

Missteps in Psychotherapy With Transgender Clients: Promoting Gender Sensitivity in Counseling and Psychological Practice

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Transgender and gender nonconforming (TGNC) clients often report negative experiences in the receipt of medical and mental health services (Poteat, German, & Kerrigan, 2013; Shipherd, Green, & Abramovitz, 2010; Xavier et al., 2013). Problematic psychotherapy experiences can impact symptom severity, treatment satisfaction, and help-seeking (Bockting, Robinson, Benner, & Scheltema, 2004; Willging, Salvador, & Kano, 2006). The present grounded theory study was conducted with 45 TGNC participants to identify the specific psychotherapy missteps psychotherapists make in working with this group. These themes include education burdening, gender inflation, gender narrowing, gender avoidance, gender generalizing, gender repairing, gender pathologizing, and gate-keeping. Findings indicate that psychotherapists might make errors in overemphasizing, underemphasizing, or stigmatizing TGNC identities in psychotherapy sessions. Psychotherapy missteps also reflected problems related to placing the burden of education on the client, overasserting power, or performing care in a perfunctory manner. Recommendations are discussed for supporting gender diversity in clinical practice and promoting trans-affirmative care. Limitations of the study and directions for future research will also be discussed.

Keywords: transgender, gender nonconforming, therapy barriers, psychotherapy, stigma

There is a need for psychotherapy that is affirmative of transgender and gender nonconforming (TGNC) identities and competent in their care. TGNC clients frequently report negative experiences in psychotherapy, including encounters with discrimination, and prejudice such as offensive statements, dehumanizing treatment, and outright refusal of care (Grossman & D'Augelli, 2007; Poteat, German, & Kerrigan, 2013; Shipherd, Green, & Abramovitz, 2010; Xavier et al., 2013). The lack of TGNC affirmative training and awareness among psychotherapists may interfere with care, worsening TGNC client's mental health symptoms, diminishing treatment satisfaction, and interfering with future help-seeking (Bockting et al., 2004; Willging, Salvador, & Kano, 2006).

Barriers to care have been identified in medical and mental health care services of TGNC individuals (Grant et al., 2011; Poteat et al., 2013). Additional research is needed to further delineate problems in the psychotherapy process with TGNC clients. This study was conducted to identify the specific missteps that psychotherapists might make in the psychotherapy encounter with TGNC clients—errors in judgment or actions that interfere with gender sensitive psychotherapy.

Barriers to TGNC Mental Health and Medical Care

Transgender individuals often present for mental health services for the same needs as cisgender clients, including anxiety, depression, relationship concerns, substance abuse, and other common presenting problems (Meier & Labuski, 2013; Shipherd, Green, & Abramovitz, 2010). Some TGNC clients seek psychotherapy for more gender-specific reasons, including to explore decision-making surrounding one's gender affirmation process (Rachlin, 2002) or family adjustment to one's gender (Bockting et al., 2004). Psychotherapy may be sought to support the process of gender affirmation in the workplace, finding and adjusting to a job after transitioning or affirming one's gender, dealing with associated social isolation in the workplace, and coping with potential harassment and discrimination (Chope & Strom, 2008). In addition, some TGNC clients may present for psychotherapy as part of the World Professional Association for Transgender Health (WPATH) Standards of Care for medical procedures pertaining to gender affirmation (Meier & Labuski, 2013) in which they are required to secure letters from mental health professionals to seek gender affirmation surgery.

However, TGNC individuals encounter a number of barriers to care, addressed in the new Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (American Psychological Association [APA], 2015). Guideline 1 indicates that practitioners may conflate gender identity and sexual orientation for TGNC individuals. Guideline 5 encourages practitioners to recognize how their own biases and attitudes may impact the quality of care they provide, which is a common problem in the care of TGNC individuals. This stigma in mental health and medical care can have negative effects on the health of TGNC individuals, as seen in Guideline 16. Ultimately, many providers

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lack training in working with not only TGNC adults, but also children, adolescents, and older TGNC adults as reflected in Guidelines 10, 13, and 15.

