gender is relatively permanent and does not account for development, change, and progressive growth into one's appropriate gender (Butler). Applicants for medical transition had to report gender dysphoria, a history of playing with toys stereotypically for the opposite sex, sexual attraction exclusively to the same biological sex, an ability to pass successfully as the desired sex, and so on. If applicants did not meet this singular life path, they risked exclusion from treatment

(Denny). This put some people in the position of telling their therapist and doctor what they believed would qualify them for treatment rather than risk sharing their true stories when they did not fit these specific criteria. Such practices of exclusion persisted at least through the 1990s, and perhaps continue today in some areas. Applicants were denied for any number of reasons that would seem blatantly discriminatory by today's standards, as will be discussed in the following section (Denny). The medical model exemplified by the Benjamin Standards also encourages the assumption that the gender binary is accurate and fixed and that a transgender person's dysphoria will be cured by transition to the opposite sex and becoming a "normal" man or woman (Butler; Denny; Gagné & Tewksbury, 1998).

The diagnosis presumes that one feels distress and discomfort and inappropriateness because one is in the wrong gender, and that conforming to a different gender norm, if viable for the person in question, will make one feel much better. But the diagnosis does not ask whether there is a problem with the gender norms that it takes as fixed and intransigent, whether these norms produce distress and discomfort, whether they impede one's ability to function, whether they generate sources of suffering for some people or for many people, and what the conditions are in which they provide a sense of comfort, or belonging, or, even, become the site for realizing certain human possibilities that let a person feel possibility, futurity, life, and well-being. (Butler, 2006, p. 291)

Experiences of Discrimination in Treatment

The evidence of discrimination against trans individuals and oppressive factors including heterosexism and gender normativity within the mental health profession must be considered (Gagné & Tewksbury, 1998; Mathy et al., 2003; Vitale, 1997). Clinicians' training, competence and experience in treating trans people effectively is widely varied (Raj, 2002). In fact, many transgender persons have faced various levels of victimization and transphobia at the hands of mental health and medical professionals,

ranging from the disrespect of staff refusing to use a person's preferred pronoun, staring, humiliation and name-calling, to refusal to provide treatment (Embaye, 2006; Raj; Sperber et al., 2005).

Even when clinicians are open to working with trans individuals and knowledgeable about gender identity issues, heterosexism and gender normative bias can continue to impact treatment (Embaye, 2006; Gagné & Tewksbury, 1998; Vitale, 1997). As discussed above, the Benjamin Standards historically provided opportunity for mental health and medical providers to refuse hormones and other medical treatments to trans patients for reasons which today would seem blatantly discriminatory, despite their purpose of effectively treating transgender persons and facilitating access to such treatments.

Applicants were turned away . . . because they were “too successful” in their natal gender roles, because they were married, because they had read too much about transsexualism, because they had the “wrong” sexual orientation, because clinical staff didn't consider them sexually attractive the in the cross-gender role, or because they wouldn't comply with lifestyle requirements imposed on them by the clinics. (Denny, 2006, p. 177)

In the rather unique position of being a trans-identified clinician, Embaye (2006) offered personal examples both of witnessing co-clinicians' prejudicial beliefs about trans clients and their choices about whether or not to medically transition, and of his own experiences of prejudice in therapy. He described experiences with therapists who had clear ideas about whether and when he should medically transition; one therapist stated that he was “too pretty to be a man” (Embaye, p. 62); another said that he should make a feminist statement by not changing his body; still another encouraged him to transition immediately. Embaye also cited an experience with one colleague who stated that a

client must be mentally ill because the client was “too old to transition” (p. 61) while another colleague stated that an 18-year-old client was too young and immature to complete sexual reassignment surgery. Given the aversive impacts of experiences of discrimination on mental health discussed earlier in this paper, it must be considered that discrimination occurring in the therapeutic context may be all the more damaging.

Affirmative Treatment Models

Regardless of a person’s reasons for seeking treatment, whether fulfilling a requirement to get a letter authorizing medical care or seeking therapy for personal growth, it is the imperative of mental health professionals to know how best to serve this clientele to result in the best possible outcome. The importance of traditionally therapeutic qualities such as warmth, a non-judgmental stance, and respect of the client remain critical in treatment with trans individuals (Bockting et al., 2004), perhaps even more so because of the high rates of discrimination that may be faced by trans individuals in their daily lives. Rachlin (2002) surveyed 93 transgender and transsexual persons, recruited through convenience sample and snowball method, about their experiences in therapy across a range of treatment settings, gathering information including reasons for seeking treatment, respondents’ opinion of their therapists’ competence in working with gender issues, and the outcome of treatment. In addition to the traditional qualities of good clinicians named by Bockting, Rachlin found a high correlation in her study between therapist knowledge of and experience with gender issues and overall client satisfaction with treatment and better rapport.

Identity-affirming therapeutic models are also now gaining recognition as preferable methods of treatment for trans populations (Embaye, 2006; Newman, 2002;

Nuttbrock et al., 2002; Raj, 2002). Such models consist of affirmation of a client's gender identity and sexual preference exactly as the client explores and expresses it, as well as emphasizing a client's right to self-determination and self-empowerment in obtaining appropriate health care, including hormones and SRS if appropriate (Raj, 2002). While there is still very little written on affirmative therapy for trans populations, there is a great deal more about affirmative therapy with GLB populations; this model of affirmative therapy will be presented to explicate the therapeutic methods, since struggles with identity and self-perception are relevant in both populations.

Affirmative therapy models for treatment with gay, lesbian, and bisexual populations began to emerge in the late 1970s and early 1980s as the gay civil rights movement grew and strengthened (Langdrige, 2007). Most of the literature prior to this time regarding psychotherapy with these populations was written with the assumption that homosexuality was pathological (Ritter & Terndrup, 2002), and often, therapeutic practices seemed intended more for the purposes of enforcing the values of the therapist on the client rather than for the purposes of helping the client (Harrison, 2000). Gay affirmative therapy introduced therapeutic guidelines which adhere firmly to the ethical tenets of traditional psychotherapy, but with the assumption that it is homophobia and heterosexism which are pathologies, not homosexual identity (Maylon, 1982). This section discusses the guidelines presented in the gay affirmative therapy model and how these guidelines may be applied to treatment with transgender populations.

One version of gay affirmative therapy can be summarized as a strictly ethical approach to treatment, meaning fully respecting the client, valuing LGB identities equally with heterosexual identities and taking into account the LGB culture and unique problems

that these clients may present in treatment, without making any technical modifications to the treatment approach to strengthen or foster LGB identities (Langdridge, 2007).

However, Maylon (1982), who is credited by many as the first to outline a gay affirmative treatment model, stated that it is essential for the affirmative therapist to understand and consider how homophobic bias impacts the self-concept and identity development of LGB clients. In fact, he stated that socialization in a heterosexist and homophobic society and internalization of these values may arrest the process of identity development since same-sex desires are socialized as deviant and unacceptable even before a person may be aware of one's own sexual desires. In light of the impact of oppressive factors on LGB clients, Maylon recommended that this oppression must be ameliorated by "corrective experiences" (p. 62) in treatment. This correlates with the more robust version of gay affirmative therapy found in current literature, which involves pro-active affirmative responses to LGB identity in addition to identifying internalized homonegative beliefs and working with the client to deprogram society's negative conditioning (Davies, 1996b; Harrison, 2000; Langdridge, 2007; Ritter & Terndrup, 2002). The goals of this proactive treatment model include decreasing feelings of shame or guilt about LGB identities and behaviors while encouraging and affirming LGB thoughts and feelings (Davies, 1996b; Langdridge), thus helping the client to "develop an identity that is personally meaningful, and not just based on responding to heterosexual assumptions and prejudices" (Davies, 1996b, p. 31).

There has been little written about how the principles outlined in gay affirmative therapy apply to transgender clients, but there are numerous similarities in stressors and oppressive factors faced by these marginalized populations that would support the

efficacy of an affirmative treatment model. Just as LGB identity has been historically pathologized and viewed by society's medical, religious and legal institutions as sick, sinful and illegal (Harrison, 2000), transgender identity continues to be pathologized and undermined in these same ways through the societal value placed on the gender binary (Nuttbrock et al., 2002; Raj, 2002). Just as homophobia and heterosexism negatively impact LGB identity formation and self-concept (Davies, 1996b; Maylon, 1982; Ritter & Terndrup, 2002), oppressive factors such as heterosexism and gender normative bias negatively impact identity formation, self-concept and mental health of trans individuals (Nuttbrock et al.). It therefore stands to reason that the tenets of affirmative therapy that have been useful in treatment of LGB populations would be similarly useful in treatment of trans populations (Embaye, 2006).

