

THE STATE OF TRANSGENDER AND NON-BINARY AFFIRMATIVE TRAINING IN
MENTAL HEALTH GRADUATE EDUCATION: EXPLORATIONS AND IMPLICATIONS
FOR CLINICAL PRACTICE

by

JOSHUA LEROY BOE

(Under the Direction of Elizabeth Wieling)

ABSTRACT

Transgender and non-binary (TGNB) people continue to face marginalization within the mental health field. Such barriers include provider's insensitivity, internalized cisgenderism, microaggressive behaviors (e.g., misgendering TGNB clients), and lack of skills and knowledge to work effectively with the TGNB community. Scholars continue to find mental health providers report a lack of knowledge in their clinical training. This dissertation used a multi-method, multi-phase design to explore the state of TGNB affirmative therapy in mental health graduate education. In the Phase 1, data was collected from students ($N=134$) and faculty ($N=55$) from nationally accredited clinical training programs (APA, CACREP, COAMFTE, and CSWE). Non-parametric tests were used to examine mean score differences in student's and faculty's self-reported clinical competency and perceived level of affirmative training of their program. In addition, path analyses were conducted to examine associations between self-reported clinical competency and perceived level of affirmative training. Phase 2 used contextually-situated narrative inquiry to gather in-depth accounts from eight experts in TGNB affirmative therapy of their professional development, experiences in the field, and their recommendations for the

future. Using the three interviews, narratives were constructed for each participant. These narratives were then used for a deductive thematic analysis within the pre-established categories: professional development, experiences in the field, and recommendations. Results indicated students and faculty self-reported limited clinical competency and affirmative training in their graduate programs. These findings were substantiated from the eight mental health experts in TGNB affirmative therapy who reported noticeable changes in their subdiscipline, but more work needs to be done in terms of providing adequate education to mental health providers. In particular, the effects of cisgenderism on the mental health field needs to be examined and cisgender mental health providers need to engage in their own gender work to be proactive against cisgenderism in their clinical practice. Implications for clinical training are discussed in light of these findings.

INDEX WORDS: Transgender; Non-binary; Mental health; Affirmative training;
Clinical practice; Cisgenderism

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DEDICATION

First, I would like to dedicate this dissertation to the trans lives lost over the dissertation period: Dustin Parker, Alexa Neulisa Luciano Ruiz, Yampi Méndez Arocho, Monica Diamond, Lexi, Johanna Metzger, Penélope Díaz Ramírez, Layla Pelaez Sánchez, Serena Angelique Velázquez Ramos, Nina Pop, Helle Jae O'Regan, Tony McDade, Dominique "Rem'mie" Fells, Riah Milton, Jayne Thompson, Selena Reyez Hernandez, Brayla Stone, Merci Mack, Shaki Peters, Bree "Nuk" Black, Summer Taylor, Draya McCarty, Tatiana Hall, Marilyn Cazares, Tiffany Harris, Quesha D. Hardy, Brian "Egypt" Powers, Aja Raquell Rhone-Spears, and many others. May this dissertation serve as a step towards dismantling cisnormativity and transnormativity ideology that robs trans people, particularly trans women of color, of their lives, but not their dignity.

Second, I would like to dedicate this dissertation to the trans folks who do not have the privilege of obtaining a higher degree or those who had to choose their mental health over the degree because of trans-negativity in the academy. May this work serve to create a more trans inclusive environment.

Lastly, I dedicate this work to my family of origin: Jerad, Zach, Mackenzie, Haley, and Jr. – You all told me not to return to North Dakota until I was a doctor, so the next time we meet kindly refer to me as "Dr. Boe." And to my chosen family: Dawn, Kalene, Meredith, Sam, Suz, Sara, Figz, and many more – I thank you for being there through the laughter, tears, at times immobilizing doubt, and righteous anger. Without all of your continued support, I would not have made it to another closing of a chapter.

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CHAPTER 1

INTRODUCTION

In the past decade, lesbian, gay, bisexual, and transgender (LGBT) rights have progressed for United States (US) citizens. Examples of these rights include the right to legally marry in all states and territories, laws supporting child adoption by LGBT people in some states (Hooghe & Meeusen, 2013), and alterations of sex markers on birth records for transgender and non-binary people (Singh & dickey, 2017). With increased visibility, the US has become more tolerant towards the LGBT community (Jacobs & Meeusen, 2020). While visual representation for LGBT people has increased, representation remains cisgender focused (Jacobs & Meeusen, 2020). Gay men and lesbians are more actively represented in the media compared to transgender people (Jacobs & Meeusen, 2020). Such inequitable representation occurs within many systems, including research.

Singh and Shelton (2011) conducted a content analysis examining the past decade of journal articles on LGBT issues in counseling and psychology, which revealed a total of 12 empirical articles published. This trend is similar in the couple and family therapy (CFT) field. Blumer, Green, Knowles, and Williams (2012) found that of 10,379 articles examined across 17 journals, only nine were related to transgender issues or used gender variance as a variable. These content analyses indicate literature on gender identity, specifically transgender identities, is an underserved and under-researched area (Balsam, Molina, Beadnell, Simoni, & Walters, 2011; Singh & Shelton, 2011). In fact, research and literature on LGBT issues often excludes the “T” entirely, even when using the acronym (Koken, Bimbi, & Parsons, 2009; Sanchez & Vilian,

2009). Within the past few years, there has been an increase in articles related to the TGNB people's experiences in mental health. There have been notable contributions to the mental health field in understanding TGNB clients' experiences in seeking services (Anzani et al., 2019; Brotman et al., 2015; Conlin et al., 2019; Lefevor et al., 2019; Matsuzaka, 2018), strategies for providing TGNB affirmative care (Boe et al., 2019; Edwards et al., 2019; Knutson et al., 2019; McGeorge et al., 2021; Oransky et al., 2019; Rider et al., 2019), and examining how cisnormativity (see p. 4 for definition) shapes the mental health field (Boe et al., 2020; Borba & Milani, 2017; Wagaman et al., 2019; Worthen, 2016). Because there is a lack of articles focusing on transgender and non-binary (TGNB) issues, clinicians often report feeling under-educated and lack the necessary training to work effectively with TGNB people (Benson, 2013; Whitman & Han, 2017).

Statement of the Problem

Compared to their cisgender peers, TGNB people face physical and mental health inequalities (White-Hughto et al., 2015). To address these inequalities, the World Professional Association for Transgender Health (WPATH) created guidelines for promoting inclusive and trans-specific care (i.e., Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People [SOC]; Coleman et al., 2011). Although these guidelines exist, there is still a lack in TGNB affirmative care (Brown et al., 2018). TGNB people are concerned with real and perceived stigma, transgender oppression, and cisnormative attitudes perpetuated by clinicians (Austin et al., 2017; Benson, 2013; Coleman et al. 2011), which impacts their willingness to seek services. Shipherd, Green, and Abromovitz (2010) reported that of the 130 TGNB people in their survey, 68 verified the need for mental health services, but failed to seek

support in the last year. Key barriers addressed were knowing someone who had received inadequate care and stigma concerns, which may relate to provider insensitivity.

As TGNB issues become more visible in the literature, scholars are finding that clinicians often hold negative attitudes toward TGNB people (Brown et al., 2018; Dorsen, 2012; Grant et al., 2011; Johnson, 2014). Nadal, Skolnic, and Wong (2012) found that TGNB clients experience numerous forms of micro-aggressions from mental health providers. Microaggressions are “brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups” (Nadal, 2008, p. 23). Common micro-aggressions TGNB people experience in the mental health field are explicit expressions of disapproval or discomfort with TGNB people, pathology, and inappropriate questions about genitals (Johnson, 2014). In addition, TGNB people often experience misgendering from their providers (Blumer et al., 2013).

Few studies investigate clinical competency related to TGNB issues. Dispenza and O’Hara (2016) examined correlates of TGNB competencies among 102 master’s level counselors and social workers, as well as doctoral-level psychologists. They found identifying as a sexual minority, ethnic and/or racial minority, and having eight or more years of clinical experience was associated with higher levels of TGNB competency. Dispenza and O’Hara (2016) did not examine the role receiving TGNB affirmative training has on levels of TGNB competency. Riggs and Bartholomaeus (2016) examined mental health professionals’ competencies when working with TGNB clients in Australia. They found that training and previous experiences in working with TGNB clients was associated with increased levels of knowledge. Whitman and Han (2017) investigated training experiences, understanding

terminology, and TGNB competencies at various training levels. They found participants expressed unfamiliarity with, and a lack of training on, TGNB issues. However higher clinical competency was associated with increased introspection and examining biases.

The purpose of this multi-method dissertation study was two part. First, I sought to investigate faculty and student levels of TGNB clinical competency and levels of training in TGNB affirmative therapy using validated and reliable measures. Second, I qualitatively examined the experiences of elites, those who have obtained expert knowledge related to TGNB affirmative therapy, and how they believe the mental health field can improve clinical training and increase TGNB competency in service delivery. There were three aims to this dissertation. First, to assess faculty and student perceptions of TGNB affirmative training in their program and clinical competency working with the TGNB community. Second, to generate strategies from elites in the mental health field to continue to advance TGNB affirmative training practices. Lastly, the larger aim of this dissertation was a call to the broader mental health field to address the inequality and transgender oppression the TGNB community experiences at the hands of “helping” professionals. The remainder of this chapter is dedicated to terminology and theoretical frameworks that guide the dissertation.

Terminology

There are several terms used in this dissertation that require a clear definition. I acknowledge the terminology within the TGNB community continues to evolve, and these terms are bound within this specific context (Singh & dickey, 2017). Cisnormativity and transnormativity shape the context in which these terms are defined. Cisnormativity is a cultural phenomenon in which people privilege and normalize non-transgender experiences (Hudson, 2019), which leads to marginalizing and oppressing transgender people. Transnormativity is a set

of politics that reify cisnormative assumptions of sex and gender (i.e., binary system). Identities outside of the gender binary (i.e., woman/man) and sex binary (i.e., female/male) are dehumanized.

In an act of resisting cisnormative and transnormative ideologies, I want to disentangle sex and gender. Sex and gender are often conflated and used interchangeably (Lev & Sennott, 2012). On the one hand, sex refers to the determination of biological femaleness and maleness (West & Zimmerman, 1987), which is usually determined by a person's genitalia and other "sex" characteristics (e.g., voice, body hair, hormones, and genetics). In the US, sex is typically thought of as being either female or male and is assigned to us at birth (Singh & dickey, 2017). On the other hand, gender is socially constructed often originating with assumptions that people make about a person's sex (Singh & dickey, 2017). There are various implicit and explicit rules about how a person should perform their gender (Butler, 1990). Feminine and masculine characteristics are often markers of how gender is performed. TGNB people often do not ascribe to the gender binary.

TGNB people often define and describe gender on a spectrum and that a person may identify along that spectrum (Singh & dickey, 2017). Gender identity is a term used to describe a person's felt sense of themselves regardless of their sex assigned at birth (Lev, 2004). It is fluid and can shift over time, especially for TGNB people (Singh & dickey, 2017). Within the TGNB community there are a variety of terms a person might use to describe their gender identity. In one study, over 500 respondents used different terms to describe their identity (e.g., trans man, trans woman, female-to-male, and male-to-female; Grant et al., 2011). In addition, gender diverse, gender expansive, and gender creative are terms used with TGNB youth (Angello, 2013; Ehrensaft, 2011). More recently, some youth will use the terms assigned female at birth or

assigned male at birth (Singh & dickey, 2017). Gender expression is the culmination of many factors such as gender performance and outward appearance (e.g., style and manner of dress, type of haircut worn, and the pronouns used; Lehavot, King, & Simoni, 2011; Singh & dickey, 2017). Because there are a variety of ways in which TGNB people may identify and express themselves clinicians are cautioned to not make assumptions about the labels or lack of labels people use to describe themselves (Singh & dickey, 2017).

For those who do not identify as TGNB, the term cisgender is used to describe those whose assigned sex at birth is consistent with their gender identity (Serano, 2007). Cisgenderism is a component of cisnormativity in that it privileges the gender binary and creates an expectation that people will perform their gender as dictated by their assigned sex at birth (Serano, 2007). In this dissertation cisgenderism is used in lieu of cissexism. Cisgenderism expands the oppression that encompasses sexism (i.e., power and privilege associated with “maleness”) and the power and privilege of identifying as cisgender (Lennon & Mistler, 2014). For example, a cisgender woman may advocate for anti-transgender legislation. Such an action would not be considered sexism but would be captured under cisgenderism (Lennon & Mistler, 2014). Because of these social constructs, TGNB people often face discrimination and oppression related to their gender identity and expression. Transgender oppression refers to the system of oppression that targets and marginalizes TGNB people (Catalano & Shlasko, 2013), which can in turn be internalized.

Theoretical Framework

For the purpose of this dissertation research, I utilized queer theory as a meta-theory to inform ecological systems theory. Meta-theory is “primarily the study of theory, including the development of overarching combinations of theory, as well as the development and application of theorems for analysis to reveal underlying assumptions about theory and theorizing” (Wallis,

2010, p. 78). From a meta-theoretical perspective, queer theory can be used as tool to examine how larger social structures influence the types of systems we interact with and how those systems turn us towards cisnormative ideologies. In this section, I further outline queer theory and ecological systems theory.

Queer Theory

Butler (1993a) suggests the term “queer” remains never fully owned, only redeployed and twisted from prior usages. It continues to be elusive and expansive (Sullivan, 2003), yet can become what is urgently necessary for political expansion (Butler, 1993a). Therefore, the “queer” in queer theory can be read differently. As a noun, queer refers to subjective experiences. That is queer (n) theory is used to center the experiences of LGBT people and queer subjectivity. However, when “queer” is used as a verb, it takes a different stance. Queer (v) theory challenges theorists to look at theory from different perspectives and highlight taken-for-granted assumptions to reveal hidden radical potential (Greene, 1996). In this vein, queer is a resistance to normal rather than a subjective position (Butler, 1993b; Halperin, 2003). For the purpose of this dissertation research, I employed queer (v) theory. While the subject of this dissertation is related to TGNC subjectivities, I intentionally invoked queer theory to reveal and unhinge the influence of cisnormativity and transnormativity in clinical graduate training programs and how these impact competency and affirmative training. The meta-theoretical application of queer theory also extended into my research methodology.

Queer scholars contest the hypothetico-deductivism that social scientists use to mimic the “natural” sciences by using words like *theory*, *experiments*, and *laws* (Clarke & Primo, 2012). Queer methods use the limitations of hypothetico-deductivism model to advance two major innovations about how we study the social world. First, queer social research methods question

the origins and the effects of concepts or categories rather than perpetuating the “allegedly generalizable variable-oriented paradigm” (Brim & Ghanziani, 2016, p. 16). Second, queer social research methods reject the fetishizing of the observable. That is queer empiricism seeks to embrace multiplicity, misalignments, and silences (Brim & Ghanziani, 2016). Queer methods offer a framework for “making space for what is” as they illuminate the messiness of the intersections among theory, lived experience, and practice (Love et al., 2012, p. 144). In many ways this dissertation is informed by queer methods as I sought to explore the messiness of faculty and student self-reported level of competency and affirmative training, and the lived experiences of elites in the field, which may illuminate multiple narratives. For example, faculty members and students may rate themselves highly, whereas elites may share that clinical graduate training programs are not doing enough to adequately prepare students to work effectively with TGNB clients.

Phenomenological Variant of Ecological Systems Theory (PVEST)

Human experiences are shaped by objective reality and perception. From a phenomenological perspective, individuals come to understand and respond to their world through interactions with others, and through the meaning they make from those encounters (Spencer, 2008). These interactions are mediated through social settings. For example, Bronfenbrenner’s ecological system theory (1977) posits that individuals interact with intersecting and overlapping systems (i.e., micro-, meso-, exo-, and macro-system). Therefore, it is unavoidable that individuals have experiences that represent active meaning making as the function of the quality of the individual-context interactions (Spencer, 2008). As such, combining phenomenology with ecological systems perspectives improves the *how* of development, which differs from the traditional linear assumptions of the *what* of development

(Spencer, 2008). To account for this phenomenological quality of ecological systems theory, Spencer (1995) developed the phenomenological variant of ecological systems theory (PVEST).

PVEST is a dynamic and recursive framework that Spencer developed to encourage the critical analysis of human developmental processes that unfold within multilevel contexts over time. This process-focused perspective contributes to understandings about individual-context interactions. Specifically, it attends to the following: a) the inescapable and diverse phenotypic expressions of human genotype, b) biologically influenced temperament, c) outcomes of socially constructed categories, and d) interactions with the multiple characteristics of psychosocial contexts (Spencer, 1995, 2008). Because PVEST combines phenomenology with ecological systems theory, it provides a heuristic device for understanding the unique experiences of diverse group members with varying developmental periods and social locations. In addition, it seeks to account for the social inequalities that impact contextual experiences (Spencer, 2008). To further extend PVEST's foundation, I incorporate ideas from Edwards, Goodwin, and Neumann's (2019) extension of Bronfenbrenner's ecological systems theory. In their model, they discuss the ways in which trans oppression and clinical implications for TGNB inclusive practices are nested within and across the micro-, meso-, macro-, and chrono-system. Because of the nature of this dissertation, I would be remiss if I limited data analysis, interpretation, and implications to certain systems while neglecting how these systems co-act in various ways. For example, a TGNB clinical graduate student may have a phenomenologically different contextual experience compared to their cisgender peers because of the influence of transgender oppression within and across systems. That is, they may experience microaggressions in their clinical graduate program, the university system, national and international organizations, and the larger society. Another example is the phenomenological differences in education and clinical experiences

among master's level trainees, doctoral level trainees, and faculty with more years of practice. Such experiences may or may not contribute to competency and skills related to TGNB affirmative therapy because of their varied contextual experiences.