Specifically, providers in medical settings and their support staff who lack expertise or general competence in TGNC care have been reported to make derogatory comments, violate confidentiality, use the wrong pronouns, blame them for health problems, or avoid touching them during the exam (Bockting et al., 2004; Lambda Legal, 2010; Lombardi, 2001). TGNC patients have reported medical treatment that was blaming, shaming, objectifying, or discriminating (Poteat et al., 2013). TGNC patients have expressed concern about medical providers acting in overly restrictive gate-keeping roles in the access to hormone therapy and gender affirmation surgeries (Bockting et al., 2004). TGNC patients have also complained about needing to educate their medical providers about their identities and health needs (Grant et al., 2011; Poteat et al., 2013). As a result, TGNC patients experience diminished patient satisfaction and wariness toward the health care system (Bockting et al., 2004; Poteat et al., 2013), interfering with access to various levels of health care, including surgery, hormone therapy, and preventive care (APA, 2015).

Transgender individuals have also reported a lack of knowledge, cultural sensitivity, and discrimination as common barriers to mental health care (Sperber, Landers, & Lawrence, 2005). TGNC clients have found their therapists and those of their peers to perpetrate transphobia, leading to anticipation of stigma and avoidance of mental health services (Rachlin, 2002; Shipherd et al., 2010). TGNC clients have also faced problems with their psychotherapists' curiosity-driven questions, assumptions about genital confirmation procedures, expectations of a solitary narrative of the "transgender experience," as well as gender reparative approaches (Meier & Labuski, 2013). Other problems include the tendency of psychotherapists to enforce the gender binary, label transgender identity as repressed homosexuality, discourage gender confirmation procedures due to judgments about clients' body types, and pressure TGNC clients to come out or dress as a particular gender (Carroll & Gilroy, 2002). Lastly, psychotherapists may overfocus on issues of gender when the topic is not relevant to the care being provided (Sperber et al., 2005).

As evidenced by this literature, a number of positive and negative encounters in the medical and mental health care have been touched upon in previous theoretical and empirical studies. This study was conducted to interview TGNC participants to identify a more comprehensive list of the specific issues that have emerged in the psychotherapy process. It is important to note that the qualities of successful experiences in psychotherapy among TGNC clients are an important counterpoint to this focus in the present study. However, the scope of the present article is to delineate the specific psychotherapy barriers described by TGNC participants in this study order to inform care from this perspective.

Method

Participants

The present study included 45 participants who self-identified as TGNC. This sample included 21 participants who identified as (both or either) trans women or male-to-female (MTF), 17 participants who identified as (both or either) trans men or female-to-

male (FTM), and seven participants who identified genderqueer or gender fluid. The terms *trans men* or *trans women* and MTF and FTM were both options for identification on survey to be inclusive in capturing different participant preferences in terminology. The average age of participants was 46 years ($SD = 16.5$) with a range between 21 and 71. The racial ethnic makeup of the sample was predominantly White (34 participants), with seven biracial participants, one African American participant, one Asian American participant, one Latino American participant, and one Native American participant. With regard to employment, 28 participants were employed, 16 were unemployed, and one was retired. In addition, 31 participants indicated that they were attending outpatient psychotherapy at the time of the study. Specific information with regard to outpatient psychotherapy type (i.e., individual, couples, family) and employment type (i.e., full-time or part-time) was not assessed.

Procedure

Participants were recruited to participate in semistructured interviews at a conference in the Northeast for transgender individuals. Selection criteria included age 18 years and older, history of receipt of mental health services, and identification as transgender or gender nonconforming. Participant incentives included \$25 for participation in the interviews. The university institutional review board granted approval for the study.

The interviews lasted approximately 60 min and took place by phone or in a private research space on a university campus where the research team was affiliated. Data recruitment and analysis was conducted in 2013. Recruitment continued until saturation of themes occurred, determined by consensus of the research team, per the standards of grounded theory methodology (Mason, 2010). Saturation was achieved when little new information emerged from data analysis (Corbin & Strauss, 2008). Audio recordings of the interviews were transcribed verbatim. Each participant signed a consent form to participate and be recorded.