In affirmative therapy applied to transgender individuals, the model endorses client-centered therapy in which all alternative gender identities and presentations are valued as equal to the socially accepted gender identities that match the sex assigned at birth and even those alternative gender identities that still fall within the gender binary, such as those who fully medically transition from male to female and vice versa and therefore pass as their self-identified gender (Embaye, 2006; Nuttbrock et al., 2002; Raj, 2002). It is essential that clinicians working from an affirmative treatment model become comfortable with the shades of gray on the spectrum of gender identity rather than adhering to the binary construct legitimized by our society; in this way, the client can be encouraged to develop their own personally meaningful identity, which is likely not to fall into the dimorphic categories of male and female (Embaye; Raj). Transgender identities are not seen as pathological in an affirmative treatment model, despite the

diagnostic categories for gender dysphoria still present in the DSM-IV; rather, the oppressive systems of gender normative and heteronormative bias in our society are seen as pathological. Thus, an essential component of transgender affirmative treatment is to address the impact of oppressive factors on transgender identity development and to begin the process of dismantling the internalized negative beliefs about trans identity that result from this oppression (Raj).

As the LGB population has continued the struggle for civil rights and recognition in a society that has chronically devalued a central part of their identity, affirmative therapy has assisted individuals in overcoming the impact of oppression in their lives and developing healthy and positive identities and self-concepts. An affirmative treatment model has great potential to do the same for transgender individuals as they, too, continue the struggle for rights, recognition, and acceptance in this society.

Summary

The information presented in this chapter reviews the role of the gender binary in Western culture, including how the binary has developed a social stigma toward any persons with an alternative gender identity. The discrimination faced by transgender persons persists today in dangerous and insidious ways, and such experiences of discrimination have been shown to negatively impact victims' mental health. The mental health field has certainly played a role in the perpetuation of stigma and discrimination, but new theories of affirmative treatment for transgender identity offers hope for development of a different dynamic and a changing cultural perception of transgenderism. The mental health field has an ethical imperative to treat all persons with respect and cultural competence, and it is therefore of the utmost importance to

examine the dynamics of the therapeutic relationship with transgender clients. This project explores transgender persons' experiences of affirmative and discriminatory behavior in treatment and how these experiences impact their satisfaction with treatment and the working alliance with their therapists.

CHAPTER III

METHODOLOGY

The purpose of this quantitative study is to investigate transgender individuals' experiences in therapy and the impact that clinicians' affirmative behaviors and their heteronormative and gender normative biases may have on reported satisfaction with treatment. The research design described in this chapter was approved by the Human Subjects Review Committee at Smith College School of Social Work (see Appendix A).

Recruitment

People were invited to participate in this study if they identified as any gender other than the one assigned to them at birth, including transgender, transsexual, trans, bigender, FTM, MTF, transgenderist, genderqueer, gender variant, gender non-conforming, agender, cross-dresser, two spirit, kothi, hijra, drag queen, drag king. Participants were asked to self-identify current gender in the survey in an open-ended format. They were asked to select their sex assigned at birth from the categories of male, female or intersex.

A self-selected sample of convenience was sought by posting recruitment letters on several transgender websites and forums with the webmasters' permission. In addition to these websites, recruitment took place via snowball method; I sent the link to the survey and the recruitment letter (see Appendix B) to friends and colleagues via email, asking them to forward the link to friends and acquaintances and to post the request for participants on any relevant web forums if they belonged to any.

Sample

Sixty-four people completed the screening questions beginning the survey (see Appendix C). Of these, ten participants were eliminated because they answered “no” to one or more of the eligibility requirements. Six respondents completed the first four questions and were eligible to complete the survey, but did not complete any of the other questions and were also therefore eliminated. Two participants completed only part of the survey following the screening questions, and were also eliminated. This resulted in 46 total participants from 16 different states across the country. Participants ranged in age from 18 to 64 with a mean age of 36. The majority of respondents identified their race as white (n = 38). Three people reported their race as “other,” and one respondent each reported African-American, Latino, Asian or Pacific Islander, Bi-racial, and Multi-racial. The sample was fairly evenly split regarding sex assigned at birth, with 22 participants reporting being assigned male and 24 reporting being assigned female at birth.

Data Collection

Data were collected using an anonymous online survey format using the research service Survey Monkey (www.surveymonkey.com). The link to the questionnaire (see Appendix C) was posted on web forums and sent via email to potential participants. The survey’s first page was a screening page consisting of four questions to determine eligibility for participation. The questions addressed current gender identity, age, experience in therapy, and current residency in the U.S. If submitted responses did not meet criteria for participation in the study, the respondent was directed to the final page of the survey, which included a list of trans-friendly and trans-specific resources and

support services (see Appendix C). If participants met all criteria on the screening page, however, they were directed to the informed consent form (see Appendix D).

Participants were informed of the purpose of the study, as well as a number of risks and benefits to participation, and they were instructed that by clicking “Next” at the bottom of the page, they were providing their informed consent for participation. Participants were also advised that they had the option to skip questions or withdraw from the study at any time by exiting the survey or closing the browser. However, participants were informed that they would not be able to withdraw after submitting their answers by pressing “Done” at the end of the survey due to the fact that all responses were anonymous. The informed consent included the same list of resources that was located at the end of the survey so that participants would have access to these resources even if they decided to withdraw from the study before the end of the questionnaire.

The research measure was a 53-item questionnaire (see Appendix C) consisting of eleven demographics questions followed by 41 questions on a Likert scale measuring satisfaction with treatment, quality of the working alliance, and affirmative and discriminatory therapist behaviors *regarding only their most recent therapist*, and a final open-ended question allowing the participant to provide any additional information desired. The demographics section inquired about age, geographic location, sex assigned at birth, current gender identity, sexual orientation, and racial identity. The demographics section also addressed the therapy experience and asked about total number of therapists seen to date, time since termination from most recent therapy experience, length of treatment, primary presenting concern, and therapist training.

To assess participants' satisfaction with treatment, selected questions from two pre-established measures were used with the authors' permission. The Working Alliance Inventory (WAI) (Horvath, 1994) is designed to assess the quality of the alliance between therapist and client in a variety of contexts. It should be noted that the questions taken from the WAI could not be reproduced here due to the limited copyright release obtained from the author (see Appendix C). The Reid-Gundlach Social Service Satisfaction Scale (R-GSSSS) (Reid & Gundlach, 1994) is an instrument that provides an overall score for satisfaction with treatment as well as sub-scores for 1) perceived relevance of the service to the client's concerns, 2) impact, or the extent to which the service reduces the problem, and 3) gratification, or the extent to which the service enhances self-esteem and a sense of power and integrity. However, I did not use these subscales due to the reduced number of questions I chose from the instrument. Both of these measures show robust internal consistency and reliability (WAI alpha = .92; R-GSSSS alpha = .95) and good face validity. I amended the Likert rating scale in each survey to maintain response consistency across all questions, and I also amended the wording on some questions to relate to the population being studied. For example, I added the alternative pronouns "ze" and "hir" where gendered pronouns were included in questions, and I substituted the word "therapist" for "worker."

After amending the Likert scales and choosing a limited number of questions from each instrument (15 questions from the WAI and 14 from the R-GSSSS), the scales maintained good internal reliability (WAI alpha = .873, N = 46, N of items = 15; R-GSSSS alpha = .866, N = 46, N of items = 14). In addition to using 15 questions from the WAI and 14 from the R-GSSSS, I wrote twelve questions for the survey in order to

directly address issues related to gender identity and to measure experiences of common affirmative and discriminatory therapist behaviors. The overall scale of therapist behaviors showed high internal reliability ($\alpha = .795$, $N = 46$, N of items = 12), while the sub-scale of affirmative therapist behaviors showed a moderate internal reliability ($\alpha = .77$, $N = 46$, N of items = 7) and the discriminatory therapist behavior sub-scale showed low internal consistency ($\alpha = .532$, $N = 46$, N of items = 5). While I used the discriminatory behavior scale in my analysis, there were limited implications that could be drawn from related findings due to this low internal reliability. As a way to better address these discriminatory experiences, I also analyzed individual questions related to discriminatory therapist behaviors. I also wrote the final, open-ended question which allowed participants to add any other information about their experience in therapy.

Data Analysis

All data were coded by the researcher and analyzed with the assistance of the statistics support services at Smith College School for Social Work. The WAI and R-GSSSS were scored according to the scales' respective instructions. The Therapist Behavior Scale was scored by reverse-scoring the discriminatory behavior questions and finding the mean for each respondent's answers. Descriptive statistics were used to describe and summarize the demographics of the participants. Inferential statistics such as oneway ANOVA and T-tests were used to determine statistically significant differences and correlations between data.