Self of the Scholar

Pillow (2003) defines reflexivity as the critical reflection on how researchers, participants, settings, and procedures interact and influence each other. Qualitative researchers often illustrate reflexivity through inquiring about their own subjectivities and how those influence the study throughout the entire process from developing to disseminating knowledge (Glesne, 2016). While bias should be monitored, researchers' subjective experiences in terms of personal history and passions can contribute to research (Glesne, 2016). As a scholar informed by queer theory, I align with practices that require us to question our "self" and how we shape *what, when, where, and how* we examine phenomena. Therefore, my goal is to articulate the ways my personal background and professional interest shaped the current study. I acknowledge it is not possible to fully understand how each of these domains influenced the study, nor which feelings emerged throughout the process. However, through memo-writing and peer debriefing I was able to become more aware of how my feelings could impact my interpretation of the data.

Personal Background

I write this dissertation from a stance of humility, grief, and righteous anger. I think about the unsurmountable number of TGNB lives taken by transgender oppression. Those who had dreams that may not have come to fruition – dreaming of old age, only to be murdered at a young age. Even in this moment, I reflect on how my cousin died from the internalized transgender oppression which convinced them they were better off dead. I think of my own experiences with ignorance and bigotry – the uncountable times where I had to educate others; those who claim to

be affirming, and those who do not. I feel the emotional, physical, and spiritual exhaustion of living in a cisnormative world, yet I move forward. I am propelled by desire to honor the many TGNB people who came before me and those who will come after me. In many ways, I owe it to my TGNB siblings who have risked their lives to envision and create an inclusive world.

Owning one's story is somewhat difficult, especially as I write this for others. I am aware gender identity varies among readers of this dissertation. Therefore, I am going to take a moment to address cisgender and TGNB readers. You may feel discomfort in what I am about to share. I encourage you to sit with the feelings evoked and to critically reflect on why certain feelings emerged. First to the cisgender readers, I struggle with how much of my experience I can authentically share with you all. I am sure what I do share with you all leaves you with more questions and a desire to know more. Although that is a typical response, I want you to recognize how that in some ways positions myself and other TGNB people as exotic. I am sure at this point some of you are thinking to yourself, "But I would never do that. I am an ally/advocate/co-conspirator." Whichever label you give yourself does not matter. You need to understand TGNB people rarely experience *true* safety. I can tell you even with my committee of strong cisgender women, who are often expected to be safe within academia, there were moments I was not safe and took various risks. Because of the lack of safety, I relied on others outside of the system of UGA to process and navigate my encounters with cisnormativity and trans oppression. For the cisgender readers who made it this far, I offer two pieces of advice – take some time to work through your cis fragility and please quit trying to offer what you think are solutions to trans oppression.

To the TGNB readers, your experiences are valid, and you are far from crazy. From what I have experienced, I have come to wonder how our "mental health" is weaponized by cisgender

peers and faculty as a distraction for them to avoid doing their work to dismantle cisnormativity and trans oppression within academia and larger society. Our pain is real as too is our resiliency. For the BIPOC TGNB readers, I will work tirelessly to counter how Whiteness is leveraged within the community and hold myself and other White TGNB people accountable for how we perpetuate White supremacy at the costs of your lives. I know I will repeatedly fail but I will dust myself off and be better.

It is interesting for me to use narrative inquiry because I often feel constrained by traditional narrative structures (i.e., beginning, middle, and end). I find being non-binary does something with time. TGNB people, especially TGNB women of color, are murdered for merely existing. I do not know when my final day on this plane of existence will be. Therefore, this feels like my beginning, middle, and end. It is hard to put into words how my non-binary identity emerged, it has always been present yet out of reach. The cliché of feeling different is the theme of my life. I hate being confined to how one must be and act. I have always played with gender. Even though I am read as a man, I resist cisnormative behavioral expectations. For example, my friend group continues to consist only of cisgender women. As a child, I was called a tom-girl and an uncle questioned why I was friends only with girls. I remember thinking, “Why does it matter that my friends are girls? Why does it matter if I enjoy doing things that are *typical* for girls?” And while I questioned/question what was/is normal, I still feel the pull towards it, almost longingly. There are days where I question if I am non-binary and other days where I truly feel and know that I am. Hell, there are moments I think to myself, “Should I just transition to a woman?” I am realizing I feel more peace with who I am when I am with others who are inclusive, embrace my playfulness with gender, and fight with me against cisnormativity and transgender oppression. I think of the lives that may not have been taken if the world was more

inclusive. If those people had someone to fight with them, would they still be here? There's liberation with queerness and there's heartache. Those experiences are what informs my professional interests, as the saying goes, "research is me search."

Professional Interests

First and foremost, I am a feisty activist trying to disrupt normative ideologies. Most days, I fall short and reify what I hope to dismantle. This stance is etched into the entire premise of this study and I do have a political and professional agenda. This dissertation is a call to action and a call to arms. It is long overdue for mental health providers and scholars to act. The field is in desperate need for transformative change. To begin, I align with critical social theories and post-structuralism. I believe the experiences and stories we construct are done so relationally; with people as well as with the existing social structures in place, which are rooted in systemic power, privilege, and oppression. Epistemologically, I believe there are multiple truths; however, I acknowledge certain truths are valued more than others. As such, I value the personal experiences of those silenced, including myself. There is a richness to the stories that are told and untold. The acts of silence rendering thunderous echoes of resistance.

As a Human Development and Family Science doctoral candidate with an emphasis in systemic therapy, I am committed to systems perspectives in my research and practice. People develop and interact in various relational contexts (Bronfenbrenner, 1977), which are not without consequence. Living in a cisnormative society negatively impacts TGNB people, as evidenced by the disproportionate health outcomes they experience compared to cisgender people (Newcomb et al., 2020). Knowing this information, I am professionally invested in eradicating the discrimination and oppression the TGNB community experiences. Specifically, I enrolled in an LGBT affirmative family therapy training program at North Dakota State University and

continue to educate myself on this important topic. More recently, I have expanded my education to consider how race and social class intersect with gender identity, and how my own experiences as a White, well-educated person shapes my non-binary experience. Lastly, I am committed to advancing TGNB affirmative training in clinical graduate programs and transforming the existing policies (i.e., accreditation standards) to be more TGNB inclusive. Currently, I experience accreditation standards across mental health disciplines to be vague and passive with regards to the TGNB community.

CHAPTER 2

LITERATURE REVIEW

Gender stereotypes are deeply entrenched within our daily experiences. Halim and colleagues (2014) suggest our perceptions of gender influence our decisions and behaviors (e.g., personal interactions). In fact, gender is the most common way in which the world and people are organized (Hare-Mustin, 1978, 1987; Silverstein, 2003). People are influenced by these gender scripts and norms affecting the ways in which they parent (Cinamon & Rich, 2002; Cowdery & Knudson-Martin, 2005), divide tasks (Pollman-Schult, 2015), and engage in intimacy and sex (Rutter & Schwartz, 2012). Theorists and clinicians have discussed how gender norms are restrictive for couples and families (Hare-Mustin, 1978, 1987; Haddock, Zimmerman, & Macphee, 2000), and how these scripts reinforce gendered power dynamics (Knudson-Martin, 2013). However, much of this literature is produced through a cisnormative lens, often neglecting the experiences of TGNB people. In this chapter, I review the existing literature on the lived experiences of TGNB people, the barriers they encounter in the mental health field, TGNB affirmative care, and end with a discussion of ethical guidelines and accreditation standards across the mental health disciplines.

Lived Experiences of TGNB People

Although TGNB is intended to be inclusive of people whose gender identities do not fall within the gender binary system, some non-binary people identify as TGNB, whereas others do not (Davidson, 2007; McLemore, 2015). In addition, there are within group differences among TGNB people. While as a group TGNB people are more likely to be stigmatized than

LGB people (Grossman & D'Augelli, 2006), those who identify as non-binary have a varied experience in terms of how they are treated by others in society (Chang et al., 2017). These variations may exist within how the individual is perceived by others, differ between individuals with different gender expressions, or be highly influenced by other cultural identities, particularly race and class (Saketopoulou, 2011). Non-binary people are more likely to be people of color and multiracial than binary transgender people (Harrison et al., 2012).

Compared with binary transgender people, non-binary people face unique patterns of gender identity-based discrimination and violence. For example, they are more likely to experience higher rates of physical assault and police harassment (Harrison et al., 2012; Hill & Willoughby, 2005). In addition, they experience higher rates of suicidality (Budge et al., 2013b; Clements-Nolle et al., 2006). Non-binary people also experience institutional and environmental barriers. These examples include completing paperwork with only two options for gender, not having their names and pronouns respected, and difficulty navigating spaces that are traditionally sex-segregated (i.e., restrooms; Budge et al., 2010; Herman, 2013). In addition to the above-mentioned experiences, there are common misconceptions and microaggressions that are unique to non-binary people.

First, non-binary people are often told they do not exist. Because of the medicalized narrative for TGNB experience (de Vries, 2012), there is an assumption that all TGNB people identify as the opposite of what they were assigned at birth (Chang et al., 2017). Second, people often assume non-binary people are pre-transgender. Like bisexual people, non-binary people are viewed as not yet fully embracing their true identity (Eisner, 2013). Third, non-binary people are often pathologized and given the label of having borderline personality disorder (Meyer-Bahlburg, 2010). Lastly, non-binary people labeled as seeking special treatment from society.

For example, when non-binary people express the need for all gender restrooms, gender neutral pronouns, or more than two gender boxes on a form they are labeled as wanting special privileges rather than the right to exist and be seen like everyone else (Herman, 2013). While there are indeed disparities for non-binary people, there are particular health disparities for TGNB people of color (POC; Hwahng & Nuttbrock, 2014; Singh & McKleroy, 2011).

Within the TGNB literature, there is limited attention to the experiences of TGNB POC (Singh et al., 2017). This lack of literature is often related to the invisibility of these populations and the trans oppression in communities of color can influence individuals to conceal their identities (Bailey, 2011). However, this concealment is warranted given the wave of murders that occur particularly against TGNB women of color (Chatelain & Asoka, 2015). The co-action among racism, misogyny, and transgender oppression is signified by the statistics that TGNB women of color are more likely to be targets of violence and murder victims within the broader LGBT community (National Coalition of Anti-Violence Programs [NCAVP], 2011). The NCAVP reported TGNB women make up 72 percent of anti-LGBT homicide victims, and 89 percent of these victims were women of color (Ahmed & Jindasurat, 2014). In addition, the multiple oppressions TGNB BIPOC experience is associated with 2.59 times higher rate of police violence compared to White cisgender people (Ahmed & Jindasurat, 2014).

Although the TGNB population experiences these higher rates of stigma, oppression, and violence, they have been vital to queer liberation (Singh et al., 2017). TGNB POC are prominent leaders and participants within the larger LGBT rights movements and are instrumental in developing strong communities within their own ethnic and/or racial communities (Moradi et al., 2011). An example of their leadership is the House/Ballroom community. Ballroom culture is a practice in which there are competitions in dance, fashion, beauty, and many more between

“houses.” Within these houses there are mothers and fathers, typically TGNB women and men, who help their “children” through pivotal life moments such as homelessness and other economic based oppression (Kubicek et al., 2013). While the House/Ballroom community may experience similar challenges to other TGNB POC communities (i.e., substance abuse and survival sex work), they foster much needed support for their community members; support they may not receive from their biological families (Bailey, 2011; Hwahng et al., 2013). Given the complexity of TGNB people’s daily experiences, there is clear evidence for the need for access to affirming and quality therapy services.

Barriers to Accessing TGNB Affirming Therapy

TGNB individuals present to therapy for similar concerns as cisgender clients, including anxiety, depression, relational concerns, substance use, and other common presenting issues (Meier & Labuski, 2013; Shipherd et al., 2010). Some TGNB clients engage in services for accessing transgender specific care (i.e., hormone replacement therapy and gender affirming surgeries; Meier & Labuski, 2011), or assisting with relational dynamics related to the transition process (Bockting et al., 2004; Boe et al., 2019). In addition, some TGNB clients work with therapists to develop strategies for safely disclosing in the workplace and how the client would like to best handle instances in which transgender oppression emerges (Chope & Strom, 2008). Although there are various reasons TGNB clients seek therapy services, they frequently encounter barriers to accessing affirming services.

Because of the historical treatment of TGNB by mental health professionals, TGNB people are reluctant to seek services (Weeks et al., 2016). The TGNB community has been pathologized by the mental health community (American Counseling Association, 2010; Benson, 2012; Lev, 2004; Lev & Sennott, 2012a, 2012b; Malpas, 2006, 2012). For example, TGNB

people have previous experiences in which a clinician has attempted to change their gender identity (Weeks et al., 2016). Sperber, Landers, and Lawrence (2005) found provider ignorance and insensitivity to transgender clients' needs were the primary barriers for transgender clients in seeking services. While provider ignorance and provider insensitivity may have been the primary barriers to treatment, cost of treatment, fear of treatment, and concerns of treatment are other barriers for transgender people (Shipherd et al., 2010). These previous experiences and barriers to treatment more than likely reflect the limiting conceptual framework for working with transgender clients and the larger systems of power, privilege, and oppression that all too often influence clinicians and treatment (McDowell, 2015).

Malpas (2006) indicated there are three primary conceptual therapeutic frameworks when working with transgender individuals, their partners, and their families: the medical approach, the developmental approach, and the deconstructive approach. Per the medical approach, the treatment of couple therapy is centered on the pathology of the gender variant partner, to which much of the research has focused (Benson, 2013). In addition to focusing on the pathology of TGNB individuals, there was attention from the medical fields to construct mental health diagnoses for TGNB people (i.e., Gender Identity Disorder and Gender Dysphoria; Malpas, 2006). While the medical approach is still prevalent and has created a gate-keeping role for therapists and medical professionals, there have been considerable paradigm shifts that seek to humanize the TGNB community and normalize their experiences.

Through the developmental approach, gender transitioning is a possible and *natural* developmental trajectory (Lev, 2004). Therapists' tasks through a developmental approach are to de-pathologize TGNB people, educate and support their families, and aid all family members through the gender transition (Malpas, 2006). While a developmental approach normalizes

transgender experiences, this approach has been critiqued for perpetuating a binary view of gender that limits the experiences of non-binary experiences of gender (Malpas, 2006). As such, some clinicians have shifted away from the developmental approach to a deconstructive approach.

Through a deconstructive approach, clinicians challenge not only the gender binary, but the nature of gender (Dimen & Goldner, 2005). For clinicians to challenge notions of gender with their clients, they first must examine their own biases of masculinity and femininity (Malpas, 2006) as well as their cisnormative assumptions (Boe et al., 2019). The aim of the deconstructive approach is not to enforce gender norms but to promote gender fluidity (Malpas, 2012). Malpas (2006) suggests postmodern therapies such as narrative therapy or collaborative language systems lend themselves to the deconstructive approach as these therapies are in and of themselves deconstructive. Because of this intense stigmatization and culture of transgender oppression, TGNB clients may require more support from clinicians (Grossman & D'Augelli, 2006).

Lev (2004) and Coolhart, Provancher, Hager, and Wang (2008) report clinicians often lack the training that is required to serve this population. This lack of training is unsurprising given that 60.5% of students from accredited couple and family therapy programs had received no training in providing affirming therapy services to LGB clients (Rock et al., 2010), and that 50% of therapists do not feel prepared to work with LGBT clients (Green & Bobele, 1994). Although LGB-affirmative therapy practices have been presented for working with LGB clients within the literature (McGeorge & Carlson, 2011; Rock et al., 2010), there remains limited literature on TGNB affirming practices and how therapists can claim a TGNB affirming stance.

TGNB Affirmative Therapy

When mental health providers are working with TGNB clients, it is important to ensure assessments, interventions, and advocacy are grounded in TGNB-affirming theories (Singh & dickey, 2017). TGNB affirmative therapy is defined as an approach that embraces TGNB identities and seeks to actively dismantle the influence of cisgenderism and cisnormativity on clients lives (Singh & dickey, 2017; McGeorge et al., 2020). There are currently no specific TGNB-affirmative therapy treatment modalities, but mental health provides can draw on various theoretical perspectives and strategies to inform their practice (Singh & dickey, 2017). These theories include the minority stress model (Meyer, 2003), trauma clinical principles (Briere & Scott, 2012), strengths-based and resilience approaches (ACA, 2010; APA, 2015a), and multiculturalism and social justice advocacy approaches (Ratts et al., 2015).

Meyer (2003) described minority stress as the additive stress, stress that is experienced over and above the average stress people have, which is constantly present. For example, TGNB people feel constant fear that they may be harmed because of their gender identity and their expression (Singh & dickey, 2017). In addition, minority stress is socially bound and related to institutional structures of cisnormativity and transnormativity that produce anti-TGNB values and legislation. From Meyer's (2003) framework this minority stress becomes internalized leading to psychological harm. Because of the minority stress TGNB people experience, it is important for mental health providers to continually assess for minority stress with their clients (Hendricks & Testa, 2012; Singh & dickey, 2017). Unfortunately, minority stress theory does not account for the trauma TGNB people endure.