The research team developed the semistructured interview guide to focus on several topics related to internalized and external stigma, coping strategies to deal with stigma and enhance vocational functioning, as well as research and service recommendations. The focus of the present article pertains to participants' experiences in mental health services. Some relevant examples of questions on this topic from the interview guide include the following: "Have you face any experiences of prejudice, discrimination, and stereotypes related to being transgender?" and "Do you have any recommendations for mental health services and research related to the topics we've addressed today?" The semistructured interview guide was reviewed by a qualitative research expert to ensure the collection of rich qualitative data and narratives on the topics at hand. The guide was then reviewed by the data auditor and expert in TGNC research and mental health care. Per the iterative process of grounded theory, interview questions were modified on an ongoing basis to address new questions that arose pertaining to the target topics of the interview. In addition, a questionnaire was used to gather demographic information.

Research Team

The primary research team members included a clinical psychologist specializing in psychotherapy and research with TGNC

individual, as well as a public health student focused in social justice-oriented research. These research team members identified as White American, cisgender, heterosexual women. The third research team member served as a data auditor and is a white American and heterosexual man with a trans history. The data auditor has a background in counseling psychology and is directly involved with advocacy and access to health care within TGNC communities. The research team held an initial meeting to examine implicit assumptions and biases (Morrow, 2005) to promote reflexivity and manage subjectivity in the process of grounded theory. This process of reflexivity in the data analysis process facilitates a researcher's examination and awareness of the impact of his or her standpoint and personal history on interpretation of data (Morrow, 2005). The specific assumptions and biases related to the research team composition that were examined for potential impact on data analysis included cis-centric and heterocentric perspectives, with input elicited from the content expert to reduce bias.

Memos were kept to track, monitor, and explore the impact of researcher biases on the interpretation of data that were discussed throughout research team meetings (Corbin & Strauss, 2008). Memos also included notes regarding each participant to assess issues of "context, culture, and rapport" (Morrow, 2005, p. 253) in the interview, specifically as to the intersection of sociocultural locations and identities of the researcher and participant, the quality and nature of the researcher-participant relationship that developed, and the impact of these factors on the interview data and interpretations generated by the research team.

Data Analysis

The grounded theory approach was used for data analysis (Corbin & Strauss, 2008). The grounded theory is an established research tradition for developing theory from raw, qualitative data (Corbin & Strauss, 2008). Grounded theory is used to develop theory as it emerges from the data depending on the extent to which the data fits the conceptual categories identified by the research team (Suddaby, 2006). This process is characterized by a constant interchange between data collection and analysis.

The first and second author conducted the data analysis. The data auditor and content expert in TGNC mental health care and research offered feedback on the codebook that was established by the two researchers, integrating revisions into the codebook. A representative sample of five interviews was selected by the research team for preliminary coding to develop the codebook (Corbin & Strauss, 2008).

A code was created for each concept that arose from participant responses during the initial review of text. After coding the first sample of interviews, the research team established the preliminary codebook. The remaining interviews were coded using the codebook. Weekly meetings were held to compare and establish consensus on codes. When occasional disagreements regarding coding arose, the coders established consensus with equitable discussion from each team member and attention to researcher power and positionality (Hill, Knox, Thompson, Williams, & Hess, 2005).

Coding was an inductive and reductive process with data organized through the identification of common themes and categories and comparison of similarities and differences in the participants'

narratives (Walker & Myrick, 2006). A comprehensive list of over 200 codes gathered from all 45 interview transcripts. Once a complete list of codes was created from all 45 interview transcripts, the codes were applied to the transcripts using NVivo qualitative analysis software, which allowed the codes to be further aggregated using axial coding to relate codes together under overarching themes that were established by the research team (Corbin & Strauss, 2008).

Trustworthiness

Various strategies were used to enhance trustworthiness of the present grounded theory study. The validity strategy of a multimember research team (Barbour, 2001) was used to develop the codebook, revise it, and create the aggregate themes. A data auditor was also used in this study (Polkinghorne, 2007) to check the codes generated by the other researchers and make recommendations for revision of the codebook. The use of this content expert served as a third research team member, allowing for investigator triangulation to enhance trustworthiness (Barbour, 2001) by taking into account and integrating multiple perspectives in interpreting the data (Morrow, 2005). Research team members conducted cross-checking (Polkinghorne, 2007) of one another's transcript coding to enhance reliability and internal validity.