The open-ended questions on the survey included current gender identity, sexual orientation, reason for seeking treatment, and the final question on the survey inviting participants to share any additional comments. There were numerous different responses

for both current gender identity and sexual orientation. Among the 45 participants who answered the questions, there were 23 unique gender identities listed, and there were 21 unique responses for sexual orientation. I categorized the responses for gender identity into 11 groups of common responses, first by looking for the same words used, then by looking for the same theme expressed. For example the terms “genderfluid” and “genderflexible” were put into the same category, and were later collapsed into the category of “genderqueer” for purposes of analysis. I then created a twelfth category for “other” (see Findings, Table 1). For sexual orientation, I categorized the responses into eight groups of common responses and created a ninth group for those responses that did not answer the question in a way that I could categorize, including answers such as “yes” or “female” (see Findings, Table 2). Since many people listed more than one sexual orientation, I used only the first sexual identity listed for purposes of categorization and analysis.

Responses to the final open-ended question were coded thematically by the researcher. Themes were coded by first categorizing participants’ responses as positive regarding the treatment experience, negative, or neutral. Each of these categories of experiences was examined for commonly expressed themes, such as therapist qualities and behaviors, reasons for treatment, seeking a gender specialist, and so on.

CHAPTER IV

FINDINGS

This descriptive, quantitative study's purpose was to gather information about transgender people's experiences in mental health treatment, evaluate experiences of affirmative and discriminatory therapist behavior, and examine the relationship between therapist behavior and treatment experience. Analysis of the data in this study showed that there were significant relationships between affirmative therapist behaviors and both better working alliance and greater treatment satisfaction, as well as significant relationships between discriminatory behaviors and both diminished working alliance and lower treatment satisfaction. There were also significant relationships between the length of time in treatment and both working alliance and reported affirmative and discriminatory therapist behaviors. Details of these and other findings are presented in this chapter.

Demographics

The demographic data requested from participants included age, state of current residence, sex assigned at birth, current gender identity, sexual orientation, racial identity, and demographic information about their therapy experiences such as number of therapists seen, reason for seeking treatment, and therapist training. Findings from these demographic questions are presented below in the order the questions were asked on the survey (see Appendix C).

Age

Participants' ages ranged from 18 to 64, and the age range most commonly reported was 20 through 29 (41.3%). Two participants were eighteen or nineteen (4.3%), nine were aged 30 through 39 (19.6%), nine were aged 40 through 49 (19.6%), four were aged 50 through 59 (8.7%), and three were aged 60 through 64 (6.5%).

Geography

Participants hailed from sixteen different states across the U.S., including Arkansas, California, Illinois, Indiana, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New York, Pennsylvania, Tennessee, Texas, Virginia, Washington, and Wisconsin. The most frequently reported states of residence were California (21.7%), Massachusetts (15.2%), and Washington (10.9%).

Sex Assigned at Birth

Participants were distributed almost equally between those who were assigned male at birth (n=22, 47.8%) and those who were assigned female at birth (n=24, 52.2%).

Current Gender Identity

Participants were asked to provide their own answers to an open-ended question about current gender identity rather than choosing from a list. Of the 45 people who answered the question, many identified as male (31.1%) or female (24.4%) but responses were also quite heterogeneous; participants used between one and 23 words to describe their gender, and there were 23 unique responses. In order to complete a meaningful analysis of the numerous unique responses, respondents were sorted into twelve total categories. In some instances in which multiple identities were given, the first identity given was used for categorization. For example, the response "FTM, male-gendered"

was categorized as “FTM.” Fluidity in one’s gender was repeatedly expressed, as well. In some cases, fluidity was explicitly stated (genderfluid or genderflexible), and in other cases, fluidity or transition was expressed in other ways (“male who wants to be female,” and multiple stated identities, such as “genderqueer trans woman”).

Table 1
Frequencies of Gender Identities Named in the Sample

Gender Identity	Frequency	Valid Percent
Male	14	31.1
Female	11	24.4
Transgender	2	4.4
FTM	4	8.8
Genderqueer	2	4.4
Genderqueer male	1	2.2
Genderqueer female	2	4.4
Male and Trans	3	6.6
Genderfluid/genderflexible	2	4.4
Crossdresser	2	4.4
Bigender	1	2.2
Other	1	2.2
Total	46	100

Sexual Orientation

Participants were also asked to provide their own answers to an open-ended question about their sexual orientation. As with gender identity, responses were

heterogeneous. Participants used between one and nine words to describe their sexuality, and 20 unique responses were given. These responses were sorted into nine total categories, one of which was for those responses that could not be categorized as a sexual orientation. This category included answers such as “yes,” “no,” and specific genders to which the respondent is attracted, and the five responses in this category were eliminated for purposes of analyses based on sexual orientation. Also similar to gender identity, fluidity was a commonly expressed theme in respondents’ sexual identification.

Table 2
Frequencies of Sexual Orientations Named in the Sample

Sexual Orientation	Frequency	Valid Percent
Heterosexual/Straight	12	29.3
Gay	4	9.8
Lesbian	3	7.3
Bisexual	3	7.3
Queer	11	26.8
Pansexual/Open	6	14.6
Asexual	1	2.4
Unsure	1	2.4
Total	41	100

Racial Identity

The majority of participants self-identified their race as white (82.6%). There was one respondent (2.2%) in each of the following categories: African-American/Black, Latino/a, Asian-American/Pacific Islander, Biracial, and Multi-racial. Three participants

(6.5%) chose “Other” to describe their race. Because none of the racial categories other than “White” had enough participants for meaningful inferential analysis, all other groups were grouped together as “People of Color.” While this categorization may be problematic due to the diversity of experiences between racial groups, similarities between these groups may be drawn due to similar experiences of being targeted by racism.

Demographics of Therapy Experiences

Participants were asked five demographic questions regarding their experiences in therapy. These questions addressed the total number of therapists the participant had seen, how long ago their most recent treatment ended, how long they were in treatment with their most recent therapist, the primary reason they sought treatment, and their therapist’s training, if known. Participants’ responses regarding the total number of therapists they had seen in their lifetimes are presented in Figure 1 below. As one can see, the most frequently reported response is five therapists (n=11), followed closely by two therapists (n=10).



Figure 1. Number of therapists seen by participants in their lifetimes

Many participants (45.7%) were currently in treatment at the time of taking the survey. Of the remaining participants, 15.2% had ended their treatment six months ago or less, 8.7% ended six to twelve months ago, 17.4% ended one to two years ago, 10.7% ended two to five years ago, and only one participant (2.2%) ended treatment over five years ago. Of the 44 participants who answered the question about length spent in treatment, the most frequently reported length was six months or less (n=13, 29.5%). Additional findings for length of treatment are presented in Figure 2 below.

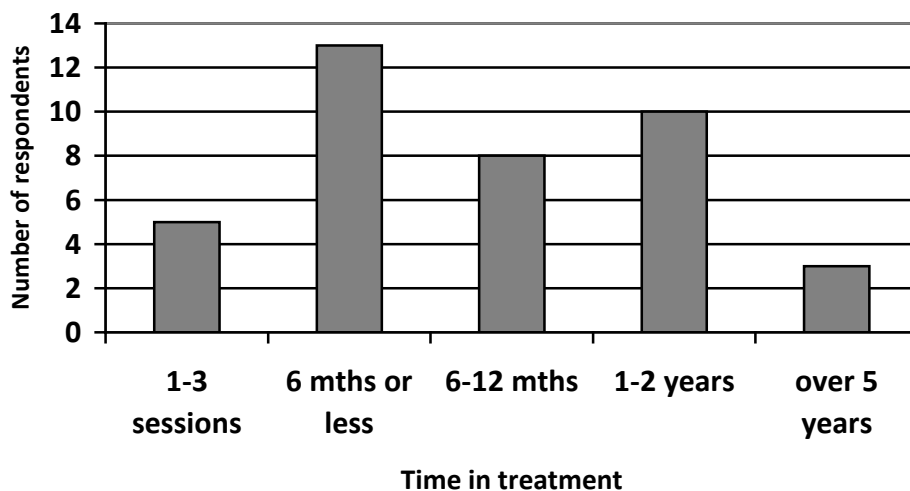


Figure 2. Reported length of time spent in treatment with current therapist

Participants were asked to fill in the blank with their primary reason for seeking treatment with their most recent therapist. Some participants listed more than one primary concern, and in these instances, only the first reason listed was used for categorization and analysis. Reasons for seeking treatment were categorized into gender-related reasons and non-gender-related reasons. Of the 44 participants who answered this

question, there was a fairly even distribution between these categories; 21 participants (47.7%) reported seeking treatment for reasons primarily related to gender and 23 (52.3%) reported non-gender-related reasons as primary for seeking treatment. A more detailed list of presenting concerns for treatment is included in Table 3 below. Please note that since many people wrote more than one response, and all responses were categorized in Figure 3, responses total more than 44.