Compared to the cisgender population, TGNB individuals are more likely to experience ongoing trauma (Mizock & Lewis, 2008), which increases their susceptibility to develop

posttraumatic stress disorder (PTSD) and/or complex PTSD (Richmond et al., 2017). There are numerous trauma informed theories mental health providers can utilize with their clients; however, Richmond, Burnes, Singh, and Ferrara (2017) discuss vital strategies to holistically assess for trauma. They suggest assessment of trauma must focus on intersectionality and be developmental in nature (i.e., assessing for traumatic events across the lifespan). In fact, the effects of traumatic stressors on TGNB individuals throughout lifespan development is well documented (Richmond et al., 2012; Singh & McKelory, 2011). For example, one third of TGNB people have made a suicide attempt (Kenagy, 2005). Additionally, dickey, Reisner, and Juntunen (2015) found that 42 percent of TGNB adults in their study reported a lifetime history of non-suicidal self-injurious behaviors.

While TGNB individuals experience minority stress and complex trauma, they are resilient. It is important for mental health providers to use a strengths-based approach to help clients recognize the resources clients have that help them reduce stress in their lives (Budge et al., 2013a). For example, developing racial and ethnic pride alongside gender identity as well as being connected to spirituality are sources of resiliency for TGNB POC (Singh et al., 2011). In addition, TGNB people who report higher levels of perceived relational support often report a reduced risk of suicide (Edwards et al., 2020). TGNB people can further experience resiliency by connecting with TGNB activist communities to help facilitate access to financial and legal resources (Singh, 2013).

Across the mental health discipline, there is a commitment to being trained in multiculturalism (American Psychological Association [APA], 2015b; Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2015; Commission on Accreditation for Marriage and Family Therapy Education [COAMFTE], 2017; Council on

Social Work Education [CSWE], 2015). From a multicultural framework, mental health providers understand that cultural backgrounds (e.g., race, ethnicity, class, religion, gender) have important influences on mental health and overall well-being (Sue et al., 1992). In addition, multicultural competency is characterized as mental health providers having the awareness, knowledge, and skills to be able to work with various cultural groups (Singh & dickey, 2017). Related to TGNB affirmative therapy, mental health providers should actively develop awareness about their own internalized cisnormativity and how that impacts their ability to work with TGNB clients. For knowledge and skills, mental health providers should consistently seek out continuing education to develop a TGNB affirmative therapy practice (Singh & dickey, 2017). Engaging in such practices have important clinical outcomes. TGNB clients who seek services from a TGNB affirmative therapist report experiencing fewer microaggressions and feel supported by their therapists when they disrupt cisnormativity and affirm their gender identity (Anzani et al., 2019).

Ethical Codes and Accreditation Standards

Ethical practice with TGNB individuals has advanced over the past 50 years (APA, 2015a). Major documents have been constructed by scholars and clinicians to guide TGNB affirmative therapy and they are routinely revised to include up-to-date best practices. When first published, the SOC was quite prescriptive with regards to clinical treatment and made the assumption that all TGNB people wanted to medically transition (Singh & dickey, 2017). The current version of the SOC indicates there is no one way to transition and provides a glossary of terms to help further educate mental health providers (Coleman et al., 2012). In addition, the American Counseling Association (ACA) and the APA developed guidelines to ethically work with TGNB individuals (Singh & dickey, 2017). While these documents exist, mental health

providers are bound by ethical codes, and clinical graduate programs are bound by ethical codes and accreditation standards. Below I discuss the ethical codes and accreditation standards across the mental health disciplines. It is apparent that there are similarities among these ethical codes and accreditation standards. In addition, it is important to note that while these similarities exist, advancements in TGNB affirmative therapy are often siloed within disciplines, which limits the impact such advancements have on those who practice in another discipline (Bidell & Stepleman, 2017).

APA Code of Ethics and Accreditation Standards

As situated within the APA (2010) code of ethics, psychologists recognize fairness and justice is an entitlement for all persons and must exercise reasonable judgment and take precautions to ensure that their potential biases do not perpetuate or condone unjust practices. In addition, psychologists must receive the training, experience, consultation, and supervision necessary to ensure the competence to work with a variety of clients based on social identities. Therefore, per the APA code of the ethics, ethical conduct would be for psychologists to seek out TGNB affirmative training in order to promote justice. In addition, they should not condone unjust practices such as referring clients out due to their own personal biases or utilizing reparative therapies to attempt to change a TGNB person's identity.

According to the APA accreditation standards (2015b), graduate training programs are committed to ensuring a welcoming, supportive, and encouraging learning environment for students. Particular to educational requirements, graduate training programs should prepare students with the knowledge, skills, and competencies in the practice of psychology. As such, programs must provide students with the opportunity for educational attainment, which includes

preparing students beyond a generalist track. Per these standards, students should be receiving education related to working affirmingly with the TGNB population.

ACA Code of Ethics and CACREP Accreditation Standards

The ACA (2010) provides the most inclusive guideline for TGNB competencies for counselors. These competencies acknowledge that transgender oppression is present in society and likely internalized by counselors. In addition, counselors are encouraged to reflect on how helping professionals participate in the oppression that TGNB individuals experience. The ACA code of ethics (2014) states counselors do not condone any discrimination on the basis of gender identity and must respect all clients regardless of social identities. Furthermore, counselors are responsible for abiding by all competencies as outlined by the ACA, seeking further education and supervision to develop greater competencies.

CACREP (2016) standards require programs to reflect current knowledge and projected needs concerning practice in multiculturalism. As such, programs are to train their students in theories and models that support multiculturalism and to recognize how power and privilege impact counselors and clients. In addition, students are trained in understanding how oppression shapes clients' help-seeking behaviors. Given that TGNB affirmative therapy is a branch of multicultural practice, it should be within the curriculum of CACREP accredited programs.

AAMFT Code of Ethics and COAMFTE Accreditation Standards

The AAMFT code of ethics state marriage and family therapists (MFTs) provide professional assistance to people without discriminating based on social identities (AAMFT, 2015). In addition, MFTs should in no way inflict harm onto clients. Although the AAMFT code of ethics, states that MFTs must practice from empirically based best practices, AAMFT has yet

to take a clear stance against anti-transgender approaches. Such a vague stance is in-and-of-itself counter to ethical practice as defined by the code of ethics.

The COAMFTE accreditation standards (2017) state that MFTs have a systemic philosophy and endorse systemic ethics, which faculty must teach to their graduate trainees. Part of this systemic philosophy is considering the effects of multiculturalism, and faculty must educate their students on the ever-changing diverse world. In addition, programs ensure that all clients, students, supervisees, and research subjects are treated with respect and dignity regardless of their social identity. To achieve such a goal COAMFTE requires programs to provide students with 3 hours of course credit related to issues of diversity. Because TGNB people are to be treated with respect; programs need to be ensuring students are receiving TGNB affirmative training.

NASW Code of Ethics and CSWE Accreditation Standards

According to the National Association of Social Workers code of ethics (2017), social workers should obtain education about, and seek understanding of, social diversity and oppression with respect to all social identities. Social workers should not practice, condone, facilitate, or collaborate with any form of discrimination based on social identities. In these sections of the code of ethics, gender identity is listed as one of the social identities. As such, social workers have an ethical obligation to receive further education with regards to TGNB affirmative training and to not engage in or condone therapy practices that are anti-TGNB.

Per the social work competences, outlined by CSWE (2015), social work graduate trainees should be able to understand how diversity and difference characterize and shape human experiences. Further, social work graduate trainees should be able understand the forms and mechanisms of oppression and discrimination. As such, TGNB affirmative training is warranted

in social work curriculum both explicitly (i.e., course materials) and implicitly (i.e., the learning environment is TGNB affirming).

Summary

TGNB clients report numerous barriers when seeking services. These barriers include provider's ignorance and lack of knowledge (Benson, 2013; Sperber et al., 2005), prior negative experiences with providers attempting to change clients' identities (Weeks et al., 2015), and providers engaging in microaggressions, most commonly misgendering clients (Blumer et al., 2013; Johnson, 2014). Mental health providers consistently report receiving little training on how to work effectively with TGNB populations (Benson, 2013; Whitman & Hahn, 2017). As ethical and accreditation standards position multiculturalism as a goal for their profession, graduate training programs appear to be failing to meet educational requirements. To address this gap, I sought to investigate faculty and student levels of TGNB clinical competency and levels of training in TGNB affirmative therapy to assess their experiences in their graduate training program. In addition to faculty and student self-reports, experts in TGNB affirmative therapy were interviewed to provide their accounts on where they believe the mental health field is at with providing training in TGNB affirmative therapy and their recommendations for advancing education.

CHAPTER 3

METHODOLOGY

This dissertation employed a two-phase multi-method design. It is important to distinguish that this design is different from a mixed method's design, which has implications for data presentation. Unlike mixed methods, the data collected in this two-phase multi-method study were not designed to communicate with one another (Creswell & Plano Clark, 2018). In the first phase, I examined clinical faculty and clinical graduate trainees' preparedness to work with TGNB clients. As this phase was an extension of Rock and colleagues (2010) work, their research questions and analytic plan served as a model. For the second phase, I qualitatively explored the experiences of eight elites/experts in the mental health field and how they saw the training in TGNB affirmative therapy advancing.

Phase 1: Research Questions

The research questions for the student sample were: 1) What are students' assessments of the level of TGNB affirmative training they receive in their program? And does this differ among individual and program characteristics? 2) What is the level of students' self-reported competency working with TGNB clients? And does this differ among individual and program characteristics? 3) To what degree is students' assessment of the overall level of their TGNB affirmative training associated with their self-reported competency working with TGNB clients?

The research questions for the faculty sample in this study will be: 1) What are faculty's assessments of the level of TGNB affirmative training they give in their program? And does this differ among individual and program characteristics? 2) What is the level of faculty's self-

reported competency working with TGNB clients? And does this differ among individual and program characteristics? 3) To what degree is faculty's self-reported competency working with TGNB clients associated with their assessments of the level of TGNB affirming training in their program?

Phase 2: Research Questions

The aims of the second phase were to: 1) Garner in-depth accounts of experts in TGNB mental health and their experiences engaging in the field to advance training initiatives, and 2) Understand and document specific strategies to increase TGNB affirming training in mental health as recommend by these eight individuals.

Phase 1 Methods

Research Design

A cross-sectional quantitative survey design guided this study. Because the aim of this study was exploratory, a survey design was beneficial for assessing current trends in TGNB affirmative training in clinical graduate programs (Nardi, 2015). As such the goal of this study was not to determine causal inferences but to examine associations between faculty and trainees' competency and attitudes when working with TGNB clients, and to explore any differences across clinical disciplines in accredited graduate training programs.

Sample Recruitment

Clinical faculty and graduate student trainees were recruited from nationally accredited master and doctoral training programs (i.e., APA, CACREP, COAMFTE, and CSWE) across the US. Programs were identified from the national accreditation websites. 1206 program directors and directors of training were sent three separate recruitment emails for faculty and graduate student trainees. Across these recruitment efforts, 197 students and 89 faculty participated in the

study. Of the student sample, 2 participants were eliminated from analyses for characterizing themselves as clinical program faculty and 20 were eliminated for not completing the survey. The final student sample included 155 participants. Of the faculty sample, 15 participants were eliminated from analyses for not completing the survey and 5 were eliminated for not being a faculty member. The final faculty sample included 69 participants. Sample demographics are presented in the Chapter 4 (see p. 57).

Procedures

After obtaining approval from the Institutional Review Board at the University of Georgia (see Appendix A), identified program directors and clinical training directors received an initial invitation email for clinical graduate students and faculty to participate in the study. The invitation to participate contained a link to a Qualtrics survey for participants to complete a brief demographic questionnaire and the survey (see Appendix B for the demographic questionnaire). To ensure participants received the email, two additional follow up emails were sent after the initial invitation. One follow-up occurred approximately three weeks after the initial invitation and the final follow-up occurred two months after the first follow up to account for holiday breaks.

Instruments

The instruments in this study were the Gender Identity Counselor Competency Scale – Revised (GICCS-R) (Cor, 2016) and the Affirmative Training Inventory (ATI) (Carlson et al., 2013; McGeorge et al., 2015). The GICCS-R is a validated instrument that seeks to measure competency among mental health professionals and trainees with regards to working with TGNB individuals (Cor, 2016). The GICCS was adapted by O’Hara, Dispenza, Brack, and Blood (2013) from the Sexual Orientation Counselor Competency Scale (SOCCS; Bidell, 2005). Because the

GICCS was adapted from the SOCCS, it is important to discuss how adaptation and validation of the GICCS occurred. The original SOCCS is a 29-item instrument that measures the following subscales: counselor knowledge, awareness, and skills for working with lesbian, gay, and bisexual (LGB) clients on a 7-point Likert scale (i.e., 1 = not true at all to 7 = totally true; Bidell, 2005). When developing the GICCS, O'Hara and colleagues (2013) altered the language to fit for transgender clients. For example, one question of the SOCCS reads, "I have received adequate clinical training and supervision to counsel lesbian, gay, and bisexual (LGB) clients" and the adapted item states, "I have received adequate clinical training and supervision to counsel transgender clients."

The SOCCS appears to demonstrate good reliability and validity. Bidell (2005) reported an alpha coefficient of .90 for the overall scale. The alpha coefficients for the subscales were as follows: Awareness ($\alpha = .88$), Skills ($\alpha = .91$), and Knowledge ($\alpha = .76$). In addition, Bidell conducted a 1-week test-retest reliability with an alpha coefficient of .84. Criterion validity was established by examining how scores on the SOCCS varied based on participants' sexual orientation and level of education. Specifically, participants who identified as LGB and with greater levels of education scored higher on the SOCCS compared to participants who identified as straight and with lower levels of education. Convergent validity was assessed by high correlations between the three subscales of the SOCCS and three existing measures (i.e., Attitudes Toward Lesbians and Gay Men Scale, Multicultural Counseling Knowledge and Awareness Scale, and Counselor Self-Efficacy Scale). Although the GICCS was adapted from a reliable and valid measure, O'Hara and colleagues (2013) did not establish validity in their original adaptation.

Cor (2016) established discriminant and convergent validity of the GICCS-R based on O'Hara and colleagues (2013) work, which required revisions to the original instrument. From this validation study, the GICCS-R appears to demonstrate adequate reliability and validity. Cor (2016) reported an alpha coefficient of .78 for the overall scale. The alpha coefficients for the subscales are as follows: Awareness ($\alpha = .84$), Skills ($\alpha = .79$), and Knowledge ($\alpha = .76$).

Discriminant validity was assessed by examining the bivariate correlations between MCSDS Form-C, an instrument that measures social desirability, and the GICCS-R. Results indicated a statistically significantly weak negative correlation ($r = -.184, p = .012$). In addition, a bivariate correlational matrix was used to examine discriminant validity between the MCSDS Form-C and the GICCS-R subscales. Results demonstrated no significant relationship between the knowledge and awareness subscale. However, a weak, negative relationship was observed ($r = -.162, p = .027$). To establish convergent validity, bivariate correlation matrix was used to examine the relationship between the MCI, an instrument to examine multicultural competence, and the GICCS-R. Results indicated a statistically significant, moderate positive relationship ($r = .574, p = .001$). An additional bivariate correlation matrix was used to examine the convergent validity between the MCI subscales and the subscales of the GICCS-R. Results indicated a moderate, positive relationship between the Knowledge subscale and the MCI knowledge subscale ($r = .429, p = .001$). The Awareness subscale had a weak, positive relationship with the MCI awareness subscale ($r = .192, p = .008$). Lastly, the Skills subscale had a moderate, positive correlation with the MCI skills subscale ($r = .446, p = .001$). For this study, the alpha coefficients for the revised subscales for the student sample were as follows: Awareness ($\alpha = .87$), Skills ($\alpha = .79$), Knowledge ($\alpha = .68$), and overall scale ($\alpha = .78$). For the alpha coefficients for the revised subscale for the faculty sample in this study were as follows: Awareness ($\alpha = .79$), Skills ($\alpha =$

.79), Knowledge ($\alpha = .75$), and overall scale ($\alpha = .74$). These alphas are an acceptable level of reliability for the GICCS-R instrument (Ursachi et al., 2015). The GICCS-R can be found in Appendix C.

The ATI measures the extent to which clinical training programs integrate LGB affirmative training practices into the curricula (Carlson et al., 2013; McGeorge et al., 2015). Specifically, the ATI assesses the following: a) course material on LGB topics, heterosexism, heterosexual bias, heterosexual privilege, and affirmative therapy, b) opportunities for personal reflection on student and faculty's own heterosexual privilege and bias, and c) the opportunity to work with LGB clients in therapy (Rock et al., 2010). Currently, there are two versions of the ATI, a student version and a faculty version.