Memos (Corbin & Strauss, 2008) of research meeting notes and themes were recorded and redistributed to the research team during the 4 months of data analysis to support the reflective process of qualitative analysis and data credibility. Memos included logging key excerpts, themes, preliminary interpretations of the data, as well as researcher biases and positionality. The research team aimed to achieve consensus (Edwards, Dattilio, & Bromley, 2004) to resolve infrequent disagreement about codes with attention to issues of power and social location among the researchers to manage power differential. Lastly, trustworthiness was supported through the primary researcher's activism and engagement with the TGNC community (Singh, Hays, & Watson, 2011) and involvement in the transgender conference from which the majority of participants were recruited.

Results

Grounded theory data analysis resulted in identification of several psychotherapist missteps (see Table 1). These include the education burdening, gender inflation, gender narrowing, gender avoidance, gender generalizing, gender repairing, gender pathologizing, and gate-keeping. These psychotherapy missteps are described in the following sections.

Education Burdening

This psychotherapy barrier refers to the participant feeling the need to educate the psychotherapist on TGNC issues for psychotherapy to proceed. Participants had an ineffective psychotherapy experience when the psychotherapist did not have sufficient expertise in working with TGNC clients. For example, one participant described the relief of having a competent psychotherapist given previous negative experiences. "The reason we go to [my current health center] is because you don't have to go in and teach

Table 1
Therapy Missteps With Transgender Clients

Therapy missteps	Definitions
Education burdening	Relying on the client to educate the psychotherapist on transgender issues
Gender inflation	Overlooking other important aspects of a transgender client's life beyond gender
Gender narrowing	Applying preconceived, restrictive notions of gender onto transgender clients
Gender avoidance	Lacking focus on issues of gender in psychotherapy with transgender clients
Gender generalizing	Making assumptions in psychotherapy that all transgender individuals are the same
Gender repairing	Conducting psychotherapy as if the transgender identity of a client is a problem to be fixed
Gender pathologizing	Stigmatizing transgender identity as a mental illness to be treated or cause of all problems
Gate-keeping	Focusing the psychotherapist's role on controlling access to gender affirmative medical resources

your counselor. The counselor knows things. . . . You don't have to spend 10 sessions getting them up to speed." Similarly, another participant commented on problems in training and education of psychotherapists: "There needs to be a lot more training for therapists to be able to handle gender psychotherapy." A third participant explained that this lack of training is a common phenomenon: "I think that trying to find a competent, friendly therapist is a struggle and a lot of trans people don't have a therapist that is completely aware and comfortable." Participants indicated that the lack of psychotherapists trained in TGNC care contributed to the burden of educating their psychotherapists, taking them out of the client role.

Gender Inflation

For some participants, psychotherapy was ineffective because they experienced the psychotherapist as having an exaggerated focus on gender, excluding exploration of other aspects of life. For example, one participant described the frustration of this inflated focus: "If I'm going to somebody for anxiety, all they want to talk about is how it must be because I'm trans, and how that must be the cause of all my problems, and that's very frustrating." Overstating the role of gender in one's mental health experiences and life can take psychotherapy off track and contribute to experiences of objectification of one's gender. Psychotherapists may overemphasize the impact of gender on the lives and mental health of TGNC clients. This overfocus may lead to erroneous assumptions about the etiology of a mental health problem or focus of care. As a result, a gender inflation approach can lead TGNC clients to feel that they are not being viewed as a whole person, or having their needs met in psychotherapy.

Gender Narrowing

Some participants felt that their psychotherapists had a view of gender that was limited. Participants reported experiences of the psychotherapist in these cases as attempting to fit them into preconceived notions of gender. One participant expressed her difficulty with a psychotherapist who she felt had a "formula" for gender: "She . . . had a very narrow view of gender and wanted to talk about it her way and not my way." This theme revealed the potential tendency of psychotherapists to make clinical errors by assuming a right or wrong way to explore and express one's gender. This view could overlook the diverse range of gender

identities and experiences among TGNC clients. Psychotherapists with gender narrowing tendencies may further reify traditional notions of gender and impose their implicit attitudes about gender onto the client. Psychotherapists who hold limited notions of gender may reduce the ability of TGNC clients to fully explore, clarify, and communicate their unique experiences of gender. Gender narrowing could thus interfere with the client's gender expression and diminish satisfaction with psychotherapy.