Table 3

Reasons for Seeking Treatment with Most Recent Therapist

Gender-Specific Reasons	Frequency	Non-Gender-Specific Reasons	Frequency
General gender concerns/ exploration	11	Depression	7
“Get a letter”/Required for SRS and/or hormones	8	General treatment	5
Beginning transition	4	Anxiety	4
		PTSD/Trauma	4
		Relationships	4
		Work-related concerns	2
		Post-inpatient follow-up	1
		HIV	1
		Substance abuse	1

The last demographic question asked of participants was their therapist’s training, if known. The most frequent response was Psychologist (Ph.D. or Psy.D.) (n=17, 37%), followed by Social Worker (MSW) (n=12, 26.1%), Counselor (MA or MC) (n=5, 10.9%), Psychiatrist (MD) (n=4, 8.7%), and Marriage and Family Therapist (LMFT) (n=3, 6.5%). Additionally, one participant (2.2%) reported “Other” for their therapist’s

training, and four participants (9.8%) reported that they did not know their therapists' training.

Treatment Experience

Overall, respondents reported positive experiences in treatment. The vast majority of participants reported affirmative experiences on the therapist behavior scale, with 54.3 % of respondents scoring in the range of strongly affirmative and 28.3% in the range of somewhat affirmative therapist behaviors while 13% scored in the range of somewhat discriminatory and only 2.2% scored in the range of strongly discriminatory behaviors. The sample in this study also reported high rates of satisfaction and strong working alliances with their therapists according to the Reid-Gundlach Social Service Satisfaction Scale (R-GSSSS) and Working Alliance Inventory (WAI). Summary scores are presented for these scales in Figure 3 below:

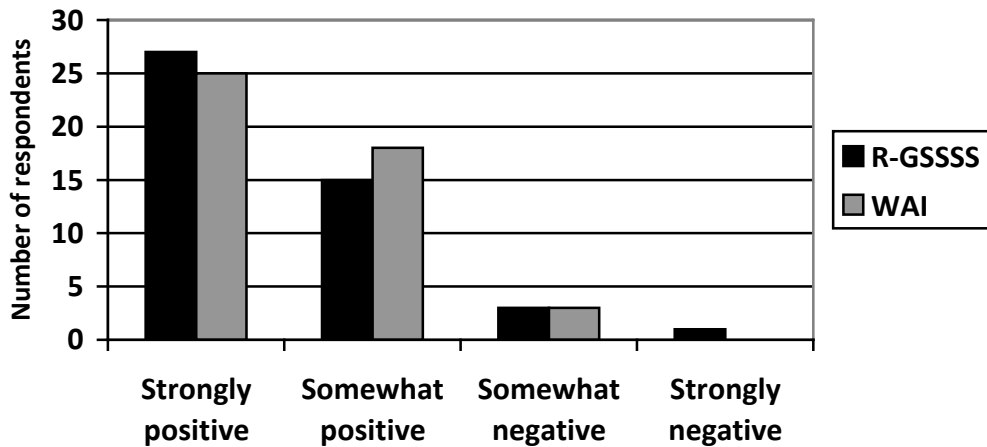


Figure 3. Reported satisfaction with treatment and strength of working alliance according to R-GSSSS and WAI

Even with the small number of respondents reporting negative experiences in treatment, affirmative therapist behaviors and discriminatory behaviors were found to be very much related to the respondents' working alliance with their therapists and their satisfaction with treatment. Pearson's Correlation was used to determine the relationship between affirmative therapist behaviors and both the WAI and R-GSSSS, and significant relationships between each of these variables were found. There was a strong positive correlation between affirmative therapist behaviors and the WAI ($r = .634$, $p = .000$, two-tailed), and a moderate positive correlation between affirmative behaviors and the R-GSSSS ($r = .486$, $p = .001$, two-tailed), suggesting that higher rates of affirmative therapist behaviors are related to stronger working alliance and higher rates of satisfaction. As may be expected, there was also a very strong positive correlation between working alliance and treatment satisfaction ($r = .849$, $p = .000$, two-tailed), meaning that respondents who reported a positive working relationship with their therapists reported higher rates of satisfaction with treatment, and those who reported poor working relationships reported lower rates of treatment satisfaction. Pearson's Correlation was also used to determine the relationship between discriminatory therapist behaviors and the WAI and R-GSSSS, and again, there were significant relationships between these variables. There was a weak positive correlation between discriminatory therapist behavior scale (after the scale was reverse-scored) and the WAI ($r = .405$, $p = .005$, two-tailed) and a moderate positive correlation between the reverse-scored discriminatory therapist behavior scale and the R-GSSSS ($r = .513$, $p = .000$, two-tailed). These correlations suggest that discriminatory therapist behaviors are related to diminished client satisfaction with treatment and poor working alliance. However, since

the discriminatory therapist behavior scale showed poor internal reliability, analyses of relationships were also conducted with the two most frequently reported behaviors in the discriminatory therapist behavior scale.

The discriminatory therapist behavior most commonly reported by this sample was the therapist lacking education on trans issues and the client feeling that they had to educate the therapist, with 8.7% of respondents strongly agreeing that they had to educate their therapists, and 13% of respondents somewhat agreeing that they had to educate their therapists. A Pearson's Correlation was used to determine the relationship between a client feeling that the therapist needed education on trans issues and both the WAI and the R-GSSSS, and there were significant correlations between the variables. There was a significant, albeit weak, positive correlation between the reverse-scored variable of the client feeling that the therapist lacked education on trans issues and the WAI ($r = .370$, $p = .012$, two-tailed), suggesting that clients feeling that they had to educate their therapists on trans issues is related to diminished working alliance. There was also a significant positive correlation of moderate strength between the reverse-scored variable and the R-GSSSS ($r = .557$, $p = .000$, two-tailed), suggesting that satisfaction with treatment was also lower when clients felt they had to educate their therapists.

Several respondents reported in the open-ended question, however, that educating their therapists did not bother them, and this may be because other affirmative therapist behaviors mitigated the lack of knowledge so that it was not perceived as either discriminatory or uncaring to the client. One respondent wrote, "I have had therapists that really didn't know their ass from their elbow and were uncomfortable to work with, and also frustrated me because I had to do a lot of educating. [But] my most recent and

valued therapist was not very gender/queer savvy but was an amazing therapist nonetheless.” Another respondent shared a similar experience:

My therapist was new to genderqueer perspectives, and was always open to learning. She was also attentive to the fact that when I first met her, I was suspicious and evaluating how she would respond to me. She understood that I often had to educate my therapists before we could reach a place to work together.

A third respondent said, “I was lucky in that, although my therapist was new to gender issues, she was very compassionate and willing to learn . . . I have NO complaints about the professionals I hired to help me [in my transition].” These experiences indicate that the factor of lack of therapist knowledge may not negatively impact working alliance or client treatment satisfaction when other affirmative therapist behaviors are present.

The second most frequently reported therapist behavior in the discriminatory scale was therapist discomfort with the client’s gender identity, with 6.5% of respondents strongly agreeing and 10.9% of respondents somewhat agreeing that they felt their therapists were uncomfortable with the respondents’ gender identities. Pearson’s Correlation was used again to determine the relationship between this therapist behavior and both the WAI and R-GSSSS, and results were similar to the previously described behavior. There were significant positive correlations between the reverse-scored variable of therapist discomfort with the client’s gender identity and both the WAI ($r = .306, p = .041$, two-tailed) and the R-GSSSS ($r = .305, p = .042$, two-tailed). Although both correlations were weak, this finding suggests again that the discriminatory therapist behavior is related to both lower working alliance and lower client satisfaction with treatment.

Most demographic variables were also measured to determine any factors that impact treatment experience in addition to the therapists' behaviors. An oneway analysis of variance (ANOVA) was used to determine whether there were differences in reported therapist behaviors, WAI or R-GSSS scores by therapist education, sexual orientation, current gender identification, and by the three states most represented in this study. No significant differences in therapist behavior, treatment satisfaction or working alliance were found in these variables. T-tests were used to determine whether there were differences in therapist behaviors, WAI or R-GSSSS scores based on sex assigned at birth, primary reason for seeking treatment, or racial groups (white or people of color), and no significant differences were found between these groups, either.