The student version (ATI-S) is comprised of nine items and uses a 6-point Likert scale (1 = strongly disagree to 6 = strongly agree). The ATI-S demonstrates adequate reliability and validity. The overall scale alpha coefficient was .86 (Carlson et al., 2013). The ATI-S encompasses two subscales: classroom and program. The classroom subscale is a six item measuring students' perceptions of the type and level of LGB affirmative course content. This subscale has an alpha coefficient of .87. The program subscale is comprised of three items measuring the extent to which students believe the overall program takes an affirmative stance and provides experiences with the LGB community. This subscale has an alpha coefficient of .67 (Carlson et al., 2013).

The faculty version (ATI-F) is comprised of 27 items used to measure the level of LGB affirmative training in clinical programs. In addition, it measures faculty members' beliefs about the role of LGB affirmative training in clinical programs (McGeorge et al., 2015). The ATI-F consists of three subscales: a) Teaching, b) Program, and c) Faculty. The Teaching subscale is

comprised of 14 items that measure the type and amount of LGB affirmative content that faculty include in their curricula ($\alpha = .90$). The Program subscale consists of nine items related to the extent to which the faculty report their program embraces an LGB affirmative stance and identity at the programmatic level ($\alpha = .78$). Lastly, the Faculty subscale includes four items that assesses faculty members' experience supervising student research on LGB topics and clinical work with LGB clients, and the extent to which faculty sought out continuing education related to LGB affirmative therapy and training ($\alpha = .67$). The overall alpha coefficient for the ATI-F is .91, indicating adequate reliability and validity.

Because this study focused on transgender and non-binary, the language of the ATI was changed to focus on that population (Appendix D and Appendix E depict the revised ATIs). For example, an original item on the ATI-S read, "Content related to experiences of LGB individuals is specifically addressed in each of my family therapy courses" and was revised to, "Content related to experiences of transgender and non-binary individuals is specifically addressed in each of my family therapy courses." An original item from the ATI-F states, "In my family therapy courses, I specifically include content related to the experiences of lesbian, gay, and bisexual (LGB) individuals" and was revised to, "In my family therapy courses, I specifically include content related to the experiences of transgender and non-binary individuals." In addition, to revising language to be appropriate for TGNB individuals, a Department/College subscale was constructed. This subscale is similar to the Program subscale but focuses on the larger department and/or college within which the clinical program is housed. For example, one item asks, "The other faculty in my department/college take an affirmative (i.e., positive view of transgender and non-binary identities) stance toward transgender and non-binary individuals." However, there were issues of collinearity between the Program subscale and

Department/College subscale, so this subscale was dropped. The ATI-S alpha coefficients in student sample were as follows: Classroom ($\alpha = .90$), Program ($\alpha = .82$), and overall ($\alpha = .93$). The ATI-F alpha coefficients in the faculty sample were as follows: Teach ($\alpha = .95$), Program ($\alpha = .83$), Experience ($\alpha = .92$), and overall ($\alpha = .93$). These findings suggest a good level of reliability on the ATI-S and ATI-F instruments (Ursachi et al., 2015). The ATI-S and ATI-F can be found in Appendix D and E.

Lastly, faculty and students responded to three open-ended questions. These questions included: 1) What do you believe are necessary components for training on transgender and non-binary affirmative therapy? 2) What do you believe are barriers for providing training on transgender and non-binary affirmative therapy? and 3) What do you believe would be helpful for advancing training on transgender and non-binary affirmative therapy in your program?

Covariates

Several demographics were included in the regression analysis as covariates: 1) age, 2) gender identity (trans or cis), 3) religious institution (yes or no), 4) degree type (PhD or masters), 5) having worked with a trans client before (yes or no), 6) number of clinical hours, 7) hours of education related to TGNB affirmative therapy, and 8) number of workshops related to TGNB affirmative therapy attended. These covariates were included as previous literature indicated that mental health practitioners who are religious and are cisgender men tend to have more negative attitudes toward the TGNB population (Brown et al., 2018). With regards to age, there are mixed findings. Some scholars suggest age has no effect on attitudes towards TGNB people (Bowers et al., 2015, Dispenza & O'Hara, 2016); whereas Johnson and Federman (2014) found that younger people held more positive attitudes. Furthermore, engaging in professional development (i.e.,

attending trainings and working with TGNB people) related to TGNB people is associated with a decrease in prejudice towards TGNB people (Mizock et al., 2017).

Data Analysis Plan

Prior to conducting analyses missing value analyses (MVA) were conducted for both student and faculty samples. To determine if data were Missing Completely at Random (MCAR), Little’s (1988) chi-square test of MCAR was conducted. The MVA of student sample indicated 0.94% missing values. The MCAR for the student data was significant ($\chi^2 = 567.38, p = .01$). This indicated the missing data was not MCAR, which means the assumptions of MCAR were not upheld (see Table 1 for student items and percentage of missingness).

Table 1
Students’ Item Missingness

Item	<i>n</i>	%
Age	2	1.3
Race/Ethnicity	1	.6
Accreditation Type	6	3.9
ATI_Department_3	5	3.2
ATI_Department_2	5	3.2
ATI_Department_1	5	3.2
ATI_Program_4	5	3.2
ATI_Program_3	5	3.2
ATI_Program_2	5	3.2
ATI_Program_1	5	3.2
ATI_Class_6	4	2.6
ATI_Class_5	5	3.2
ATI_Class_4	4	2.6
ATI_Class_3	4	2.6
ATI_Class_2	4	2.6
ATI_Class_1	4	2.6
GKNOW_5	2	1.3
GKNOW_3	1	.6
GSKILL_8	1	.6
GSKILL_4	1	.6
GAWARE_10	1	.6
GAWARE_6	1	.6
GAWARE_5	1	.6

Note. Little’s MCAR test, $\chi^2 = 567.38, p = .01$.

Analysis of the faculty sample indicated 1.89% missing values. The MCAR analysis was nonsignificant ($\chi^2 = 567.38, p = .11$). This result indicated faculty data was MCAR and the MCAR assumptions of multiple imputation were upheld (see Table 2 for faculty items and percentage of missingness).

Table 2
Faculty's Item Missingness

Item	<i>n</i>	%
Age	1	1.5
Location	1	1.5
Hours of Client Contact	3	4.5
ATI_Department_5	4	6.0
ATI_Department_4	4	6.0
ATI_Department_3	4	6.0
ATI_Department_2	4	6.0
ATI_Department_1	3	4.5
ATI_Program_6	3	4.5
ATI_Program_5	3	4.5
ATI_Program_4	3	4.5
ATI_Program_3	3	4.5
ATI_Program_2	3	4.5
ATI_Program_1	3	4.5
ATI_Exp_4	3	4.5
ATI_Exp_3	3	4.5
ATI_Exp_2	3	4.5
ATI_Exp_1	3	4.5
ATI_Teach_10	3	4.5
ATI_Teach_9	3	4.5
ATI_Teach_8	13	4.5
ATI_Teach_7	3	4.5
ATI_Teach_6	3	4.5
ATI_Teach_5	3	4.5
ATI_Teach_4	3	4.5
ATI_Teach_3	3	4.5
ATI_Teach_2	3	4.5
ATI_Teach_1	3	4.5
GSKILL_11	1	1.5
GSKILL_3	1	1.5
GSKILL_2	1	1.5
GKNOW_4	1	1.5
GAWARE_2	1	1.5

Note. Little's MCAR test, $\chi^2 = 567.38, p = .11$.

It is evident from the pattern of missingness that item nonresponses related to the affirmative training inventories (e.g., items on the ATI yielded the most missingness) and explanations are further discussed in the discussion section (see p. 204). There are two common deletion procedures when dealing with missing data: listwise and pairwise. Listwise deletion has two advantages: 1) simplicity because it can be applied without modifications, and 2) comparability in univariate analyses. However, there are disadvantages because of the potential loss of information in discarding incomplete units (Little and Rubin, 2020). As such, list-wise deletion was used for analyses. In contrast, pairwise deletion uses all available variables and cases resulting in fewer lost cases (McKnight et al., 2007). This procedure may yield biased findings because sample size is unclear and conclusions drawn may differ for each analysis (van Ginkel et al., 2019). Although pairwise deletion is not typically considered appropriate for handling missing data (McKnight et al., 2007; van Ginkel et al., 2019), the losses of complete cases in listwise deletion may impact subgroups. Because subgroups are used in analyses for this phase, it is vital to include as many cases as possible. Therefore, pairwise deletion will be used in analyses.

Parent (2013) recommends researchers state their tolerance for missingness by scale or subscale and report the individual missingness rates by scale per data point and the maximum by participant. Rock et al., (2010) clearly situate 70% as their tolerance point. That is, a mean was created for each subscale of the ATI if participants answered at least 70% of the items for that subscale. For the purposes of this study, the tolerance point was participants' having all but one response missing per subscale for a mean score to be generated. This threshold was used because each subscale had a different number of items. For example, the department/college level

subscale has three questions. If the tolerance point was set at 70%, then participants who did not answer all the questions would not have a mean score generated.

Univariate analyses of each of the primary study variables were conducted to explore normality of data distribution. Because data was heavily skewed, the assumption of normality was violated, and limitations were discussed (see p. 204). To examine mean score differences on the GICCS-R and the ATI-S/ATI-F a series of T-tests and One-Way Analysis of Variances (ANOVAs) were conducted based on individual and program characteristics for both student and faculty samples. Post hoc analyses to the univariate ANOVAs pairwise comparisons were conducted to examine within group differences. To test for student's perceived level of affirmative training in their program being associated with their reported competency multivariate regressions were conducted. Similarly, multivariate regressions were conducted to examine the association between faculty's reported competency and perceived level of affirmative training in their program.

Phase 2 Methods

Contextually Situated Narrative Inquiry

Before discussing how contextually situated narrative inquiry guides this study, it is important to deconstruct the meanings of *narrative* and *narrative inquiry*. The definition of narrative has expanded over the decades, and such discursive broadenings continually shape social science research (Chase, 2018). Labov and Waletzky (1967) defined narrative as discursive practices that link *temporal sequence* to past events. That is, there is a narrative structure that consists of a beginning, middle, and end that align with temporality (i.e., past, present, and future). With further methodological developments, narrative began to reflect personal experiences, both oral (i.e., stories told during interviews) and written (i.e., memoirs

and letters), becoming constitutive of social action (Chase, 2018). As such, researchers broadened the meaning of narrative to consist of the socially situated interactions that are embedded in our interpersonal, cultural, institutional, and historical contexts (Chase, 2005). With a shift to experience, chronological temporal ordering became less important as a narrative structure (Patterson, 2013). Although scholars continue to expand the definition of narrative, there are limits to how researchers conceptualize narratives.

Scholars identify three problems when focusing on the limits of the concept of narrative (Chase, 2018). First, Riessman (2013) suggested the term loses meaning when it is used to describe any account, object, or performance. Second, storytelling is not the only means by which people construct meanings, and assuming meanings are bound to a narrative structure marginalizes other modes of meaning-making (Chase, 2018). Third, narratives can lack clarity when researchers attempt to investigate and understand them (Chase, 2018). Riessman (2013) argued scholars must maintain some boundaries to help others understand their interpretation of narrative. One approach for maintaining clarity involves scholars defining *narratives* and structuring boundaries as permeable rather than rigid (Chase, 2018). Similar with the struggle to define *narrative*, scholars experience difficulty in defining *narrative inquiry*.

The challenge of presenting a *coherent* definition of narrative inquiry relates to diversity and complexity of researchers' interests, approaches, and commitments and to its ongoing theoretical and methodological advancements (Chase, 2018). Theoretical and methodological debates exist among narrative researchers (Atkinson, 1997; Thomas, 2010). On the one hand, Atkinson (2010) urged scholars to resist narrative essentialism situating that narratives, in-and-of themselves, are not special and to approach them as we would with any other social action. On

the other hand, Bochner (2010) centered the debate not on methods, rather as a debate among epistemological assumptions. For example, story analysts take a stance in which research as a practice is empty of all ideological interests; whereas storytellers understand and appreciate research as a messy, political, and moral profession (Bochner, 2010). Thomas (2010) introduced four questions for every researcher to address. First, what types of knowledge do we draw upon in the analysis of narratives? Second, what types of knowledge do personal narratives give us access to? Third, where do we stand ethically? Lastly, what methods do we choose to analyze and represent the narrative data? Answering these questions allow researchers to hold themselves accountable to the narrative research community (Thomas, 2010).

To answer Thomas's (2010) questions, I must first position myself epistemologically. As a scholar informed by queer theory, I often find myself reflecting on how normative structures influence knowledge construction and how these constructions have lasting impacts. For the purpose of this study, I drew on the knowledge of elites in the field. These elites have been tirelessly working to dismantle transgender oppression in mental health. From their accounts, I garnered ways of advancing their efforts and sought to understand what stands in the way of those efforts. Ethically, as an advocate of change and social justice, it is my task to continue to dismantle these oppressive forces, while attending to the various, intersecting systems. As such, contextually situated narrative inquiry was the optimal methodology for this endeavor.

Clandinin and Rosiek (2007) describe narrative inquiry as an old practice that may feel new. From a narrative perspective, we create stories of our lives, and how we tell those stories have constitutive effects (White & Epston, 1990). Although storytelling is not new to researchers, narrative methodology is new (Clandinin & Rosiek, 2007). The aim of narrative

inquiry is to systematically gather, analyze, and represent people's stories as told by them (Clandinin & Connelly, 2000). Furthermore, narrative inquiry is an umbrella term that captures human experience over time, while taking into account the relationship between individual experience and cultural context (Clandinin & Connelly, 2000). In this study, the stories shared by elites were grounded within contexts. For example, there is a narrative of psychopathology in the mental health field, a story in which TGNB people need to be *fixed*. In addition, data collection occurred during a presidential election and during a time in which Trump's administration was actively advancing anti-TGNB legislation.

Elite Interviewing

Over the last few decades, researchers have turned their attention to the role of elite members within society (Harvey, 2011). Harvey noted such an approach results from the resurgence of ethnographic research (i.e., interview, focus groups, case studies, and participant observation). Elite interviewing stems from the political science field (Berry, 2002). Qualitative researchers use the term *elite* to describe individuals or groups who are closer in proximity to power or particular professional expertise (Morris, 2009). Examples of elites may include scholars who have an established research area on the phenomenon in question or policymakers. In this interview approach, the participant creates the narrative structure and is in charge of how they tell the story. In essence, the participant is the teacher, and the interviewer is the student (Dexter, 1969). As with any qualitative approach, there are potential risks that need to be addressed.

Berry (2002) outlined potential risks when conducting elite interviews. First, it is unclear if participants will share "accurate" information or if what is shared will lead the researcher to have a distorted representation. Second, participants may exaggerate their importance in the

field, which can also mislead the researcher. Although researchers must attend to these risks, they are not uncommon in qualitative research. Berry (2002) offers the following recommendations to help reduce the influence of these risks. First, researchers can interview multiple sources. By interviewing others, researchers can honor various voices. Second, researchers must accept that interviews represent personal perspective rather than an absolute truth. Third, by asking participants to question their own stances can help them in challenging their own assumptions or perceptions. Lastly, the interviewer can prepare themselves for the interview to ensure they are knowledgeable on the topic. The interviewer can develop a preparation phase to help guard against this particular threat. While researchers are likely to encounter these risks, they will also come into contact with power and power relations.

It is important to consider the role of power between the participant and the researcher (Morris, 2009). The elites who participated in this study held expertise in content area and possible research methodology (Bryman & Cassell, 2006). Although this expertise may lead to feelings of power differentials, Morris (2009) cautions researchers to not assume their own powerlessness in the interview process. The term *elite* implies power is fixed and constant (Lancaster, 2017); however, such a classification of power neglects the complexity of power as a relational process. Neal and McLaughlin (2009) noted when power is entangled within an emotionally reflexive process it becomes messier and multidirectional, challenging the assumption that power is fixed.

Because I interviewed experts on their personal and professional journey and experiences in the field, their vulnerable stance disrupted some of the power they may hold (Lancaster, 2017; Neal & McLaughlin, 2009). In fact, the mere topic of the TGNB population and TGNB mental health evokes a myriad of emotional reactivity. For example, some mental health providers

consider TGNB people immoral in need of fixing, whereas other providers take a more inclusive and less pathologizing approach when working with the TGNB community. It is likely the experts I interviewed experienced moments where others minimized the importance of their work at best and denigrated the TGNB population at worst. Given the nature of the interviews, participants' position of power and vulnerability was in constant relation to myself as the researcher (Lancaster, 2017). As such, I engaged in reflexive memo writing which detailed my emotional reactions and questions that arose during each interview. In addition, I actively participated in systemic consultation or peer debriefing with others to gain multiple perspectives. I met weekly with Dr. Wieling to address self of the researcher concerns and potential biases. I recalled a particular meeting in which I asked her, "What is it like as a cisgender person mentoring a non-binary student on such a topic?" To provide additional context, although Dr. Wieling does not have content expertise in this topic, she was able to provide methodological support. She reflected in a meeting her own difficulties in finding meaningful ways to engage with me in the process. After each meeting, I reflected on my own experience and feelings that emerged in those meetings. In those particular moments, I reached out to colleagues both inside and outside of academia to reflect on how I was interpreting interactions. This strategy was to not rebuke the power I hold, but to embrace it and be aware of how it may alter how I experience and tell the story.