Gender Avoidance

In contrast, some participants reported experiences with psychotherapists who they felt did not concentrate enough on gender. Several participants expressed difficulties with psychotherapists who they felt did not have adequate training in both TGNC issues and mental health. For instance, a participant described the struggle to find one psychotherapist who could address all of their issues:

I feel like trans people have two options: they find a therapist who knows how to do trans stuff, but might not be good at talking about depression or anxiety or whatever other mental health issue they have going on. Or, they find a therapist who can talk about the mental health problem, and who can't understand what it means to be transgender.

Another participant indicated that TGNC identity was not explored at all in psychotherapy because the psychotherapist indicated it had been "ruled out." This participant explained, "I think that the therapist being so confident that there was no reason for us to explore trans identity really colored the course of my mental health treatment." These excerpts suggest potential experiences with psychotherapists avoiding the topic of gender due to the lack of general training in TGNC issues, or lack of awareness of the more subtle and complex ways that one's gender can impact mental health experiences.

Gender Generalizing

Another psychotherapy misstep was gender generalizing—making assumptions in psychotherapy that all TGNC individuals are the same. One participant spoke of this problem with a psychotherapist who did not appreciate the diversity and within-group differences in the experience of gender variance. This participant stated, "Each of us is unique and there's no one size fits all, so you

know. There's [sic] oftentimes I didn't listen to my therapist because I knew she was saying something that didn't fit for me." Gender generalizing involved the assumption of a universal narrative in the experience of gender, as well as the process of affirming one's gender. Gender generalizing occurs when psychotherapists do not listen for, detect, and understand the unique experiences of gender among TGNC clients. As seen in this excerpt, gender generalizing can lead TGNC clients to tune out or disengage from psychotherapy.

Gender Repairing

Some participants reported that their psychotherapists conducted sessions as if one's transgender identity was a problem to be "fixed." This process is labeled here as *gender repairing*. Reparative therapies have been used for TGNC and LGB individuals to attempt to change the person's gender or sexual orientation to the dominant norm. These types of therapies are ethically dubious and may result in significant harm. Unfortunately, some TGNC clients may have a history of encountering providers who take this approach or believe in its value. For example, one participant described an experience with gender repairing in psychotherapy.

I had gone to a therapist with my wife early on she wanted to see the two of us. She was making comments like, 'I know this hypnotist. Maybe we can get this hypnotist to help you overcome this.' I was like, 'Lady, you don't know what you are doing.' So . . . I've seen some real crackpots . . .

As seen in this excerpt, some psychotherapists might continue to make blatant recommendations of gender reparative psychotherapy to "cure" or be "trained out of" a TGNC identity. This participant appeared to experience this approach as unprofessional and incompetent and exited treatment. However, other TGNC clients may have prolonged encounters with this approach, which worsen beliefs that one's gender needs to be changed to conform to dominant norms. Although some psychotherapists might not practice a comprehensive gender repairing intervention, they may still hold subtle or covert gender repairing beliefs that can alienate or harm TGNC clients.

Gender Pathologizing

Similarly, gender pathologizing was found when TGNC clients experienced the psychotherapist to be labeling gender variance as a pathological condition or mental illness requiring treatment, or responsible for all problems. One participant spoke of her difficulty with this experience: "A lot of [doctors and psychiatrists] seem to think that me being transgender is a mental health illness, and that's why I have all these problems." As seen in this example, some providers label gender variance as a mental illness, treating TGNC folks as mentally disordered. Furthermore, pathologizing gender might entail attributing all mental health or other problems to transgender identity, contributing to further stigmatization of gender. Labeling TGNC identities as a mental illness or psychological disorder may contribute to a sense of deficiency in their gender, feelings of shame, and stigma. Gender pathologizing can lead TGNC clients to develop negative attitudes toward oneself and psychotherapy, and an aversion to seeking psychotherapy in the future due to feeling misunderstood or stigmatized.