The only demographic variable that yielded significant findings of differences utilizing an oneway ANOVA was the length of time in treatment with the current therapist. Significant differences were found in WAI scores by length of time in treatment ($F(5, 39) = 2.942, p = .024$), and a Bonferroni post-hoc test found that the significant difference was between the group of respondents that had spent one to three sessions in treatment and the group that had spent two to five years in treatment, with a mean difference in scores of 21.6. Since the one to three session group had a mean WAI score that indicated a much lower working alliance than those in the two to five year group (see Table 4), this finding suggests that people who were in treatment longer had a better working alliance. However, the mean WAI score for the group who was in treatment for over five years indicated a much lower working alliance than the group who was in treatment for two to five years (see Table 4), and there was no significant difference between this group and any other group.

Table 4

Mean WAI and Therapist Behavior Scale Scores by Length of Time in Treatment

	N of participants	Mean WAI score on a scale of 15-75*	Mean Therapist Behavior scores on a scale of 1-5*
1-3 sessions	5	41.6000	2.9958
6 months or less	14	29.8571	1.9274 (n=13)
6-12 months	8	27.6250	1.9460
1-2 years	10	27.0000	1.8439
2-5 years	5	20.0000	1.6667
Over 5 years	3	31.3333	2.8667

*Note that for both WAI and Therapist Behavior scores, lower number indicates more positive responses, and higher numbers indicate more negative responses.

Significant differences were also found in reported therapist behaviors by length of time in treatment ($F(5,38) = 2.621, p = .039$). The LSD post-hoc test indicated that there were significant differences between the group who was in treatment for one to three sessions and every other group except the group who was in treatment for over five years (see Table 5). Based on mean scores of the therapist behavior scale (see Table 4), this finding indicates that participants who had been in treatment for the shortest amount of time reported significantly fewer affirmative therapist behaviors and more discriminatory therapist behavior than any of the other participants except those who had been in treatment for over five years. Interestingly, the LSD post-hoc test also indicated a significant difference between the group who had been in treatment for two to five years and the group who had been in treatment over five years, with the two to five year group showing significantly more affirmative therapist behaviors and fewer discriminatory behaviors than the group in treatment for over five years.

Table 5

Mean Differences between Groups in Therapist Behavior Scale Scores
(with p values in parentheses)

Length of Time in Treatment	1-3 sessions	6 months or less	6-12 months	1-2 years	2-5 years
1-3 sessions	—				
6 months or less	1.06831(.013)*	—			
6-12 months	1.04973(.023)*	-.0186(.958)	—		
1-2 years	1.15182(.010)*	.08351(.800)	.1021(.783)	—	
2-5 years	1.32909(.010)*	.26078(.527)	.27936(.532)	.17727(.679)	—
Over 5 years	0.12909(.821)	-.93922(.067)	-.9206(.088)	-1.023(.053)	-1.20(.041)*

*Significant differences at $p < .05$ are marked with an asterisk

Other Findings

The above analysis of the treatment experiences of transgender people provides important information about what was helpful and unhelpful in treatment, what therapist behaviors related to improved working alliance and what behaviors hindered it. The responses to the open-ended question on the survey provide rich detail about individuals' experiences and offer greater depth to the discussion about what built a positive treatment experience and what lead to frustrating or negative experiences.

One common theme in the open ended responses, in accordance with the findings discussed above, was positive feelings about the treatment experience. Out of 27 responses to this question, 14 clearly stated that they had a positive experience with their most recent therapists. Of these 14 respondents, seven specified that they had sought a gender specialist or a therapist who had experience with transgender clients. Some comments expressing positive experience related to the positive therapist qualities, such as the person who said, "I liked her and kept seeing her because she was sympathetic,

understanding, and very gentle.” The helpful therapist qualities that came up in several people’s responses included compassion, openness, acceptance, interest in learning about or previous knowledge of trans issues, and help in finding and accessing resources.

There were also more generally appreciative responses that did not name the specific qualities in the therapist that made treatment a positive experience: “My therapist is so good that she seems like my best friend and not a paid professional. It is that relaxing to work with her – the very best!” Other comments reflected participants’ appreciation for their own growth and transformation in the course of a positive therapy experience: “Since [going to] therapy, I have started my journey toward becoming the woman I was meant to be.”

There were several participants who reported having negative experiences in therapy. Some reported being satisfied with their current therapists, but had problematic experiences in therapy in the past. One such participant wrote:

It’s too bad these questions related only to my most recent therapy experience, since I was fully transitioned by the time I went to see him. Earlier experiences, particularly those during transition and for which I needed to obtain letters for surgery, were far more fraught with problematic dynamics; with one therapist in particular, the gatekeeping role that she played by necessity dramatically altered the relationship and put me in a position not only of educator, but of advocate for my own rights.

Several other participants’ responses gave examples of the problematic dynamics during therapy for purposes of transition. One person, specifically addressing the role of the gender binary as a problem in the therapy experience, wrote:

I felt up against a wall. I had to see this therapist for as long as it took for her to feel comfortable writing a letter so that I could have surgery. I would not have been there if I didn’t need said letter. It was all about jumping through hoops and not actually [about] dealing with my concerns, fears, or other issues. I felt strongly that I had to conform to her ideas of what it meant to be a trans woman. I

didn't feel comfortable to talk about being genderqueer. Instead, I felt like I had to play into a gender binary. Therapy was more about convincing my therapist that helping me in any way.

Another person's experience reflected similar difficulties:

I am going to therapy because it is required by the current APA and WPATH standards in order to obtain the necessary treatment to bring my body into line with my mind. I would not have gone were it not for these standards. . . . While [my therapist] is a very kind person, I do not trust her to do the right thing for me, in large part due to her reluctance to recommend me for hormone therapy Also, she had at one point mentioned that maybe she couldn't "help" me because I had developed a relationship with a person who was unstable, and so now I don't trust her enough to even tell her about some [recent risky behaviors]. I want to tell someone, desperately, but I don't trust her not to use this as a reason to deny me a letter for the surgery when the time comes because I am not making 100% rational decisions all the time. . . . I feel like I have to appear completely rational and satisfied all the time or risk her having "reservations" about whether I should be recommended for surgery. My gender issues and needing to modify my body to match my mind are completely separate from my risk-taking behavior, and I just wish she was able to separate the two so I could talk to her about those things without worrying about being denied the medical treatments I need.

One person summarized the treatment experience in one sentence: "She does not like it when I dress up."

Other participants reported mixed experiences with their current therapists, reporting positive experiences in some areas, but difficulties when it came to gender.

One such participant wrote:

I originally went to my therapist for [other reasons]. Only recently did gender identity issues come up, and she said that she had absolutely no experience with it, but she would help me with how I feel about it. She did not support my decision to transition because I never really talked about it before (we were busy with other things).

Another wrote:

I haven't been very out with my therapist about my gender identity. I've perceived her to be not particularly knowledgeable about gender non-conforming issues, so I've focused on issues that are more within her range of expertise. This feels ok for me because I also feel that other issues are more in the forefront of what I want to work on in therapy right now, and I'm not experiencing a lot of

distress around my gender identity. But if I did want to work more closely around my gender identity issues, I think I would have a much harder time working with this particular therapist and would probably look into seeking another provider.

These responses provide an understanding of the breadth of transgender people's experiences with therapists. While many in this sample reported positive and helpful experiences with their therapists, the examples provided from those whose experiences were not positive point out difficulties in obtaining reliable and affirmative care. The next chapter will address ways in which these findings relate to the existing literature in the field and implications of these findings for clinical practice.

CHAPTER V

DISCUSSION

The purpose of this study was to examine the mental health treatment experiences of transgender individuals, evaluating the presence of affirmative and discriminatory therapist behaviors and how these behaviors impacted client satisfaction with treatment and therapeutic working alliance. This chapter will review the significant findings presented in the previous chapter in relation to existing research and literature and will discuss the limitations of this study and ideas for future research. Also addressed are the implications of the findings for effective clinical practice with transgender persons.

Findings in Relation to Previous Literature

The findings of this quantitative study provided interesting new information about the use of affirmative therapy techniques with transgender clients. While authors have theorized about the application of affirmative therapy principles to transgender populations (Embaye, 2006; Nuttbrock, et al., 2002; Raj, 2002), there is a dearth of research that shows it is related to an improved treatment experience. This study provided preliminary findings that affirmative behaviors are significantly positively related to higher ratings of treatment satisfaction. Similarly, the finding that affirmative therapist behaviors are significantly related to higher ratings of the working alliance, a vital therapeutic variable, provide new information to the field and add evidence to the theory that affirmative therapy would be helpful to transgender individuals.