Developing a participant list, contact, and recruitment

With the focus on the particular rather than the general, a smaller sample of participants is common in narrative inquiry (Chase, 2005). Narrative inquiry differs from other qualitative traditions in that the goal is to obtain an in-depth knowing, which does not require reaching saturation for thematic concepts. Because I conducted elite interviews, the sampling

strategies included purposive and snowball. I identified possible participants through the following: 1) those who are well known in the mental health field as an expert on TGNB mental healthcare (i.e., based on my own knowledge and committee members' knowledge of experts); 2) those who are well published in the last decade (i.e., minimum of five publications and/or has substantial experience serving the TGNB population); and 3) those who other experts recommended I contact. Once I developed my list using my own knowledge from attending conferences, those cited frequently in this document, and collaborating with other scholars in the field, I emailed 15 potential participants. In this email, I proceeded with professionalism, formality, and appreciation (Aberbach & Rockman, 2002). I detailed who I was and the aims of the project. Of the 15, 10 confirmed their interest in the project but only eight agreed to participate in the project. It was my hope to acquire a diverse sample of experts in terms of mental health discipline, gender identity, and social identities.

Interviews

To ensure I developed trust and rapport with participants, I offered to meet with them prior to conducting the interviews and conducted repeated interviews. With repeated interviews, I was able to gather richer and more storied data (Liamputtong, 2009). Participants were invited to elaborate on details they may have not shared in previous interviews before formally starting subsequent interviews. Participants engaged in three audio-recorded Zoom interviews that focused on the following domains: professional development, experiences in the field, and hopes and recommendations for the future. I intentionally began with participants' professional development for two reasons. First, our initial conversation was less charged than if we were to discuss experiences in the field, which could have invited discomfort or frustration into the dialogue. Second, it allowed for me to have a richer knowing of the participants' personal and

professional lives. Through establishing rapport, I wanted participants to have a better understanding of who I was and what I hoped to accomplish. Having such a dialogical process invited participants to share their experience working in the field and how they hoped the field would continue to transform. Constructing the interviews in this way allowed me to elicit more nuanced and vulnerable experiences of being a professional in the field.

Aberbach & Rockman (2002) outline three major considerations for how a researcher decides to structure their interviews (i.e., open-ended versus close-ended questions, and structured versus semi-structured). First, one must consider prior research. For questions that can be clearly defined and answered close-ended questions are preferred. Second, semi-structured interviews allow for participants to answer questions in ways that best fit their knowing and perspective. In addition, participants are able to share information with the interviewer that may not have come up during a structured interview. Lastly, the type of interview structure relates to the participants themselves. Elites are more likely to respond to semi-structured, open-ended questions than structured, close-ended questions. Because my study explored a series of abstract and complex issues, semi-structured, open-ended questions allowed for a wider possibility of meaning to come forward.

Appendix F depicts the interview protocol for each interview. From the months of August 2020 to January 2021, I scheduled interviews based on participant's availability and convenience. While it was my intention to have the interviews occur on a weekly basis, that did not work for all participants. For example, one participant had to wait a few weeks prior to scheduling the second and third interview. Participants received up to \$100 in gift cards for completing each of the interviews. Upon completing the first interview, they received a \$25 gift card. They received another \$25 gift card for completing the second interview. For participants

who completed the final interview, they received a \$50 gift card. Interviews were transcribed and completed within a month of participants completing all three interviews. After the interviews were transcribed, I wrote constructed narratives for each of the participants. Transcripts and constructed narratives were sent to participants for their review. All participant feedback and changes on these documents were made to ensure I was telling a story they wished to tell. For example, if a participant asked for a certain portion of the transcript or constructed narrative to be altered or to be excluded from the dissertation, I honored that decision and removed it from the document. The constructed narratives were then used for a thematic analysis to examine themes among participants' experiences. I constructed an Excel file to display coding with categories, themes, and subthemes.

Ethics

Modernist philosophers and social scientists often separate fact from value, striving for research to remain value-neutral (Brinkman & Kvale, 2005). Scholars have been dissatisfied with the modernist approach to ethics which has generated various responses (Brinkman & Kvale, 2005). One response comes from social constructionism. From a social constructionist perspective ethics are re-described as a constructed product of cultural discourse (Gergen, 1992). In addition, pragmatists question modernist assumptions of ethics and objectivity (Brinkman & Kvale, 2005). Dewey (1922) argued science is a moral activity that enables us to understand the conditions and agencies through which people live. From this perspective, being ethical is reduced to being good to other people and not imposing one's ideas and biases (Brinkman & Kvale, 2005). Brinkman and Kvale (2005) suggest there are little differences between objectivity in science and objectivity in ethics, which has implications for research.

Brinkman and Kvale (2005) question the *ethicism* that permeates qualitative inquiry in that there is an implicit assumption that qualitative research is ethically good in-and-of itself and is superior to quantitative methods. From this stance, the focus shifts from constructing and reconstructing ethics to attending to it as an inescapable domain of the human world. They suggest qualitative researchers must attend to micro- and macro-ethics. Micro-ethics refer to how researchers engage and treat the *research subject*. Examples of micro-ethics include confidentiality, informed consent, nonmaleficence, and beneficence. Conversely, macro-ethics consider how the knowledge produced will influence wider culture, human life, and society at large. As a researcher, I considered my role to be that of an advocate (Glesne, 2016). As a scholar committed to social justice, I adhered to not only micro-ethics, but to macro-ethics as well. That is, I paid attention to my own behavior in relation to participants and to the goals of the community (Strike, 2006). In order for this project to be a call to action, the goal of the study had to extend beyond merely collecting narratives about participants' experiences and knowledge to transforming the field to benefit the TGNB community, which is a democratic process (Lincoln & Denzin, 2008). The sections below describe how I attended to micro-ethics.

IRB

I obtained IRB approval for Phase 2 prior to contacting and interviewing the experts. Documentation of correspondence with the University of Georgia IRB can be found in Appendix G.

Confidentiality

There were numerous reasons as to why I could not guarantee confidentiality within this project. Because of their status of elites, they have an increased visibility in the field. In addition, the number of scholars who research TGNB mental health is small and intimate in nature. As

such, even seeking to de-identify the information (i.e., use of pseudonyms and changing location) could not grant confidentiality like in other qualitative research designs. Therefore, as part of agreeing to participate in the study, participants were made aware in the informed consent process that they were likely to be identified. I was explicit in which communications were *on the record* versus *off the record*. In addition, participants had control over what information was made public in the study. Several steps of member checking and participant approval were built into the research and analysis process.

Evolving Consent

Because of the public nature of participants and the data, I sought their guidance on what to include in the study. Participants were given my explicit permission to control the message they wanted to convey. They were able to revise transcripts of the interviews and the constructed narrative. After I received their revisions, I implemented all of their feedback. In addition to revisions, it was important for me to re-verify it was acceptable to use their name even when granted previous permission during the informed consent process. When I sent them their transcripts and constructed narrative, I invited them to choose a pseudonym if they desired.

Data Management

Data management is a vital component of micro-ethics. Because qualitative data provides a plethora of rich, personal data, researchers need to devise a plan for ethical storage (Lin, 2009). Lin (2009) suggests researchers should do the following: a) back up data as soon as possible, b) accurately complete and organize data, c) store data in various forms, and d) ensure data is secure and accessible by authorized personnel. For the purpose of this study, I backed up all data (i.e., audio recordings and transcripts) onto Outlook OneDrive, the university's sanctioned data storing software. I also downloaded these files to an external hard drive that I kept secure in

my office behind two locks. For data organization, I used OneDrive to create numerous folders to keep files organized. For example, a reimbursement excel file was created to confirm dates of interviews and when incentives were sent to participants.

Macro-Ethics

To attend to macro-ethics, I engaged in reflexivity and peer debriefing. Reflexivity was an important, ongoing process as my experiences shaped the knowledge I co-constructed with the participants. In memo-writing, I openly expressed thoughts and feelings that emerged throughout the interview. In my weekly meetings with Dr. Wieling, we discussed these feelings and how they could bias my interpretation. For example, Dr. Wieling and I processed the sadness of how cisnormativity emerged throughout the interviews with each of the experts and how my own experiences within the program and broader field could impact my interpretation of the data. It is important to note this co-construction was contextually situated. That is, what was constructed was an account of the *here* and *now*. I would be remiss if I did not situate the differences experts had in the field because of their gender identity and to hold multiple truths. There is a lack of collaboration in the field and systemic trans oppression creates barriers for TGNB scholars to have a seat at the table. In addition, this constructed story can only be told and understood in the US context at this particular moment. I would hope the knowledge constructed from this study differs if I were to conduct this in 2050 as it would indicate the field continued to develop for the better (fingers-crossed).

Analysis Plan

There are two approaches to narrative analysis: paradigmatic cognition and narrative cognition. Researchers who employ a paradigmatic cognition analyze participants' stories for common themes or ideas (Polkinghorne, 1995). This form of narrative inquiry can result in thematic findings (Roulston, 2010) or narrative structural approaches (Labov & Waletzky, 1967). Reissman (2008) combines elements of structural and thematic approaches to conduct a dialogic/performance analysis. In this approach, the researcher considers the context of the production of the narrative, the audiences, the content of the narrative, and the linguistic resources used by speakers to construct the story (Reissman, 2008). Those who employ narrative cognition are interested in producing individual cases and emplotted stories (Polkinghorne, 1995). In this approach, researchers are open to the unique elements to create plots to understand how and why things occur (Polkinghorne, 1995). For the purpose of this study, I used a paradigmatic cognition approach to data analysis.

I employed two narrative-informed analytic strategies. First, I wrote participants' stories into thick, descriptive narratives and then I conducted a thematic analysis across constructed narratives. I used examples of thick, narrative descriptions to serve as a guide for how to proceed. Examples of narrative inquiry included a study of pro-choice activist women (Ginsburg, 1989) and organizational stories (Boje, 1991). Because the participants' stories were contextually situated, I found Boje's (1991) work highly influential to this study. For example, clinical graduate training programs are couched within ethical, legal, and accreditation standards as well as the larger society. As such, certain organizational stories are told within these programs. To construct participants' narratives, I used examples from the chapters in the edited volume *Storied Lives: The cultural politics of self-understanding* (see Rosenwald & Ochsberg, 1992). Narrative

descriptions were used as a means to synthesize the three interviews into large, single units of analysis. These single units fit into the broader story of how the participants view their professional journey and their experiences as experts in TGNB mental health. I believe this structure allowed the participants' stories to be presented holistically and reflected the depths of their personal and professional perspective. Each participant narrative represents a "stand-alone story as research representation" (Saldana, 2013, p. 134).

A thematic analysis within and across the participant narratives was conducted. Braun and Clarke (2012) describe thematic analysis as a widely used, yet poorly defined method of qualitative data analysis. Thematic analysis is a method for systematically identifying, organizing, and observing themes across a data set. In addition, thematic analysis allows researchers to see and make sense of a collective or shared meaning. (Braun & Clarke, 2012). The method of thematic analysis has been employed in various studies on sexuality, gender identity, and higher education (Braun & Clarke, 2009; Clarke & Braun, 2009). Because of the accessibility and flexibility of thematic analysis (Braun & Clarke, 2012), I found it beneficial for examining across participants' narratives. For conducting the thematic analysis, I employed the six-phase approach as developed by Braun and Clarke (2006).

The purpose of the thematic analysis was not inductive, but rather deductive in that I wanted to communicate both congruent and divergent themes that emerged across participants within the pre-established categories. I began by re-familiarizing myself with the constructed narratives. During this time, I read and reread each narrative, and reflected critically on the themes generated within each and how those related to the aims of the dissertation. The second phase of this analysis required that I generate initial codes within and across the themes generated in the constructed narratives. I examined convergences and divergences through the

narratives. During phase three, I identified themes through the previously identified initial codes, which were then examined to determine how themes relate to one another. In the fourth phase, I analyzed each theme to ensure quality through cross-referencing themes, and within the fifth phase I provided names for the themes. For example, the broader category of Entry into the field was separated into two themes: If not me then who and Am I a trailblazer. In addition to naming themes, I discuss how these themes related to the overarching aim of the study. The final phase was the completed dissertation and subsequent manuscripts for publications.

Enhancing Trustworthiness

Because qualitative research does not rely on generalizability and validity as measures of strength and value, researchers assess it through trustworthiness. The criteria for trustworthiness include credibility, dependability, confirmability, and transferability (Lincoln & Guba, 1985). Credibility refers to internal consistency (Lincoln & Guba, 2000) to ensure the rigorous nature of research and how that is communicated (Gasson, 2004). It should be noted that although my major professor was able to provide oversight to methodology, she lacked content expertise. To ensure credibility, I engaged in peer debriefing with people who held content knowledge both inside and outside of UGA, researcher reflexivity, and member checking (Morrow, 2005). As previously described, participants reviewed their narrative and their interviews and provided feedback that was then incorporated.

Dependability focuses on how the study is conducted consistently across time, researchers, and analytical strategies (Gasson, 2004). That is, the construction process of findings should be as explicit and repeatable as possible (Morrow, 2005). To establish dependability, I carefully tracked the research design and maintained an audit trail. The audit trail was a detailed chronology of research activities and processes, influences on the data collection and analysis,

emerging findings, and analytic memos (Morrow, 2005). Dr. Wieling systematically reviewed sections of all transcriptions, audio recordings, research memos, and analyses that were organized in a HIPAA compliant university server. Weekly hour-long meetings were held to discuss various aspects of data collection, including the evolving interpretation of each interview and reflexive memos. For example, Dr. Wieling reviewed an interview where I expressed some concerns about how my own frustrations with the interview may have altered how I engaged with the participant. In her review, Dr. Wieling shared that it did not appear to her that my frustrations adversely impacted the interaction, but she noted to pay close attention during interpretation and representation of findings -- to my language and tone -- in that constructed narrative. During our meetings, we also challenged our own and each other's potential research biases. At times this immersed process led to what we now understand as healthy tensions and disruptions in our own relationship and critical analysis of the data. We stuck with the process and were able to return to some of those points of disruption. Isomorphically, some of the painful impacts of cisnormativity shared by participants were also taking place as we approached the data from different social locations. This awareness led us have purposeful conversations about the need to create spaces for those tensions, to note power imbalances, and commit to an ongoing reflexive process as we moved forward.

Confirmability addresses the issue of findings representing the data rather than beliefs, theories, and biases of the researcher (Gasson, 2004). More specifically, confirmability refers to the ability for the reader to confirm the adequacy of the findings based on how well the researcher ties the data, analytic process, and findings together (Morrow, 2005). To demonstrate confirmability, I used the strategies as highlighted above for dependability. Specifically, participants reviewed and provided feedback throughout the study, which I then incorporated. In

addition, Dr. Wieling and I met weekly to ensure the study was strong and of value. An example of change that was made from prospectus to final dissertation draft was a shift in formatting. I had originally planned on using the embedded manuscript format; however, after immersing myself in the data it became evident a traditional format would be able to tell a more compelling story.

Transferability refers to the extent to which readers can generalize the findings of the study to their own context (Gasson, 2004). To achieve transferability, I provided sufficient information about the self and the research context, processes, participants, and the researcher-participant relationship (Morrow, 2005). By providing this information, readers will be able to determine how the findings may or may not transfer to their context. Given the small sample size in qualitative research, I was clear to present the data in a way that did not infer generalizability in the conventional sense.

Data Presentation

While I wrote constructed narratives for each participant and conducted a thematic analysis across the narratives, I struggled to find a way to best present this data. Of course, it is traditional to report themes and provide quotations for illustration. However, as a study guided by queer theory, it provided an opportunity to be creative with data presentation. For example, data could be presented visually or poetically. As I began data collection and analysis, I consulted with Dr. Wieling on how to best present the data. For the dissertation defense, we decided it was best to proceed with a traditional approach. Beyond data presentation, we discussed various ways of disseminating findings. As a scholar pursuing an academic career, manuscripts and conference proceedings are vital for securing tenure status. Dr. Wieling and I discussed a range of creative methods for sharing results from the study. Data dissemination

strategies will continue to evolve. I am committed to identifying alternative strategies to represent the findings of the dissertation.

CHAPTER 4

PHASE 1 RESULTS

The purpose of Phase 1 of this study was to examine students' and faculty's self-reports of clinical competency working with TGNB clients and their perceived assessment of affirmative training in their clinical graduate program through a cross-sectional survey design. Data collected included demographics, GICCS-R, ATI-S for students, ATI-F for faculty, as well as open-ended responses to three prompts. The research questions for the student sample were: 1) What are students' assessments of the level of TGNB affirmative training they receive in their program? And does this differ across APA, CACREP, COAMFTE, and CSWE programs? 2) What is the level of students' self-reported competency working with TGNB clients? And does this differ across APA, CACREP, COAMFTE, and CSWE programs? 3) To what degree is students' assessment of the overall level of their TGNB affirmative training associated with their self-reported competency working with TGNB clients?

The research questions for the faculty sample in this study were: 1) What are faculty's assessments of the level of TGNB affirmative training they give in their program? And how does this differ across APA, CACREP, COAMFTE, and CSWE programs? 2) What is the level of faculty's self-reported competency working with TGNB clients? And how does this differ across APA, CACREP, COAMFTE, and CSWE programs? 3) To what degree is faculty's self-reported competency working with TGNB clients associated with their assessments of the level of TGNB affirming training in their program?