Gate-Keeping

A final barrier to trans-affirmative psychotherapy was a negative experience of psychotherapists as gate-keepers. This occurred when the client experienced the psychotherapist as overfocused on controlling access to gender-affirming medical resources. In these cases, the psychotherapist might be perceived as focused on completing the required paperwork for gender-related medical procedures, rather than focusing on the quality of the psychotherapy itself. This experience led one participant to be less open with her psychotherapist:

I was very reluctant to give her all of my feelings about being transgender because of this whole gate-keeping thing that goes on with the medical community. . . . I really told her a lot of what she wanted to hear. Honestly, I held back a lot of things.

One surprising finding pertained to issues with gate-keeping. As stated in the introduction, previous literature has presented TGNC individuals to experience gate-keeping as an overly restrictive role. However, some participants in this study reported negative experiences of gate-keeping when performed in an overly permissive manner. For example, negative experiences with gate-keeping were reported when the psychotherapist was perceived to be performing gender assessment and letter-writing responsibilities in a more perfunctory manner. For example, one participant was told by a psychotherapist, "We'll just do the eleven appointments you need, and I'll give you the piece of paper." This participant described the psychotherapists' attitude toward psychotherapy with the client as obligatory, missing the opportunity to be helpful to the client. These excerpts highlighted the negative experience of psychotherapists in a gate-keeping role that becomes a means of exerting control, power, or cursory fulfillment of WPATH Standards of Care.

Discussion

This grounded theory study identified several themes pertaining to psychotherapy missteps, including education burdening (relying on the client to educate the psychotherapist on transgender issues), gender inflation (overlooking other important aspects of a transgender client's life beyond gender), gender narrowing (applying preconceived, restrictive notions of gender onto transgender clients), gender avoidance (lacking focus on issues of gender in psychotherapy with transgender clients), gender generalizing (making assumptions in psychotherapy that all transgender individuals are the same), gender repairing (conducting psychotherapy as if the transgender identity of a client is a problem to be fixed), gender pathologizing (stigmatizing transgender identity as a mental illness to be treated or responsible for all problems), and gate-keeping (focusing the psychotherapist's role on controlling access to gender affirming medical resources). As a whole, participants identified these subtle and overt dynamics in the therapeutic process as psychotherapy barriers that could interfere with the quality of care or decision to sustain engagement in psychotherapy.

This grounded theory study links to the current literature in a number of ways. As seen in previous research, TGNC individuals have complained of needing to train or educate their medical providers in their care (Grant et al., 2011; Poteat et al., 2013). This

finding was also seen in the psychotherapy missteps in this data, termed education burdening. Naming this experience in the present study can give language to this occurrence, raising awareness of common barriers to care. It is important to note that other authors have argued for approaching the clinical encounter with clients from marginalized backgrounds with curiosity and naiveté (Dyche & Zayas, 1995). In some cases, this may be a strategic stance to rebalance power. However, this study and other literature suggest that TGNC clients might experience the educator role as burdensome and indicative of gaps in psychotherapist training and competence. In addition, the results confirmed some of the findings in a study of interpersonal and systemic microaggressions toward TGNC people in general (Nadal, Skolnick, & Wong, 2012). Specifically, the present theme of gender narrowing corresponded with their identified microaggression of “assumptions of universal transgender experience.” In addition, the theme of gender pathologizing corresponded to their identified microaggression of an assumption of sexual pathology/abnormality.

The psychotherapy missteps of gender inflation, gender pathologizing, gender avoidance, and gender repairing highlight the nuanced ways in which TGNC identities may be objectified, Otherized, ignored, or stigmatized. These incidences have been touched on in more general ways in the literature. However, the present findings distinguished the subtle and distinct differences in problems in the therapeutic encounter with TGNC clients. These factors reflect the extent to which gender may not only be avoided or pathologized but also overfocused upon or exotified due to tendencies among the public to hypersexualize TGNC identities.