The findings related to discriminatory therapist behaviors are also new to the field. While research has extensively shown the deleterious effects of discriminatory experience on mental health (Diaz et al., 2001; DiPlacido, 1998; Hershberger & D'Augelli, 1995; Krieger et al., 2005; Mays & Cochran, 2001; Ritter & Terndrup, 2002), and it may also seem commonsensical that discrimination and gender-normative bias in the treatment setting would be related to lower satisfaction with treatment and a lower rating of working alliance, this has not been previously shown. The fact that this study shows that discriminatory therapist behavior is significantly related to lower treatment satisfaction and lower ratings of working alliance is a step toward analyzing the full impact of bias in therapy.

The quotations taken from the open-ended responses confirmed the literature related to the sometimes disruptive role of the therapist as gatekeeper when using the Harry Benjamin Standards of Care for medical transition (Bockting et al., 2004; Butler, 2006; Denny, 2006; Rachlin, 2002; Vitale, 1997), as well as confirming the literature regarding the problematic nature of maintenance of the gender binary when identities actually come in numerous alternative presentations (Butler; Denny; Gagné & Tewksbury, 1998; Wilchins, 2004). An additional significant finding that was not addressed in the literature reviewed for this study was the difference in working alliance and rated therapist behaviors by length of time in treatment. Searches for literature addressing this relationship did not yield any related studies, and it is therefore difficult to ascertain possible reasons for finding.

Limitations and Suggestions for Future Research

There were several limitations to this study. The small sample size and non-random sampling techniques prevent the findings from being generalized to all transgender people. The racial representation is limited in this sample, and the fact that this sample is predominately white means that the views and experiences of trans people of color are under-represented. In addition, the online survey format may pre-suppose a certain socioeconomic standing since access to a computer with the internet was required. Although income was not asked about in the demographics of this study, socioeconomic class may impact ability to afford the mental health treatment of one's choice and to access medical treatment if desired, both of which could be factors in treatment experience.

The instrument has several flaws, as well. The Therapist Behavior Scale developed to measure specific discriminatory or gender normative behaviors had a low internal reliability, limiting its usefulness in data analysis. The instrument as a whole also relies on retrospective self-report, and memory may skew accuracy of the report to a certain extent. However, close to half of the sample ($n = 21$) was currently in therapy and therefore would be unlikely to have any difficulty in reporting their experiences and perceptions accurately.

In the course of this study, several ideas for future research developed. First, development of a more reliable measure for gender normative and heterosexist bias in therapist behaviors would be a useful contribution to the field. This study could be reproduced with several changes to eliminate limitations and strengthen its findings, including use of randomized sampling, using alternative survey methods to reach people

who may not have access to the internet, as well as active outreach to people of color in the sampling process.

This study provided initial findings that discriminatory therapist behaviors such as gender normative bias negatively impact treatment experience in measures of the working alliance and satisfaction with treatment. Given the literature's clear demonstration of the negative impact of experiences of discrimination on mental health, another area for future research would be looking at how experiences of discrimination in the specific context of mental health treatment, including heteronormative or gender normative biases, impact mental health. It would also be relevant to study the experiences of people specifically attending therapy for gender-related reasons, particularly for reasons related to medical transition, and to study the impact on the treatment experience of the dual role of therapists as gatekeepers. Additionally, since therapist knowledge of trans-specific issues was one of the factors found to impact treatment experience, studies on the amount and type of training that clinicians receive in this area from either graduate programs or continuing education courses would be important for finding and addressing gaps in education.

Implications for Clinical Practice

This study clearly indicates the importance of affirmative therapist behaviors and treatment style with transgender persons. The responses in this study indicate that clinicians were most helpful when they exhibited an openness to and compassion for a breadth of identities and experiences. A part of affirmative treatment with questioning and transitioning populations includes clinicians' recognition that gender exploration or transition is not about becoming the "other" gender, but about exploring the true identity

of the individual and respecting a fluid, non-linear process of identity formation and clarification in recognition of a gender spectrum rather than a gender binary.

Affirmative therapy techniques will also assist a therapist in openness to fluidity of sexual orientation with transgender clients. While clinical education on best practice models for gay, lesbian, and bisexual persons has increased in recent years, and a body of research has been done on affirmative treatment models for sexual orientation with persons who do not identify as transgender (Davies, 1996b; Harrison, 2000; Landridge, 2007; Maylon, 1982), an affirmative therapy model specific to needs of transgender persons is only beginning to be researched and developed (Embay, 2006; Nuttbrock et al., 2002). As can be seen in historically heterosexist treatment of trans identity, sexual orientation has often been tied to gender, such that if one transitions to a gender that does not correspond with sex assigned at birth, a heterosexual post-transition orientation has historically been perceived as the correct corresponding identity (Butler, 2006; Denny, 2006; Meyer et al., 2001). However, the multiplicity of sexual orientations identified by the 46 participants in this study alone show that societal categories of acceptable or preferred sexual orientation do not reflect the full spectrum of experienced identities nor is gender identity tied to sexual orientation. Affirmative therapy techniques will allow individuals to fully explore their sexual orientations without their identities being tied to a particular externally-imposed end result.

Another implication for clinical practice based on the findings in this study is that therapist education in transgender issues is important in effective and satisfactory treatment. While this study did not inquire as to the areas of therapist knowledge that clients found to be most important or helpful, possible ideas for areas of training and

general competency include education on both historical and contemporary perspectives on gender and gender identity such as gender theory and the social construction of the gender binary, the restrictions and challenges faced by those who seek medical transition, as well as the debated benefits to the current standards of care, and the historical pathologization of alternative gender identities in the mental health profession and the resulting role of therapists as gatekeepers to medical procedures. Clinicians should also have access to transgender-specific resources, including mental health centers, medical centers, and community support groups to provide to clients seeking gender-specific services.

The theme of the dual role of the clinician as a gatekeeper was very present in the written responses of this sample, and implications for practice regarding this aspect of relationship between clinicians and transgender clients are profound. While the conversation about the therapist as a gatekeeper is too multi-faceted to be fully addressed here, participants in this study clearly articulated the depth and complexity of the problems with this dynamic in the therapy setting. The fact that access to medical services is, in many cases, dependent on a therapist's readiness for the client to transition, rather than on a client's readiness, creates numerous ethical dilemmas. This challenges client self-determination, which is a core ethical principle in the social work profession (National Association of Social Work, 2006) and a widely-promoted principle of treatment in many other mental health professions. It also sets up a dynamic inherently opposed to the development of a trusting, open therapeutic relationship. If a client must present in therapy the version of the self that will grant access to the desired medical treatment rather than openly attending to the natural fears, concerns, and difficulties that

are a part of any life transition, then the therapeutic relationship serves no viable purpose. However, one must also acknowledge as a legitimate part of this debate the fact that the present standards of care requiring letters from therapists in order for a client to access medical transitioning services is also currently the only path by which the medical procedures might be covered by insurance (if the client has insurance). Therefore, what ultimately serves the best interest of the client, and is it possible to balance the role of gatekeeper with a legitimately therapeutic relationship?

While widely varied individual experiences and needs and complex interplay of variables make it difficult to offer concrete answers to these questions, several things are clear. First, that the setup of the therapeutic process as a hurdle to obtaining a desired end goal is an unhelpful dynamic. Second, it is particularly unhelpful and even damaging when a client's honesty about non-linear identity development, difficulties, or doubts during the process is treated punitively by withholding access to desired services, regardless of whether the motivation for withholding is perceived by a clinician as being in a client's best interest. Therefore, clinicians must maintain a high level of self-examination and awareness in such situations, seeking appropriate supervision and consultation in order to ensure that their treatment practices are affirmative and underscore the client's right to self-determination. Maintaining a high level of transparency with the client from the beginning of treatment regarding the complications that may arise in the dual role of therapist as gatekeeper can be helpful to both client and clinician in recognizing those problematic dynamics when they arise and discussing them more openly.

Conclusion

The purpose of this study was to examine the treatment experiences of transgender people, including whether therapist behaviors were affirmative or gender normative in nature and how differences in therapist behavior affected the working alliance and client satisfaction with treatment. It was discovered that affirmative therapist behaviors are strongly correlated to higher scores of working alliance and higher reports of satisfaction, while discriminatory behaviors were correlated with lower scores of working alliance and lower satisfaction. This report is intended to provide guidance to mental health service providers in developing effective treatment strategies with their transgender clients, as well as providing guidance to policy makers, whose decisions have enormous potential to impact both the treatment of transgender individuals and perception of gender identity.