Sample Demographics

The majority of the student sample were doctoral students (60.6%). Of this sample, 31% reported being enrolled in an APA accredited program, 25.2% in COAMFTE, 17.4% in CACREP and CSWE, and 5.2% in a program with dual or multiple accreditations. The majority of the sample identified as cisgender women (73.5%) and White (67.7%). The mean age of participants was 29.80 ($SD = 7.22$), with a range of 22 to 55 years. In terms of type of educational institution, 60.6% reported attending a non-religious informed or non-religious institution. In terms of direct client contact, the sample was fairly equivalent when it related to having worked with at least one TGNB client (51% = yes, 49% = no), with students reporting having an average of 3.21 ($SD = 10.33$) TGNB clients and an average of 18.66 ($SD = 48.35$) hours of client contact with a TGNB client. Finally, 49.7% indicated attending at least one workshop related to working with TGNB clients and 70.3% reported receiving education related to TGNB affirmative training. Because almost half of the sample reported not attending any workshops, it may be likely that students are receiving some form of TGNB affirmative training in their programs.

Full sample demographics are listed in Table 3. A majority of the faculty sampled worked in a master's program (75.4%). Of this sample, 34.7% reported employment in a CSWE accredited program, 27.5% in CACREP, 20.3% in COAMFTE, 14.5% in APA, and 1.4% in a program with dual or multiple accreditations. The majority of the sample identified as being a cisgender woman (72.5%) and White (82.6%). The mean age of participants was 46.47 ($SD = 12.77$), with a range of 28 to 70 years. With regards to the type of educational institution, 73.9% reported working in a non-religious informed or non-religious institution. In terms of direct client contact, the majority reported working with at least one TGNB client (81.2%), with faculty

reporting having an average of 12.08 ($SD = 21.63$) TGNB clients and an average of 85.27 ($SD = 121.55$) hours of client contact with a TGNB client. Finally, 91.3 % indicated attending at least one workshop focused on TGNB affirmative therapy and 73.9% reported having received training related to TGNB affirmative therapy.

Table 3
Student (N = 155) and Faculty (N = 69) Demographics

	Student		Student		Faculty		Faculty	
	N	%	M	SD	N	%	M	SD
Age	--	--	29.80	7.22	--	--	46.47	12.77
Gender								
Cis Woman	114	73.5	--	--	50	72.5	--	--
Cis Man	21	13.5	--	--	14	20.3	--	--
TGNB	17	10.9	--	--	3	4.3	--	--
Prefer to Self-Identify	1	0.6	--	--	2	2.9	--	--
Race/Ethnicity								
African American/Black	12	7.7	--	--	0	0	--	--
Asian	5	3.2	--	--	4	5.8	--	--
American Indian/Alaskan Native	1	0.6	--	--	0	0	--	--
Latino/a/e/x	10	6.5	--	--	2	2.9	--	--
White European American	105	67.7	--	--	57	82.6	--	--
Multi-Racial	11	7.1	--	--	6	8.7	--	--
Accreditation Type								
APA	48	31.0	--	--	10	14.5	--	--
CACREP	27	17.4	--	--	19	27.5	--	--
COAFMTE	39	25.2	--	--	14	20.3	--	--
CSWE	27	17.4	--	--	24	34.8	--	--
Dual/Multi	8	5.2	--	--	1	1.4	--	--
Level of Training								
1 st Year Student	35	22.6	--	--	--	--	--	--
2 nd Year Student	55	35.5	--	--	--	--	--	--
3 rd Year Student	42	27.1	--	--	--	--	--	--
Doctoral Candidate	23	14.8	--	--	--	--	--	--
Degree Type								
Master's	94	60.6	--	--	52	75.4	--	--
Doctoral	61	39.4	--	--	17	24.6	--	--
Religious Affiliated								
Yes	61	39.4	--	--	18	26.1	--	--
No	94	60.6	--	--	51	73.9	--	--
Worked With TGNB								
Yes	79	51.0	--	--	56	81.2	--	--
No	76	49.0	--	--	13	18.8	--	--
Hours of Education	--	--	7.96	48.86	--	--	19.81	25.85
Number of Workshops	--	--	1.33	2.32	--	--	5.06	4.87

Note. TGNB = Transgender and nonbinary.

Research Question 1: Individual and program differences in Students' Level of TGNB Affirmative Training

Research Question 1 sought to assess the level of TGNB affirmative training students reported receiving in their clinical graduate programs. The mean score on the ATI-S for all participants was 4.52 ($SD = 0.94$) with a range of 1.64 to 6.00. Higher scores on the ATI-S indicated greater levels of affirmative training. It is interesting to note that 70.2% of participants reported receiving at least one hour of affirmative training and 51.1% reported attending one or more workshops focusing on TGNB affirmative training.

Student's Mean ATI-S scores by individual and program characteristics are displayed in Table 4. There were no significant differences by program type, degree type, age, having worked with a TGNB client, hours of client contact, nor number of workshops attended. However, there were significant differences based on gender identity, institution type, and hours of education related to TGNB affirmative training. Specifically, cisgender students reported higher scores on the total ATI-S, Classroom Subscale, and Program Subscale indicating they perceived their programs to be more affirming and receiving greater affirmative training compared to their TGNB counterparts. With relation to institution type, students from non-religious institutions reported higher scores on the total ATI-S, and the Program Subscale compared to students from religious institutions. Lastly, there were mean score differences in the total ATI-S score and Classroom Subscale for those with varying hours of education. Post-hoc analyses revealed that students who reported receiving 11-20 hours of education reported higher means on the ATI-S and Classroom Subscale compared to students who reported receiving 0-10 hours of education.

Table 4*Differences in Student ATI-S Scores by Individual and Program Characteristics (N = 155)*

	ATI-S Total Score		Classroom Subscale		Program Subscale	
	M (SD)	t/F	M (SD)	t/F	M (SD)	t/F
Program type						
APA	4.74 (0.79)	2.14	3.92 (1.17)	2.19	5.13 (0.71)	1.82
CACREP	4.16 (0.89)		3.12 (1.06)		4.60 (1.08)	
COAMFTE	4.45 (1.23)		3.74 (1.38)		4.94 (1.12)	
CSWE	4.61 (0.68)		3.69 (1.30)		4.94 (0.63)	
Age						
20-30	4.45 (0.97)	1.28	3.67 (1.19)	0.35	4.87 (0.96)	1.23
31-40	4.76 (0.89)		3.85 (1.46)		5.14 (0.77)	
41+	4.65 (0.89)		3.51 (1.37)		5.13 (0.76)	
Gender identity						
Cis	4.61 (0.92)	3.32**	3.78 (1.24)	2.71**	5.03 (0.84)	3.88***
Trans	3.72 (0.88)		2.81 (1.06)		4.06 (1.06)	
Degree type						
Masters	4.45 (1.01)	0.87	3.62 (1.26)	0.52	4.89 (0.94)	0.62
Doctoral	4.59 (0.90)		3.73 (1.26)		4.99 (0.89)	
Institution type						
Non-religious	4.66 (0.92)	2.06*	3.82 (1.23)	1.60	5.09 (0.86)	2.33*
Religious	4.32 (0.96)		3.47 (1.28)		4.72 (0.95)	
Prior work with TGNB						
No	4.41 (0.98)	1.52	3.51 (1.28)	1.61	4.81 (0.99)	1.78
Yes	4.65 (0.91)		3.85 (1.21)		5.08 (0.81)	
Hours of client contact						
0-25	4.49 (0.93)	2.14	3.62 (1.24)	1.53	4.90 (0.93)	1.09
26-50	4.90 (0.87)		4.13 (1.28)		5.23 (0.81)	
51+	4.25 (1.15)		3.52 (1.29)		4.91 (0.85)	
Hours of education						
0-10	4.45 (0.95) _a	3.75*	3.56 (1.24) _a	3.91*	4.90 (0.92)	2.57
11-20	5.18 (0.55) _a		4.51 (1.02) _a		5.48 (0.53)	
21+	4.69 (1.09)		4.06 (1.44)		4.81 (1.00)	
Number of workshops						
None	4.50 (0.93)	0.50	3.62 (1.18)	0.37	4.92 (1.00)	0.36
0-3	4.61 (0.96)		3.79 (1.34)		5.01 (0.80)	
4+	4.30 (1.07)		3.52 (1.30)		4.75 (0.88)	

Note. TGNB = transgender and non-binary. Means that share a subscript differed significantly in post-hoc analyses.

* $p < .05$, ** $p < .01$, *** $p < .001$

Research Question 2: Individual and program differences in Students' Level of Perceived Clinical Competency

Research Question 2 assessed students' self-reported clinical competency related to working with TGNB clients. The mean score of the GICCS-R was 5.19 ($SD = 0.51$), with a range of 3.80 to 6.48. Higher scores on the GICCS-R indicated greater levels of self-reported clinical competency. As explained previously, the GICCS-R is comprised of three subscales. The Awareness Subscale assesses participants' attitudes toward TGNB clients and individuals. The mean score for the Awareness Subscale was 6.74 ($SD = 0.47$), with a range of 4.50 to 7.00. The Knowledge Subscale assesses participants' understanding of cisnormativity and the discrimination faced by TGNB clients. The mean score for the Knowledge Subscale was 5.50 ($SD = 0.80$), with a range of 2.83 to 7.00. The Skills Subscale assesses participants' skills and experiences working with TGNB clients. The mean score for the Skills Subscale was 3.32 ($SD = 1.07$), with a range of 1.00 to 6.45.

Differences in students' self-reported clinical competency by individual and program characteristics are displayed in Table 5. There were significant differences on the Awareness Subscale by program type. Post-hoc analyses indicated students in APA programs reported greater awareness compared to students in CACREP programs. There was a significant difference on the Skill Subscale by students' age. Specifically, students who were 20-30 years old reported lower skill than those aged 31-40, and those aged 31-40 reported higher skill than those who were over 41 years old. With relation to gender identity, TGNB people reported greater awareness than their cisgender peers. Master's students reported higher overall competency compared to doctoral students. Students who were enrolled in a non-religious institution reported greater skill than students enrolled in a religious institution.

Students who have worked with a TGNB client reported greater overall competency, knowledge, and skill compared to students who have not worked with a TGNB client. Students with 0-25 hours of client contact reported less overall competency and skill compared to those with 26-50 hours and those with more than 51 hours of client contact. Students who reported receiving 0-10 hours of education reported higher knowledge than students who reported receiving more than 21 hours of education. Moreover, students who reported receiving 0-10 hours of education reported less skill compared to those who received 11-20 hours and those who received more than 21 hours. Students who reported attending no workshops rated less overall competency compared to those who attended between 0-3 workshops and those who attended four or more workshops. In addition, those who attended between 0-3 workshops reported less overall competency compared to those who attend four or more workshops. Lastly, students who reported attending no workshops also reported less skill compared to those who attended 0-3 workshops and those who attended four or more workshops

Table 5*Differences in Student GICCS-R Scores by Individual and Program Characteristics (N = 155)*

	GICCS-R Total Score		Awareness Subscale		Knowledge Subscale		Skill Subscale	
	<i>M</i> (SD)	<i>t/F</i>	<i>M</i> (SD)	<i>t/F</i>	<i>M</i> (SD)	<i>t/F</i>	<i>M</i> (SD)	<i>t/F</i>
Program type								
APA	5.30 (0.41)	2.23	6.88 (0.19) _a	3.12*	5.55 (0.80)	0.55	3.49 (0.90)	1.20
CACREP	4.99 (0.56)		6.54 (0.65) _a		5.34 (0.86)		3.10 (1.14)	
COAMFTE	5.22 (0.48)		6.72 (0.54)		5.50 (0.78)		3.43 (1.06)	
CSWE	5.15 (0.64)		6.73 (0.48)		5.60 (0.79)		3.13 (1.25)	
Age								
20-30	5.20 (0.46)	1.34	6.78 (0.42)	0.95	5.58 (0.73)	1.39	3.25 (1.02) _a	3.46*
31-40	5.26 (0.63)		6.65 (0.68)		5.35 (0.90)		3.78 (1.05) _{a,b}	
41+	5.00 (0.59)		6.68 (0.41)		5.31 (0.97)		3.02 (1.23) _b	
Gender identity								
Cisgender	5.18 (0.52)	1.20	6.72 (0.16)	3.21**	5.46 (0.79)	1.70	3.34 (1.09)	0.18
TGNB	5.35 (0.47)		6.92 (0.16)		5.84 (0.79)		3.29 (0.91)	
Degree type								
Masters	5.32 (0.45)	2.43*	6.82 (0.43)	1.64	5.59 (0.81)	1.12	3.53 (0.94)	2.00*
Doctoral	5.10 (0.54)		6.69 (0.51)		5.44 (0.77)		3.18 (1.13)	
Institution Type								
Non-Religious	5.25 (0.54)	1.74	6.74 (0.49)	0.11	5.49 (0.84)	0.28	3.52 (1.05)	2.84**
Religious	5.10 (0.46)		6.75 (0.45)		5.53 (0.72)		3.01 (1.02)	
Prior work with TGNB								
No	4.90 (0.38)	8.07***	6.71 (0.49)	0.86	5.35 (0.84)	2.73**	2.66 (0.77)	9.27***
Yes	5.48 (0.47)		6.78 (0.46)		5.68 (0.72)		3.97 (0.90)	
Hours of client contact								
0-25	5.08 (0.49) _{a,b}	12.96***	6.72 (0.50)	1.03	5.44 (0.83)	1.83	3.10 (1.01) _{a,b}	13.91***
26-50	5.57 (0.36) _a		6.84 (0.35)		5.79 (0.66)		4.08 (0.81) _a	
51+	5.59 (0.47) _b		6.88 (0.36)		5.64 (0.60)		4.26 (0.97) _b	
Hours of education								
0-10	5.16 (0.50)	1.37	6.73 (0.50)	0.38	5.56 (0.74) _a	3.66*	3.19 (1.02) _{a,b}	7.01***
11-20	5.38 (0.57)		6.75 (0.42)		5.45 (0.91)		3.94 (1.04) _a	
21+	5.31 (0.63)		6.88 (0.19)		4.83 (1.11) _a		4.22 (1.02) _b	
Number of workshops								
None	5.05 (0.46) _{a,b}	9.26***	6.77 (0.39)	0.49	5.48 (0.81)	2.20	2.90 (0.94) _{a,b}	16.16***
0-3	5.28 (0.50) _{a,c}		6.70 (0.58)		5.45 (0.80)		3.70 (0.96) _a	
4+	5.71 (0.62) _{b,c}		6.81 (0.34)		6.04 (0.55)		4.29 (1.28) _b	

Note. TGNB = transgender and non-binary. Means that share a subscript differed significantly in post-hoc analyses.

* $p < .05$, ** $p < .01$, *** $p < .001$.

Research Question 3: Students' Affirmative Training and Perceived Clinical Competency

Research Question 3 sought to determine whether the level of TGNB affirmative therapy training students receive was associated with students' self-reported clinical competency related to working with TGNB clients. The Pearson correlations between the student GICCS-R subscales and the student ATI-S were $r(135) = -.02, p = .79$, $r(135) = -.18, p < .05$, $r(135) = .33, p < .001$ for Awareness, Knowledge and Skills, respectively. The results of the Pearson correlation revealed students' reported level of affirmative training they received in their program was not correlated with their awareness. Students' reported level of affirmative training was negatively correlated with their knowledge and positively correlated with their skill. Given that the Awareness Subscale and the ATI-S were not significantly correlated, this subscale was excluded from the multivariate regression analyses. Table 6 reports the multivariate regression of the student GICCS-R subscales on the ATI-S adjusting for individual and program characteristics.

After adjusting for individual and program characteristics, there was no significant association between a student's experience of affirmative training and the Knowledge subscale of the GICCS-R. In contrast, there was a significant association between experience of affirmative training as measured by the ATI-S and the Skills subscale of the GICCS-R. Students who reported higher amounts of affirmative training perceived themselves to be more competent in terms of their clinical skills with TGNB clients.

Table 6

Regression of Student GICCS-R Subscales on Individual Characteristics, Programmatic Characteristics, and Affirmative Training Experience

	Knowledge Subscale		Skill Subscale	
	b (SE)	<i>t</i>	b (SE)	<i>t</i>
Intercept	6.20 (0.36)	17.19***	1.77 (0.45)	3.96***
Age	--	--	-.01 (0.01)	-1.03
Gender identity (1= cisgender)	-0.30 (0.23)	-1.30	--	--
Degree type (1 = master's)	--	--	-0.16 (0.14)	-1.11
Institution type (1 = religious)	.02 (0.14)	0.15	-0.22 (0.14)	-1.56
Prior exp w/TGNB Client	.44 (0.13)	3.29**	1.00 (0.16)	6.31***
Hours of client contact	--	--	0.01 (0.00)	2.07*
Hours of education	-.01 (0.01)	-1.94 ⁺	0.01 (0.01)	1.20
Number of workshops	--	--	0.12 (0.04)	2.77**
ATI-S Total score	-0.13 (0.07)	-1.79 ⁺	0.27 (0.07)	3.72***

Note. TGNB = Transgender and nonbinary.

⁺ $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$.

Research Question 4: Individual and program differences in Faculty's Level of TGNB

Affirmative Training

Research Question 4 sought to assess the level of TGNB affirmative training faculty reported providing in their clinical graduate programs. The mean score on the ATI-F for all participants was 4.47 ($SD = 0.76$) with a range of 2.13 to 5.73. Higher scores on the ATI-F indicated greater levels of affirmative training. It is interesting to note that 73.1% of participants reported receiving at least one hour of affirmative training and 91% reported attending one or more workshops focusing on TGNB affirmative training.