The gender pathologizing theme raises the debate associated with the gender dysphoria diagnosis, formerly gender identity disorder (Meier & Labuski, 2013). Part of this theme reflected problems that occur when gender variance is labeled as a mental disorder. One argument in this controversy is that the gender dysphoria diagnosis helps to garner insurance reimbursement for hormone psychotherapy and gender confirmation surgeries. Another argument is that the diagnosis might legitimize the psychological distress some experience in the incongruence between one’s gender identity and birth sex. Alternatively, it is argued that this diagnosis might stigmatize gender variance, resembling previous labeling of homosexuality as a psychiatric disorder. Regardless of one’s position on this controversy, this theme clarifies that issues emerge when one’s problems—psychological, medical, or otherwise—are misattributed to gender nonconformity.

The gate-keeping theme also corresponds with previous literature on problems with the WPATH Standards of Care letter writing and psychotherapy mandates for individuals seeking medical resources to affirm one’s gender. Psychotherapy mandates in the WPATH Standards of Care can interfere with client satisfaction, pose financial hardship, and reflect ethical problems of this role (Bockting et al., 2004). Rachlin (2002) also found that the psychotherapist’s gate-keeping role may not be perceived as a barrier to care when clients still feel their needs are being met. However, this psychotherapy misstep suggests that the gate-keeping role of the psychotherapist may be problematic when the psychotherapist is experienced as noncollaborative or superficial in the performance of this role. In these cases, gate-keeping can pose problems to the psychotherapy process. A particular contribution in the present study to the literature was the finding that gate-keeping could be experienced not only in an overly restrictive approach.

Gate-keeping was also experienced in an overly loose approach that could be perceived as not taking the role seriously and not carrying out this responsibility with care and precision.

It is also important to note the potential impact of transphobia and anticipatory stigma on participants’ descriptions of the therapeutic relationship. Anticipatory stigma among TGNC individuals refers to expectations and preparations for prejudice and discrimination (Mizock & Mueser, 2014). Experiences with transphobia and minority stress could potentially lead to expectations of rejection or discrimination in the therapeutic relationship, weakening the therapeutic alliance. The client might expect or prepare for transphobia in psychotherapy and thus engage in repetitions of previous patterns of educating the psychotherapist and over- or underfocusing on gender. Moreover, psychotherapists may be attempting to avoid pathologizing TGNC identities or demonstrate competence by avoiding or inflating gender, respectively. This dynamic might suggest a transactional nature to the impact of transphobia in the therapeutic encounter; previous experiences with transphobia might impact future interactions between a psychotherapist and client, interfering with treatment satisfaction.

Implications for Counseling and Psychological Practice

Several clinical implications arise from these findings. First, it is important for all psychotherapists to be trained in the provision of mental health services to TGNC clients. The Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (APA, 2015) provide comprehensive guidance for competent and ethical treatment of TGNC individuals. Many of the findings in our study make direct links to these guidelines, suggesting further clinical implications of this work. For example, the therapy misstep of gender narrowing describes the tendency for therapists to apply preconceived, limited notions of gender onto TGNC clients. Linking to this theme is Guideline 1, which indicates that psychologists recognize that gender is not a binary construct but allows for a range of gender identities. Guideline 1 encourages practitioners to avoid imposing rigid gender expectations onto the client that occurs with gender narrowing approaches, making room for gender diversity. Our findings stressed the importance of supporting clients’ individual narratives of gender, avoiding limited assumptions. This openness might reduce gender-stereotyped responses in gender assessments and psychotherapy sessions. Caution should be taken to avoid pathologizing gender nonconformity, creating a nonjudgmental space to explore one’s gender expression.

Conversely, we identified the theme of *gender inflation*—the tendency for practitioners to excessively focus on the issue of gender among TGNC clients, overlooking other important aspects of life. The gender inflation theme pertains to Guideline 3, which specifies that psychologists must understand that gender is not always the most salient aspect of a TGNC person’s life. The gender inflation approach may dehumanize or exotify the TGNC individual, interfering with addressing important aspects of one’s mental health and life experience.