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Appendix A

Human Subjects Review Approval Letter

February 25, 2009

Jeannette Sheerin

Dear Jeannette,

Thanks for clarifying your participant description. That was very helpful as were the changes you made in the **Participant** part of your Application. I was just concerned that someone would come forth and then be found to not be eligible but with your clarification of your use of transgender as an umbrella term, it will work. We are therefore glad to give final approval to your study.

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.

Good luck with your very interesting project.

Sincerely,

Ann Hartman, D.S.W.
Chair, Human Subjects Review Committee

CC: Mary Beth Averill, Research Advisor

Appendix B

Recruitment Letter

I am writing to ask your help in a study on transgender people's experiences in therapy being conducted for my MSW thesis. This study's purpose is to better understand the kind of therapeutic experiences that transgender folks have and whether they are satisfied or dissatisfied with these experiences.

Results from this survey will benefit the transgender community and will help clinicians evaluate their own practices and behaviors with transgender clients and will give you a voice in that process. By hearing from transgender people who have been in therapy, clinicians can learn what has been useful in treatment and what has been unhelpful, or even harmful, to transgender clients. This survey will give the transgender community an opportunity to provide feedback about their therapy experiences.

I invite you to participate in this study if you are 18 or older, are a current U.S. resident, have had at least one experience in therapy, and identify as transgender, transsexual, trans, bigender, FTM, MTF, genderqueer, gender variant, gender non-conforming, agender, cross-dresser, two spirit, kothi, hijra, drag queen, drag king, or if you do not identify with a particular gender. I invite you to participate if your current gender identification is different from the one your parents or guardians gave you at birth, if people see you as androgynous, or if you or other people question your gender identity. I invite you to participate if you clearly pass, as long as you have had the experience of not clearly passing at some point in your life.

Your answers to this survey will be completely anonymous and will be released only as summaries in which no individual's answers can be identified. All information gathered will be encrypted, and there will be no way to track your participation in this study. Participation is completely voluntary. However, you can help me very much by taking a few minutes to share your experiences and opinions about your therapy experiences.

You can access the survey by clicking on the following link:

www.tinyurl.com/transstudy

If you have any questions or comments about this study, I would be happy to talk with you. You can contact me at jsheerin@smith.edu or by phone at (206) 744-1638.

Thank you very much for your time and willingness to participate in this important study!

Jeannette Sheerin
MSW Student '09
Smith College School for Social Work

Appendix C

Questionnaire

Transgender Experiences in Therapy

1.

Welcome! Before beginning the survey, we want to make sure you fit the criteria for respondents. Please answer a few quick questions below to determine eligibility, and then you'll be directed either to the survey or to a resource page as appropriate. Thanks so much for your participation!

1. Do you currently identify as transgender, transsexual, trans, bigender, FTM, MTF, transgenderist, genderqueer, gender variant, gender non-conforming, agender, cross-dresser, two spirit, kothi, hijra, drag queen, drag king, or is your current gender identification different from the one you were assigned you at birth?

- Yes
- No

2. Are you 18 or older?

- Yes
- No

3. Have you had at least one experience of seeing a therapist for any reason?

- Yes
- No

4. Do you currently reside in the United States?

- Yes
- No

Transgender Experiences in Therapy

2. INFORMED CONSENT

Dear Participant:

My name is Jeannette Sheerin, and I am a MSW student at Smith College School for Social Work. The study in which you are about to participate is research exploring trans-identified people's experiences in therapy and how these experiences impacted their satisfaction with treatment. The data collected in this study will be used for my MSW thesis and other publications and presentations.

Participation in this study consists of anonymously completing an internet survey regarding your own experiences in therapy. This survey consists of 53 questions including demographic data, and usually takes approximately 10-20 minutes. Most questions will ask you to rate how strongly you agree or disagree with a statement about your therapy experience.

Some of the questions in this survey are very personal, having to do with gender identity, satisfaction with psychotherapy, and experiences of discrimination. These questions may be easy to answer, or they may be difficult to think about. You might find yourself thinking about difficult times in your past. If any of these thoughts become too overwhelming or distressing, I encourage you to consult the list of trans-friendly support services below that provide low-cost or free help. You will also be directed to this list when you submit the survey.

This study is important in order to gauge how trans-identified clients experience mental health services and to help clinicians evaluate their own practice in order to best meet the needs of trans people in treatment and to meet professional levels of cultural competency. Participation in this survey is your opportunity to let your voice be heard about your own experiences in therapy, and will give you the opportunity to reflect on what was helpful for you and what was not. Your contribution to the field in taking the time to complete this survey is greatly appreciated.

This survey is entirely anonymous – all information gathered via Survey Monkey is encrypted, and there is no way to track your participation in this study. Your complete honesty is greatly appreciated. Data will be seen by me and my research advisor for the MSW thesis. All data gathered in these surveys will be stored electronically on a password-protected computer for a period of three years, as required by Federal guidelines. Should I need the materials beyond the three year period, they will continue to be kept in a secure location and will be destroyed when no longer needed.

Participation in this study is voluntary, and you can withdraw from the survey at any point by closing this website before you submit your answers. You can also skip questions you do not want to answer. If you would like to change answers that you gave on previous pages, you may click on the button marked "Prev." However, once you submit your completed survey, you will not be able to withdraw since your answers are anonymous and will not be able to be identified. In the case that you have any additional questions, or any concerns about your rights or about any aspect of the study, please contact the researcher at 206-744-1638 or by email at jsheerin@email.smith.edu. You can also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

Transgender Experiences in Therapy

Below is a list of resources which will also be provided at the end of the survey for your reference.

The GLBT National Hotline

1-888-THE-GLNH (1-888-843-4564)

<http://www.glnh.org/hotline/index.html>

The Gay, Lesbian, Bisexual and Transgender National Hotline provides telephone and email peer-counseling, as well as factual information and local resources for cities and towns across the United States.

Gay, Lesbian, Bisexual and Transgender Helpline

1-888-340-4528

Fenway's Gay, Lesbian, Bisexual and Transgender Helpline is an anonymous and confidential phone line that offer gay, lesbian, bisexual and transgender adults and youths a "safe place" to call for information, referrals, and support. In addition to issues like coming out, HIV/AIDS, safer sex and relationships, our trained volunteers also address topics such as locating GLBT groups and services in their local area.

Northwest Gender Alliance (NWSGA of Portland, OR)

503-533-8787

nwga@nwgapdx.com

Seattle Counseling Service

206-323-1768

<http://www.seattlecounseling.org/Contact.htm>

Seattle Transgender

<http://seattletransgender.org/default.aspx>

206-910-0403

Transgender Counseling at The Center in San Diego

<http://www.thecentersd.org/transgendercounseling.php>

(619) 260-6380, x 115

Southern California Transgender Counseling

(310) 281-9658

<http://www.transgendercounseling.com/>

Los Angeles Gender Center

<http://www.lagendercenter.com/>

(310) 475-8880

Fenway Community Health - Transgender Health Services, Boston

(617) 267-0900

http://www.fenwayhealth.org/site/PageServer?pagename=FCHC_srv_services_trans

FORGE (For Ourselves - Reworking Gender Expression) - Milwaukee, WI

<http://www.forge-forward.org/>

Whitman-Walker Clinic - Washington, DC

http://www.wwc.org/common/mental_health_main.html

(202) 939-7690

Indy Boyz - an FTM+/SOFFA Social Support Group Serving the Indianapolis Area

<http://www.indyboyz.org/>

BY CLICKING "NEXT" AT THE BOTTOM OF THIS PAGE, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please print a copy of this consent form for your records.

Thank you!

Transgender Experiences in Therapy

3.

5. What is your age?

6. What state do you currently live in?

State

7. What sex were you assigned at birth?

- Male
- Female
- Intersex

8. How do you currently identify your gender?

9. How do you currently identify your sexual orientation?

10. How do you identify your race?

- White
- Black/African-American
- Latino
- Asian-Pacific Islander
- Native American
- Bi-racial
- Multi-racial
- Other

11. How many therapists have you seen in your life?

12. When did your most recent experience in therapy END?

- Currently in therapy
- Ended within the past 6 months
- Ended 6 to 12 months ago
- Ended 1 to 2 years ago
- Ended 2 to 5 years ago
- Ended over 5 years ago

Transgender Experiences in Therapy

13. How long were you in treatment with your most recent therapist?

- 1 to 3 sessions
- 6 months or less
- 6 months to 1 year
- 1 to 2 years
- 2 to 5 years
- over 5 years

14. What was the primary reason you sought treatment in your most recent therapy experience?

15. What training did your therapist have, if you know?

- Social worker (MSW)
- Counselor (MA or MC)
- Psychologist (PhD or PsyD)
- Psychiatrist (MD)
- Marriage and Family Therapist (LMFT)
- Other training
- Don't know

Transgender Experiences in Therapy

4.