Faculty's mean ATI scores by individual and program characteristics are displayed in Table 7. There were no significant mean score differences on the ATI-F total score or the subscales for program type, degree type, institution type, nor prior work with TGNB clients. However, there were significant mean differences based on age, gender identity, hours of client contact, hours of education, and number of workshops on the ATI-F and subscales. Post hoc analyses indicated faculty aged 20-30 reported greater programmatic affirmative stance

compared to those aged 31-40 and those 41 and older. TGNB faculty reported higher experience than their cisgender counterparts. Post-hoc analyses for client contact hours indicated those who had between 0-25 client contact hours with TGNB clients reported less affirmative training provided, less TGNB content included in their curricula, and less experience compared to faculty who had 26-50 client and those with 51 or more hours of client contact. Faculty with 0-10 hours of education reported less inclusion of TGNB content in their curricula compared to faculty with 21 or more hours of education. Faculty who reported attending no workshops reported less affirmative training provided and less TGNB content in curricula compared to faculty who attended four or more workshops. In addition, faculty who reported attending no workshops reported less experience compared to faculty who attended 0-3 workshops and faculty who attend four or more workshops. Faculty who reported attending 0-3 workshops reported providing less affirmative training, less TGNB content inclusion in their curricula, and less experience compared to faculty who attended four or more workshops.

Table 7*Differences in Faculty ATI-F Scores by Individual and Program Characteristics (N = 69)*

	ATI-F Total Score		Teaching Subscale		Program Subscale		Experience Subscale	
	M (SD)	t/F	M (SD)	t/F	M (SD)	t/F	M (SD)	t/F
Program type								
APA	4.52 (0.90)	0.47	4.59 (1.34)	0.65	4.60 (0.88)	0.57	4.18 (1.35)	0.93
CACREP	4.62 (0.75)		5.02 (1.01)		4.49 (0.86)		4.58 (0.89)	
COAMFTE	4.41 (0.90)		4.61 (1.28)		4.32 (1.06)		4.38 (1.05)	
CSWE	4.35 (0.63)		4.59 (0.99)		4.22 (0.80)		4.03 (1.14)	
Age								
20-30	4.86 (0.63)	1.37	5.38 (0.98)	1.17	4.97 (0.65) _a	4.70*	4.40 (1.35)	0.39
31-40	4.27 (0.82)		4.54 (1.20)		3.92 (0.88) _b		4.44 (1.26)	
41+	4.51 (0.73)		4.73 (1.06)		4.52 (0.81) _{a,b}		4.19 (0.99)	
Gender identity								
Cisgender	4.43 (0.77)	1.01	4.67 (1.12)	1.29	4.36 (0.89)	0.50	4.20 (1.08)	2.01*
TGNB	4.79 (0.52)		5.33 (0.71)		4.57 (0.64)		5.20 (0.86)	
Degree type								
Masters	4.50 (0.69)	0.58	4.82 (1.02)	1.23	4.35 (0.80)	0.74	4.37 (1.08)	1.05
Doctoral	4.37 (0.94)		4.44 (1.29)		4.47 (1.04)		4.04 (1.12)	
Institution type								
Non-religious	4.49 (0.71)	0.37	4.76 (1.08)	0.44	4.43 (0.81)	0.74	4.29 (1.04)	0.13
Religious	4.41 (0.89)		4.61 (1.21)		4.24 (1.04)		4.25 (1.27)	
Prior work with TGNB								
No	4.22 (0.82)	1.27	4.36 (1.34)	1.28	4.13 (0.91)	1.13	3.96 (1.15)	1.14
Yes	4.52 (0.74)		4.80 (1.04)		4.44 (0.86)		4.36 (1.07)	
Hours of client contact								
0-25	4.17 (0.91) _{a,b}	3.77*	4.15 (1.31) _{a,b}	7.59***	4.24 (1.00)	0.60	3.82 (1.11) _a	5.40**
26-50	4.74 (0.55) _a		5.32 (0.57) _a		4.51 (0.83)		4.90 (0.88) _a	
51+	4.63 (0.57) _b		5.00 (0.78) _b		4.46 (0.75)		4.44 (0.99)	
Hours of education								
0-10	4.32 (0.74)	2.83	4.42 (1.10) _a	5.14***	4.35 (0.79)	1.10	4.01 (1.10)	2.63
11-20	4.38 (0.95)		4.62 (1.17)		4.12 (1.29)		4.52 (0.98)	
21+	4.81 (0.55)		5.37 (0.78) _a		4.60 (0.70)		4.67 (1.04)	
Number of workshops								
None	3.92 (0.53) _a	5.64**	3.67 (1.03) _a	10.00***	4.42 (0.65)	1.30	2.92 (0.89) _{a,b}	12.13***
0-3	4.24 (0.84) _b		4.31 (1.18) _b		4.17 (0.92)		3.97 (1.05) _{a,c}	
4+	4.74 (0.61) _{a,b}		5.22 (0.77) _{a,b}		4.54 (0.86)		4.77 (0.85) _{b,c}	

Note. TGNB = transgender and non-binary. Means that share a subscript differed significantly in post-hoc analyses.

* $p < .05$, ** $p < .01$, *** $p < .001$.

Research Question 5: Individual and program differences in Faculty's Level of Perceived Clinical Competency

Research Question 5 assessed faculty's self-reported clinical competency related to working with TGNB clients. The mean score of the GICCS-R was 5.62 ($SD = 0.57$), with a range of 4.14 to 6.67. Higher scores on the GICCS-R indicated greater levels of self-reported clinical competency. As explained previously, the GICCS-R is comprised of three subscales. The Awareness subscale assesses participants' attitudes toward TGNB clients and individuals. The mean score for the Awareness subscale was 6.79 ($SD = 0.40$), with a range of 4.90 to 7.00. The Knowledge subscale assesses participants' understanding of cisnormativity and the discrimination faced by TGNB clients. The mean score for the Knowledge subscale was 5.79 ($SD = 0.88$), with a range of 2.83 to 7.00. The Skills subscale assesses participants' skills and experiences working with TGNB clients. The mean score for the Skills subscale was 4.27 ($SD = 1.10$), with a range of 1.91 to 6.27.

Differences in faculty's self-reported clinical competency by individual and program characteristics are displayed in Table 8. There were no significant mean differences on the GICCS-R total score and the three subscales between program types, age, gender identity, degree type, nor institution type. There were significant mean scores differences between prior work with TGNB clients, hours of client contact, hours of education, and number of workshops. Faculty who reported prior work with TGNB clients had greater overall clinical competency working with TGNB clients and greater skill compared to those with no prior experience. Post-hoc analyses indicated faculty who reported between 0-25 hours of client contact reported less clinical competency and less skill than faculty with 26-50 client contact hours and those with 51 or more hours of client contact. Faculty who reported receiving between 0-10 hours of education

reported less skill than faculty who received 11-20 hours of education. Faculty who attended no workshops reported less overall competency and skill compared to those who attended 0-3 workshops and those who attended four or more workshops. Faculty who attended 0-3 workshops reported less overall competency and skill compared to those who attended four or more workshops.

Table 8*Differences in Faculty GICCS-R Scores by Individual and Program Characteristics (N = 69)*

	GICCS-R Total Score		Awareness Subscale		Knowledge Subscale		Skill Subscale	
	<i>M</i> (SD)	t/F	<i>M</i> (SD)	t/F	<i>M</i> (SD)	t/F	<i>M</i> (SD)	t/F
Program type								
APA	5.64 (0.52)	1.27	6.91 (0.27)	0.59	5.94 (0.87)	2.17	4.07 (1.13)	0.46
CACREP	5.52 (0.59)		6.82 (0.35)		5.52 (1.18)		4.21 (0.85)	
COAMFTE	5.87 (0.59)		6.79 (0.56)		6.25 (0.61)		4.56 (1.25)	
CSWE	5.54 (0.54)		6.72 (0.36)		5.69 (0.65)		4.22 (1.21)	
Age								
20-30	6.06 (0.60)	1.73	7.00 (0.00)	2.10	6.37 (0.70)	1.17	4.82 (1.15)	1.30
31-40	5.56 (0.64)		6.88 (0.28)		5.79 (0.84)		4.01 (1.36)	
41+	5.59 (0.51)		6.71 (0.45)		5.73 (0.92)		4.34 (0.92)	
Gender identity								
Cisgender	5.60 (0.57)	0.85	6.80 (0.38)	0.87	5.78 (0.90)	0.19	4.21 (1.10)	1.48
TGNB	5.82 (0.53)		6.64 (0.54)		5.87 (0.62)		4.96 (0.95)	
Degree type								
Masters	5.65 (0.60)	0.80	6.78 (0.42)	0.36	5.76 (0.92)	0.51	4.41 (1.09)	1.82
Doctoral	5.52 (0.46)		6.82 (0.32)		5.89 (0.79)		3.84 (1.06)	
Institution Type								
Non-Religious	5.61 (0.60)	0.27	6.76 (0.45)	1.48	5.82 (0.86)	0.41	4.24 (1.18)	0.36
Religious	5.65 (0.49)		6.87(0.19)		5.72 (0.96)		4.35 (0.89)	
Prior work with TGNB								
No	5.06 (0.57)	4.21***	6.78 (0.41)	0.12	5.56 (1.03)	1.04	2.86 (0.66)	6.15***
Yes	5.74 (0.49)		6.79 (0.40)		5.85 (.85)		4.58 (0.92)	
Hours of client contact								
0-25	5.25 (0.53) _{a,b}	13.35***	6.74 (0.36)	1.27	5.67 (1.01)	2.21	3.35 (0.96) _{a,b}	26.86***
26-50	6.00 (0.26) _a		6.94 (0.17)		6.23 (0.41)		4.84 (0.45) _a	
51+	5.78 (0.51) _b		6.76 (0.49)		5.69 (0.88)		4.88 (0.82) _b	
Hours of education								
0-10	5.49 (0.58)	2.85	6.79 (0.34)	0.03	5.72 (1.00)	0.35	3.97 (1.05) _a	5.55**
11-20	5.64 (0.50)		6.76 (0.32)		5.94 (0.81)		4.23 (1.01) _a	
21+	5.88 (0.51)		6.79 (0.55)		5.87 (0.63)		4.97 (1.00)	
Number of workshops								
None	5.09 (0.44) _a	7.36***	6.75 (0.31)	0.03	5.16 (0.95)	2.33	3.35 (1.12) _a	8.83***
0-3	5.46 (0.64) _b		6.79 (0.37)		5.72 (1.06)		3.86 (1.16) _b	
4+	5.83 (0.42) _{a,b}		6.79 (0.43)		5.96 (0.66)		4.75 (0.81) _{a,b}	

Note. TGNB = transgender and non-binary. Means that share a subscript differed significantly in post-hoc analyses.

* $p < .05$, ** $p < .01$, *** $p < .001$.

Research Question 6: Faculty provision of affirmative training as a function of perceived Clinical Competency

Research Question 6 sought to determine whether the faculty's self-reported clinical competency was associated with the level of affirmative training provide in their program adjusting for individual and programmatic characteristics. The Pearson correlations between the faculty ATI-F subscales and the faculty GICCS-R were $r(67) = -.77, p < .001$, $r(67) = .31, p < .05$, $r(67) = .62, p < .001$ for Teaching, Program, and Experience, respectively. The results of the Pearson correlation revealed faculty's reported clinical competency were positively associated with their scores on the three subscales. With the bivariate analyses indicating no significant mean score differences on the Program Subscale by individual nor programmatic characteristics it was excluded from the multivariate regression analyses. Table 9 reports the multivariate regression of the faculty ATI-F subscales on the GICCS-R adjusting for individual and program characteristics.

After adjusting for individual and program characteristics, there was a significant association between faculty's reported clinical competency and their provision of affirmative training in terms of both teaching and experience. Faculty who reported greater clinical competency were more likely to include TGNB topics in their courses and have greater experience with TGNB people through their clinical work, research, or supervision.

Table 9

Regression of Faculty ATI-F Subscales on Individual Characteristics, Programmatic Characteristics, and Clinical Competency

	Teaching Subscale		Experience Subscale	
	b (SE)	<i>t</i>	b (SE)	<i>t</i>
Intercept	-3.01 (0.94)	-3.19*	-0.81 (1.16)	-0.70
Gender identity (1= cisgender)	--	--	-0.80 (0.41)	-1.96 ⁺
Prior exp w/TGNB Client	-0.42 (0.26)	-1.63	-0.20 (0.00)	-0.66
Hours of client contact	0.00 (0.00)	0.49	0.00 (0.00)	-1.65
Hours of education	0.00 (0.01)	0.44	--	--
Number of workshops	0.03 (0.03)	1.06	0.06 (0.03)	2.22*
GICCS-R Total score	1.39 (0.18)	7.69***	1.04 (0.21)	4.97***

Note. TGNB = Transgender and nonbinary.

⁺ $p < .10$, * $p < .05$, ** $p < .01$, *** $p < .001$.

CHAPTER 5

PHASE 2 RESULTS

The aims of Phase 2 of this study were two-fold: 1) Garner in-depth accounts of experts in TGNB mental health and their experiences engaging in the field to advance training initiatives, and 2) Understand and document specific strategies to increase TGNB affirming training in mental health as recommend by the eight experts. In this contextually situated narrative inquiry study, participants engaged in three in-depth interviews. Each interview focused on a specific domain. The first interview focused on the participants' professional development, the second interview focused on experiences in the field as related to conducting TGNB inclusive work, and the final interview focused on hopes and recommendations to further advance the mental health field. The analyzed data was presented in two ways. First, an individual constructed narrative was created for each participant by drawing upon the information provided across the three interviews. Second, a thematic analysis was conducted within and across constructed narratives to highlight emergent themes and subthemes across participants' narratives. Prior to displaying the results of the constructed narratives and thematic analysis, sample demographics are provided.

Sample Demographics

With respect to racial/ethnic identification, of the eight participants, six were White, one was Persian, and one was Afro-Caribbean. With regards to gender identity, three were cisgender women, one was transgender woman, two were transgender men, and two were non-binary. In terms of highest level of education obtained, six participants reported holding a doctorate degree

and two participants have a master's degree with one of them working towards a doctorate. Participants ranged in professional affiliation. Five participants were MFTs, two participants were counseling psychologists, and one participant was a clinical psychologist. In this sample, participants' experiences in the field ranged from 9 years to 27 years. Most of the participants in this sample reported being full-time clinicians ($n = 5$) with the others working primarily in academia as either faculty or staff ($n = 3$).

Dr. Deb Coolhart

Dr. Deb Coolhart obtained her Bachelor of Science in Psychology and Families studies from Central Michigan University. She then received her MA and Ph.D. in Marriage and Family Therapy from Syracuse University. Since 2007, Dr. Coolhart has been a faculty member in the MFT program at Syracuse University and continues to practice MFT. She provides regular consultation and national trainings on transgender affirmative therapy approaches. Throughout her impressive career as both an educator and scholar, Dr. Coolhart established the Gender Expansive Support Team (GEST) which trains master's level therapists to provide therapy services to the transgender and non-binary community in Central New York. Although she has provided numerous hours of training and published extensive literature on transgender affirmative therapy, she situates *The Gender Quest Workbook: A Guide for Teens and Young Adults Exploring Gender Identity* as one of her greatest contributions to the field.

I was first introduced to Dr. Coolhart's work in my master's program. As described before, LGBT content was a center piece of the CFT program at NDSU. The faculty at NDSU, Dr. Kristen Benson, Dr. Christi McGeorge, and Dr. Tom Carlson, regularly assigned readings related to LGBT mental health and affirmative therapy and Dr. Coolhart was among those scholars whose work we read. While I understood at the time that an affirmative stance towards transgender people was emerging in the field, I did not fully recognize how new affirmative practices were to the field. As a master's level trainee, I thought it was common practice to engage in further education related to gender identity and examine your own cisnormative biases. Although I worked as an Associate Licensed Marriage and Family Therapist in Fargo and encountered trans-negativity from other mental health professionals, I was more taken aback when fellow Ph.D. students at UGA held trans-negative ideologies. I remember thinking to

myself, “The program at UGA tends to be more socially just relative to other Ph.D. programs, how are people unaware of their own cisnormative assumptions?” In many ways, my experience within this program spurred a change in my research agenda. While my research agenda has focused broadly on gender, it has evolved to focus on transgender and non-binary identities and how to work affirmatively with the trans community. It is not uncommon for me to engage in professional situations where I must encourage other mental health professionals to examine their cisnormative assumptions and how those might impact their clinical work. There were moments during my interview with Dr. Coolhart where I found myself thinking, “Had I figured out my research agenda before UGA would I have ended up at Syracuse working with her?”

“Giving back to the community”

Dr. Coolhart has been in the MFT field for 21 years. She shared her passion for transgender affirmative work begun when she was going through her own coming out process and working with a local LGBT youth group. During her time at the youth group, she recognized the unique needs of transgender children and noticed a dearth in the literature. Because of the relationship she has created with the transgender community she has found it meaningful to give back to the community.