We also identified another relevant theme to the guidelines of gender repairing—when psychotherapy is conducted as though the TGNC identity of the client is a problem to be fixed or cured. Guideline 6 also indicates that positive life outcomes are more likely when psychologists support the gender identity and gender

expression of TGNC individuals. In contrast, gender reparative approaches are more likely to yield negative life outcomes, as documented in the accounts of participants in this study who spoke to the theme of gender repairing.

Guideline 9 specifies that psychologist recognize the importance of an interdisciplinary approach to providing quality care to TGNC individuals. Our findings also suggest that the incorporation of case management and advocacy in psychotherapy can facilitate access to resources and reduce transphobia in the multiple systems in which the client lives (Carroll & Gilroy, 2002). Clinicians should seek additional training, consultation, and supervision to enhance trans-affirmative care (Mizock & Lewis, 2008). These findings add to the need for psychotherapists to assess past negative experiences with psychotherapy and broach the impact on the ongoing dynamics in the psychotherapy process. Moreover, mental health providers who are following the WPATH Standards of Care for gender affirmation procedures should avoid overasserting power in this role. However, based on our findings, psychotherapists should also take this role seriously and use the opportunity to be of greatest benefit to the client's mental wellness by carrying out required services with care.

Guideline 16 indicates that psychologists should strive to reduce stigma faced by TGNC individuals. With regard to advocacy, our findings also reflect the need for continued lobbying against gender reparative approaches and advocacy for the practice culturally responsive care in counseling and psychological practice settings that supports a range of gender expressions. Advocacy can be directed to include gender sensitive training and provision of care in mental health and medical training programs via national credentialing and accreditation programs. This advocacy can reduce education burdening dynamics. This advocacy can also enhance the quality of culturally responsive care with TGNC clients to promote positive therapeutic relationship and reduce the occurrence of psychotherapy barriers.

The general clinical implications of our findings are supported in Guideline 5, which specifies that psychologists recognize how their understanding and attitudes about gender identity and expression impact the quality of care they provide to TGNC individuals. Our findings in general reinforce the importance of self-awareness among therapists, who must examine their biases to avoid perpetuating pathological, limited, or stereotyped notions of gender in the psychotherapy encounter.

Limitations and Future Research

This research would benefit from quantitative follow-up research with a larger sample size and participants from a wider geographic area to enhance external validity, as well as randomization of selected participants to reduce selection bias. Outpatient psychotherapy type (i.e., individual, couples, family psychotherapy) could be specified in future research to collect data as to variations in treatment satisfaction among these different modalities, given that different modalities may lead to different barriers in care. The use and development of a measure with targeted questions focused on the themes found in the present study could further evaluate these findings among other TGNC participants and inform future research.

In addition, trans feminine versus trans masculine populations may have unique differences, and grouping them together in this

study may fail to fully capture within-group variation. The non-random selection process and inclusion of TGNC participants who have received psychotherapy also impact generalizability, leading to a sample of participants who were willing to speak with a clinician-researcher about their experiences in mental health care. The sample was also predominantly White, limiting generalizability to other racial-ethnic cultural groups.

Although a number of trustworthiness strategies were used, additional trustworthiness methods would have been beneficial. Other trustworthiness strategies could include member-checking (participant review of research themes), reflexive journaling, negative case analysis (searching for contradictory patterns and explanations in the data), and consultation with an outside peer debriefer. These strategies would benefit future qualitative research in this area.

Randomization would have also reduced limitations with regard to selection bias. Another limitation of the data was the impact of recall bias in participants' interviews, potentially limiting the accuracy and/or totality of the recollections of prior experiences in psychotherapy. Further assessment of the competency and training of a representative sample of psychotherapists with culturally responsive care can provide another estimation of the tendency of psychotherapists to place an educational burden on TGNC clients. The focus of the present study is on psychotherapy barriers and missteps. Further research is recommended to focus on the qualities of successful experiences in psychotherapy among TGNC clients to balance this perspective. The present study findings are presented to inform gender sensitive care as opposed to discouraging psychotherapists from conducting this work. Ultimately, therapists can become informed of these common psychotherapy missteps to enhance sensitivity to gender diversity

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