Below are questions about your relationship with your therapist. When answering, please think about only your MOST RECENT therapist. Using the scale provided, please rate the degree to which you agree with each statement, and click on the appropriate response.

16. I felt that my therapist was encouraging of my gender identity.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

17. WAI question #6 removed due to limited copyright release.*

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

18. I can tell my therapist the truth without worrying.

Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

19. My therapist was comfortable discussing issues of transphobia.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

20. WAI question #16 removed due to limited copyright release.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

21. If a friend of mine had similar problems, I would tell them to go to my therapist.

Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

22. My therapist called me by the incorrect pronoun, even after I corrected them.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

23. WAI question #24 removed due to limited copyright release.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

24. Sometimes I just told my therapist what I thought he/she/ze wanted to hear.

Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

25. WAI question #35 removed due to limited copyright release.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

*Questions taken from the WAI (Horvath, 1994) were removed due to a limited copyright release prohibiting reproduction or publication of part or all of the survey. Question numbers provided correspond to survey questions for the full WAI, client version. If the reader wishes to access questions used in this instrument, they can be viewed at the following website: <http://www.educ.sfu.ca/alliance/allianceA/>.

Transgender Experiences in Therapy

26. I felt that I had to educate my therapist on issues of transgender identity.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

27. WAI question #21 removed due to limited copyright release.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

28. When I went to therapy sessions, I felt very small and insignificant.

Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

29. I felt supported by my therapist in being my true self.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

30. WAI question #4 removed due to limited copyright release.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

31. My therapist tried hard, but wasn't too helpful.

Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

32. My therapist encouraged me toward a gender identity that I was not comfortable with.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

33. Things have gotten better since I went to my therapist.

Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

Transgender Experiences in Therapy

5.

Below are questions about your relationship with your therapist. When answering, please think about only your MOST RECENT therapist. Using the scale provided, please rate the degree to which you agree with each statement, and click on the appropriate response.

34. My therapist attributed my problems or distress to gender identity even when I felt they were due to a different reason.

- Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

35. WAI question #22 removed due to limited copyright release.

- Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

36. My therapist asked me what my preferred pronoun is and called me by it.

- Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

37. WAI question #8 removed due to limited copyright release.

- Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

38. I usually felt nervous talking to my therapist.

- Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

39. My therapist was educated and knowledgeable on issues of transgender identity.

- Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

40. WAI question #12 removed due to limited copyright release.

- Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

41. I always felt well treated when I left my therapist's office.

- Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

42. I felt that my therapist was uncomfortable with my gender identity.

- Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

Transgender Experiences in Therapy

43. WAI question #29 removed due to limited copyright release.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

44. WAI question #32 removed due to limited copyright release.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

45. I got from my therapist exactly what I wanted.

Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

46. My therapist was comfortable discussing issues of heterosexism.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

47. WAI question #31 removed due to limited copyright release.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

48. If I had been the therapist, I would have dealt with my problems in just the same way.

Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

49. WAI question #36 removed due to limited copyright release.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

50. I never looked forward to my sessions with my therapist.

Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

51. WAI question #23 removed due to limited copyright release.

Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

52. No one should have any trouble getting some help from my therapist.

Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

53. My therapist took my problems very seriously.

Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

Transgender Experiences in Therapy

54. Since I've gone to therapy, my life is more messed up than ever.

- Strongly Agree Somewhat Agree Neither Agree or Disagree Somewhat Disagree Strongly Disagree N/A

55. My therapist was comfortable discussing issues of homophobia.

- Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

56. WAI question #19 removed due to limited copyright release.

- Strongly Agree Somewhat Agree Neither Agree nor Disagree Somewhat Disagree Strongly Disagree N/A

57. Please add anything else you would like to say about your most recent therapy experience below.

Transgender Experiences in Therapy

6. Resource List

Thank you very much for taking the time to participate in this survey! PLEASE REMEMBER TO PRESS THE "DONE" BUTTON AT THE BOTTOM OF THIS PAGE, OR YOUR ANSWERS WILL NOT BE SUBMITTED!

The GLBT National Hotline

1-888-THE-GLNH (1-888-843-4564)

<http://www.glnh.org/hotline/index.html>

The Gay, Lesbian, Bisexual and Transgender National Hotline provides telephone and email peer-counseling, as well as factual information and local resources for cities and towns across the United States.

Gay, Lesbian, Bisexual and Transgender Helpline

1-888-340-4528

Fenway's Gay, Lesbian, Bisexual and Transgender Helpline is an anonymous and confidential phone line that offer gay, lesbian, bisexual and transgender adults and youths a "safe place" to call for information, referrals, and support. In addition to issues like coming out, HIV/AIDS, safer sex and relationships, our trained volunteers also address topics such as locating GLBT groups and services in their local area.

Northwest Gender Alliance (NWGA of Portland, OR)

503-533-8787

nwga@nwgapdx.com

Seattle Counseling Service

206-323-1768

<http://www.seattlecounseling.org/Contact.htm>

Seattle Transgender

<http://seattletransgender.org/default.aspx>

206-910-0403

Transgender Counseling at The Center in San Diego

<http://www.thecentersd.org/transgendercounseling.php>

(619) 260-6380, x 115

Southern California Transgender Counseling

(310) 281-9658

<http://www.transgendercounseling.com/>

Los Angeles Gender Center

<http://www.lagendercenter.com/>

(310) 475-8880

Fenway Community Health - Transgender Health Services, Boston

(617) 267-0900

http://www.fenwayhealth.org/site/PageServer?pagename=FCHC_srv_services_trans

FORGE (For Ourselves - Reworking Gender Expression) - Milwaukee, WI

<http://www.forge-forward.org/>

Whitman-Walker Clinic - Washington, DC

http://www.wwc.org/common/mental_health_main.html

(202) 939-7690

Indy Boyz - an FTM+/SOFFA Social Support Group Serving the Indianapolis Area

<http://www.indyboyz.org/>

Appendix D

Informed Consent

Dear Participant:

My name is Jeannette Sheerin, and I am a MSW student at Smith College School for Social Work. The study in which you are about to participate is research exploring trans-identified people's experiences in therapy and how these experiences impacted their satisfaction with treatment. The data collected in this study will be used for my MSW thesis and other publications and presentations.

Participation in this study consists of *anonymously* completing an internet survey regarding your own experiences in therapy. This survey consists of 53 questions including demographic data, and usually takes approximately 10-20 minutes. Most questions will ask you to rate how strongly you agree or disagree with a statement about your therapy experience.

Some of the questions in this survey are very personal, having to do with gender identity, satisfaction with psychotherapy, and experiences of discrimination. These questions may be easy to answer, or they may be difficult to think about. You might find yourself thinking about difficult times in your past. If any of these thoughts become too overwhelming or distressing, I encourage you to consult the list of trans-friendly support services below that provide low-cost or free help. You will also be directed to this list when you submit the survey.

This study is important in order to gauge how trans-identified clients experience mental health services and to help clinicians evaluate their own practice in order to best meet the needs of trans people in treatment and to meet professional levels of cultural competency. Participation in this survey is your opportunity to let your voice be heard about your own experiences in therapy, and will give you the opportunity to reflect on what was helpful for you and what was not. Your contribution to the field in taking the time to complete this survey is greatly appreciated.

This survey is entirely anonymous – all information gathered via Survey Monkey is encrypted, and there is no way to track your participation in this study. Your complete honesty is greatly appreciated. Data will be seen by me and my research advisor for the MSW thesis. All data gathered in these surveys will be stored electronically on a password-protected computer for a period of three years, as required by Federal guidelines. Should I need the materials beyond the three year period, they will continue to be kept in a secure location and will be destroyed when no longer needed.

Participation in this study is voluntary, and you can withdraw from the survey at any point by closing this website before you submit your answers. **You can also skip questions you do not want to answer.** If you would like to change answers that you

gave on previous pages, you may click on the button marked “Prev.” However, once you submit your completed survey, you will not be able to withdraw since your answers are anonymous and will not be able to be identified. In the case that you have any additional questions, or any concerns about your rights or about any aspect of the study, please contact the researcher at 206-744-1638 or by email at jsheerin@email.smith.edu. You can also contact the Chair of the Smith College School for Social Work Human Subjects Review Committee at (413) 585-7974.

BY CLICKING “NEXT” AT THE BOTTOM OF THIS PAGE, YOU ARE INDICATING THAT YOU HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND THAT YOU HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS ABOUT THE STUDY, YOUR PARTICIPATION, AND YOUR RIGHTS AND THAT YOU AGREE TO PARTICIPATE IN THE STUDY.

Please print a copy of this consent form for your records.

Thank you!