I loved that work; the kids were so advanced 20 years ago. It's a different kind of context, culturally, and I thought the kids were just amazingly brave and spunky and cool. I started working with them individually as needed, and a lot of the kids I worked with were trans kids. At the time, I didn't know much about it, there wasn't a lot available. It became apparent to me really quick that these kids and adults need mental health providers to get their medical treatments. So that was something that was a hole in terms of a missing spot, no one was really doing that work in my area. I decided that was something I could try to fill in terms of feeling like I'm being an advocate for my community.

Dr. Coolhart reflected on how her privilege as a cisgender woman enables her to create change but shared excitement in seeing and hearing more transgender and non-binary clinicians and scholars emerge.

I have a ton of privilege in the way that I am queer. And a lot of folks don't. So, I feel like I am using my privilege to create changes, that's what I want to do. I'm out here speaking up for this population that I'm not a part of. So, it's really cool to me that trans folks are starting to add to that voice.

“The OG – The Original Gangsta”

In many ways, Dr. Coolhart has been one the few original scholars paving the way for transgender affirmative practice. Dr. Coolhart reflected at the time she would attend conferences to meet with Ari Lev, the original family therapist who focuses on transgender affirmative practices. She recounted wanting to read material written by Lev because it was hard to find literature that was not trans-negative.

Ari Lev, you are probably familiar with her. I consider her the OG – the original gangsta of this work. She was doing it before me, like the only family therapist doing it before me. I would go see her at conferences and read her material. She identifies as a family therapist, and she was really the first person to write about transition as a family experience or relational experience. But in terms of thinking of it systemically – being able to support not only the trans person, but also the process that their loved ones are going through around transition or a shift in understanding.

Although Dr. Coolhart does not worry too much about how many citations she receives, she does want to be recognized for her work as one of the “original gangstas.”

Journals send me any article that has anything to do with trans stuff. There are sometimes these young scholars that are like, “No one has ever talked about this.” And I am like, “Well, actually, you need to be citing me. You need to be citing Ari Lev.” I do want to be recognized; I've been doing this for a long time before it was cool. But it's less so than feeling like I've made a change in the world.

“Well, it's a welcome shift”

In the second interview, Dr. Coolhart expressed how throughout her career her experience engaging in transgender affirmative therapy has shifted. She recounted being met

with more resistance at the beginning of her career, whereas, today she is encountering more unintentional ignorance.

Well, it's a welcome shift. Towards the beginning of my work, I had to do a lot of advocacy in schools. People were more defensive about - "what do you expect us to do?" Now it feels a lot more like people want to support but don't know how.

Dr. Coolhart reflected how her own emotional experiences in advocating for transgender affirmative therapy have evolved. At the beginning of her career, anxiety often visited her. For example, there were times when talking with school administrators and staff where she felt like she was "in front of a firing squad."

I remember how it used to feel different. I remember feeling a lot of anxiety going into those settings. Advocacy was more important. So, it's not like it made me back down. It certainly has made my job a lot easier when people are more receptive.

With garnering more experience, Dr. Coolhart feels more comfortable confronting people.

As I've gotten more experience, it has become easier for me to handle that kind of resistance, or not resistance, but like confronting people when they were not using language that was friendly. Sometimes I have to do that what when I'm doing collaborative work with providers if my clients are engaged in other services. I'm having to talk to those providers that they might be misgendering or using an incorrect name and I guess I've gotten used to correcting them.

Beyond confronting people, Dr. Coolhart also challenges others to reflect on how their assumptions come into play. She routinely invites others to engage in self-of-the-therapist work by placing the question back onto them; especially in trainings and at conferences.

Sometimes there'll be one or two people that are – usually it's a White man in his 60s or 70s. And I'll get questions like, "So what do you think about the Caitlyn Jenner thing?" And I will be like, "What do you mean? That's a pretty big question. I think it is sad that someone had to live most of their life not being able to be who they were and think it's wonderful that she's found who she is." And then they will say, "Don't you think she just does it for the money?" And I'm just like, "I think maybe it would be helpful for you to think about why you're asking that question." So, I kind of put it back on them. I've had times where I've been – I call it heckled or grilled during a workshop.

Dr. Coolhart provided insightful reflection with regards to *resistance*. She elaborated on how lack of education can appear as resistance or hesitation in not providing transgender affirmative services.

They are just sort of not educated and they want to be, they want to provide care for people. Sometimes I think people are hesitant to. So, with writing letters of support for medical treatments, any master level clinician is qualified to do that if they have the knowledge to do it. I think a lot of people are afraid to do that, so I think that's another place of resistance. And I understand that feeling, because when I first started the work 20 years ago, I was afraid too, I was like, "Oh my god, what if I make a mistake."

Another area in which Dr. Coolhart has witnessed a welcome shift is within the realm of publishing. Early in her career she noticed she had to publish her work outside of MFT specific journals. During that time, these journals were not receptive to work related to transgender affirmative therapy; however, that has shifted over the decades.

I'm crossing back over into publications that earlier on in my career I would publish outside of the family therapy journals, because the family therapy journals weren't receptive. And that's changed, so I was talking to you about how sometimes people will write articles and they'll be like, "You know this is the first family therapy thing to ever think about this." And it's like no, family therapists had to publish outside of family therapy. But the newer generation doesn't understand that historical context.

"I often feel disappointed with the national organization"

Although Dr. Coolhart expressed appreciation for the advancement in the larger mental health field, she shared frustration and disappointment with the national organization for MFTs, AAMFT.

APA, social work, and all of these other organizations have very clear statements saying reparative therapy is unethical. MFT has said something like, "It's been shown that being LGBT is not pathological. So, we don't see the need for reparative therapy." Which is a very different statement than saying its wrong. It feels more wishy-washy to me. The national conference, they don't accept me. I remember one year, I proposed to do a workshop on working with families who are adjusting to a trans person coming out based on three qualitative studies I've done, so it was a research-based therapy model for working with families. They rejected it, and the trans topic they allowed that year was like trans 101. So, I often feel disappointed in my national organization around some of this stuff.

Dr. Coolhart shared the wishy-washy statement produced by AAMFT sends a clear message that it's okay to not be LGBT affirmative, which she has encountered in her own experience as a faculty member. She told the story of a master's level student expressing the desire to not see an LGBT client. Without the larger organization taking a clear stance toward becoming inclusive, Dr. Coolhart expressed concerns that it continues to perpetuate the field not to change or to change more slowly relative to the other mental health disciplines.

I find it embarrassing. I love my field because I think systemic thinking is vital. And you know family systems is one level of systemic thinking, but larger systems is another way of systemic thinking, and this is a way that we're not addressing a systemic problem. Systemic homophobia and transphobia is a problem. And not taking a stance on that feels embarrassing to me.

An area that relates to Dr. Coolhart's frustration with the larger organization is the varying degree of education within graduate programs. Within in her program, the faculty position social justice as a core foundational value, which does not happen within all programs. Because of the variation across institutions, it is possible for some to receive no affirmative training, some to receive minimal training, and some to receive more to advanced level of training.

And I think there's probably varying degrees, right? There's probably programs that don't address it at all, probably programs that address it with one article throughout the whole program, and then my program it's quite central in our training program.

“I feel lucky to be in a program that values my work.”

Dr. Coolhart expressed great appreciation for working at a university that values her work. She recounted numerous instances in which the program and the department supported her advocacy for transgender affirmative practices. For example, the MFT program changed their intake documentation, signage, and pamphlets to include transgender affirming resources. In addition, the department supported her efforts in hiring an adjunct who also specializes in trans care to help with supervising clinical work. When both her and the adjunct faculty member felt

overburdened by the supervisory need, the other MFT faculty underwent the necessary training to provide quality supervision.

The department supported hiring an adjunct who also specializes in trans care. And then, even after a while, both he and I couldn't handle all of the supervisees. So, all of the faculty engaged in training with me around doing that kind of supervision that includes the readiness process.

Because of the immense support Dr. Coolhart has received from the department and university, she has hesitated to consider a move. She recounted a time in which she was considering a move and she found herself wondering if another department and university would support her research agenda.

There was a time I was considering a move and was interviewing. I felt like I didn't know how I would be received. Looking at my CV and what I focus on I probably wouldn't be accepted everywhere or supported everywhere.

“The gatekeeper role in terms of having some say in what gets out there – I really like that role.”

Dr. Coolhart reflected she is not keen on the gatekeeping role for transgender clients to receive the necessary care, but she does enjoy the gatekeeping role as a journal reviewer. She shared she feels she can somewhat control what reaches scholars and clinicians. In addition, it allows her to guard and protect transgender people from being further pathologized. The types of reviews Dr. Coolhart provides range from outright rejecting an article because of blatant transphobia to requesting revisions and having authors be explicit in their use of language.

That has taken a range of forms. There have been at least one or two pieces that I've read that have been really transphobic and very reactive. I sent a note to the editor saying, “If you publish this, it will be a huge mistake. It will perpetuate transphobia in the field. And it was rejected. I assume the other reviewers rejected it too. A lot of times I am questioning language. I question the use of “deviant.” I question the use of the word “pass.”

Although Dr. Coolhart feels at times she is being “picky,” she wants to ensure scholars are representing what they are actually gathering. For example, when quantitative researchers’ gender question provides the option of either male or female, it creates limitations within data collection and analysis.

I’m thinking of quantitative research where they’re classifying people as trans or not, or they’ll say LGBT, but it doesn’t include trans. Sometimes I want to know, what question did you ask to assess this? Because if your gender question is male or female, trans people will check male or female if you are not also asking if they are trans. If a trans man checks male, he is not captured as a trans person in the data. Sometimes I am really pushing for people to clarify that stuff and to acknowledge the limitations in their data collection.

“It feels like it’s kind of a tug of war.”

In the final interview, Dr. Coolhart shared how she feels the field has shifted and also how the field has yet to shift. She reflected on how MFT journals are publishing more trans related articles, trans focused presentations are more frequent at conferences, and more trans folks are becoming clinicians and scholars. Although these important changes have been made, Dr. Coolhart lamented resistance to transgender affirmative practice is still present in the MFT field.

I feel like we have a surge of queer folks in our field and we are pushing to move this in a different direction. And then the other side is pushing us in the other direction. There’s a lot of people in the middle that maybe aren’t centered around this topic, but you know, I feel like it’s kind of a tug of war.

When invited to speculate on how to navigate the tug of war, Dr. Coolhart reflected she gets stuck. She shared scholars need to keep publishing transgender affirmative scholarship, but it feels like to some extent the strategy is like that of larger society – to wait out the older generation, so the next generation can take the helm. Beyond waiting, she expressed curiosity around the possibility of having an open dialogue between the queer folks and the conservative religious folks with hopes of opening people’s hearts.

Wouldn't that be cool if there was like a forum at AAMFT that we could talk about this tension between religion and queerness, and what we are doing with that. That, to my knowledge has not happened and it would be congruent thinking about us as systems thinkers that we could actually have a conversation with our system. That would be cool. I think what I see more often is that some of the conservative folks will come into workshops and then there'll be arguments. I think it's not really that productive.

“I like this! I can hand over some of this stuff.”

When Dr. Coolhart was asked to share her recommendations for the next set of scholars, she expressed excitement, and the metaphor of running a relay emerged within the conversation. The first recommendation she provided was to keep doing the work, “like you have to, there’s no other options” and to have supportive colleagues and others who have been in the field to continue the necessary work is vital.

I always quote a Bob Marley song, “Rise up fallen fighters, rise and take your stance again. He who fights and run away, lives to fight another day.” So, it’s like the idea that you can’t necessarily always be fighting because you are going to run out of steam. It’s okay to not take up every single issue, but then to keep fighting. Having colleagues that are supportive. I really love this project because it’s a really cool way to connect sort of intergenerationally. We’re talking about passing the baton and like we could do a relay – you can take a lap and then I’ll come back and do a lap. I think that connecting with people that have been around is helpful.

A second recommendation is to continue to push for further education, especially for faculty. Dr. Coolhart shared an important step in increasing transgender affirmative practices is for training programs to begin to include such topics. She reflected that if faculty do not have the necessary education, then it is not likely for transgender affirmative practices to be taught. One strategy she proposed is having faculty engage in self-of-the-therapist work to examine their own biases and assumptions. Further education has implications for how trans students feel supported in their training programs.

It goes back to training the faculty. Faculty need to be knowledgeable, so that they can support students. My experience has been that trans students in my program feel really at home. I don’t know that it’s different than what we’ve talked about, programs just need to become more affirming, so they know how to affirm you. I’ve had students come from

other programs and be like, “Oh my god, this is so different, I’ve never felt like I could express myself in this way.” Or “I feel like I grew up in this program, because it was the first time I’d ever felt affirmed around my identity.” If they’re affirming in their education that’s going to affect their students too.

A third recommendation related to restructuring courses to center the experiences of trans folks. Dr. Coolhart shared how she “queers” her courses in that she will intentionally place trans issues within the first two weeks of classes to ensure her students become accustomed to discussing trans topics. In addition, she regularly provides clinical examples from her own work with trans individuals and families to increase students’ exposure to trans experiences. Lastly, she will routinely invite her students to consider how certain therapeutic topics might look different when centering trans people.

And integrating it into like, obviously, diversity classes. I think programs are also required to provide a class on sexual issues, so talking about trans folks in that context. Like how dysphoria can kind of make sexual satisfaction challenging, and how partners can help with that. Not siloing out into, “Oh, here’s your one week on trans stuff in diversity class.”

“Politically? Jesus...how much time do we have?”

Because this is a contextually situated narrative inquiry study related to a historically marginalized population, understanding the current sociopolitical climate is imperative to constructing a narrative. When presented with the question of what needs to shift socially and politically to support transgender affirmative practices, Dr. Coolhart recounted the recent US Supreme Court ruling that makes it unconstitutional to fire someone based on their gender identity and sexual orientation. However, a week or two prior, the Trump administration pushed forward legislation allowing medical providers to deny general care to LGBT people and insurance companies to deny coverage to trans related health care. She elaborated it is important for cisgender therapists, in particular, to understand that the discrimination transgender people experience is not just someone being mean.

Highlighting that there are really concrete ways in which trans people are discriminated against. It's not just that somebody was mean to them at the store, it's that they actually fear for being able to get the medical treatments they need and that they can be denied. So, you could get in a car accident, be on the verge of death, and they can just send you away. I mean, that's scary. People don't pay attention to that stuff, unless they're particularly interested. The political landscape right now is so scary for trans people. Being aware of another trans woman of color was killed last week and how that impacts clients.

When asked to share what she thinks would shift people from thinking “it’s hard to be trans” to “it’s scary to be trans,” Dr. Coolhart stated that media exposure to the murders of trans people could help with that shift.

I mean trans women of color in particular are killed all the time, and we don't put that in the forefront of the media. If there was more exposure to that, people could start to see like, “Wow, that's not right.”

Dr. Coolhart reflected she sees a lot of young people (e.g., high schoolers and college students) are well versed in gender diversity and so the momentum is strong now. However, like other civil rights movements, barriers could be put in place that impedes progress. In fact, she shared depending on the elections it is hard to answer that question.

I could see that happening for trans folks down the road. Right now, where we're at is in a stage of really strong momentum. Yes, strong momentum but also being fought from the federal level. My answer is going to be, “Can I get back to you in a couple of weeks after the election?”

Dr. Coolhart ended her thoughts related to the social and political contexts contributing to a culture of permissiveness around bigotry.

It's a culture of permissiveness around bigotry. So, if what we don't include trans education? You can outwardly hate groups of people and be a racist and a White supremacist, and it's fine.

Dr. lore m. dickey

Dr. lore m. dickey obtained his Ph.D. in counseling psychology and is board certified as a counseling psychologist. After graduating, Dr. dickey was a health policy fellow prior to working as an assistant professor. Most recently, Dr. dickey has been providing clinical services focusing on transgender health, while engaging in consultation with other service providers. Throughout his early career, Dr. dickey has been involved in national psychological organizations, serving in numerous leadership positions with the mission of advancing affirmative transgender care. Dr. dickey became engaged in leadership during his graduate program. In addition to clinical work and service, Dr. dickey created a website, my bandana project, to help reduce suicidality among transgender people by cultivating intentional hope and community each day. Moreover, Dr. dickey is well-published in the area of transgender health. These publications include peer reviewed journal articles and books. Dr. dickey anticipates the publication of his latest book on transgender affirmative care in April of 2021.

I was first introduced to Dr. dickey's work during my time at UGA. My area of expertise lies within critical theory in family science and family therapy focusing on transgender health. Because of this focus, I often took courses outside of the MFT program, which meant I landed in the counseling and education department. Taking courses outside of the MFT program broadened my perspective, increasing visibility of transgender inclusive work and trans identified scholars and clinicians. When people inquire about which literature to read on transgender inclusive therapy practices, Dr. dickey's is among one of the scholars who I recommend others read. In fact, I recommended the text, *Affirmative Counseling and Psychological Practice with Transgender and Gender Nonconforming Clients*, to Dr. Wieling and the clinic director at ASPIRE to bolster the education for other practicing MFTs. As the first

trans-identified expert interviewed, witnessing Dr. dickey's experiences of mental health had a profound impact on my own experiences. I live with effects of complex trauma and I cannot ignore how transphobia has manifested during my time at UGA. I have had my identity challenged and erased. I have experienced countless instances of misgendering even after providing gentle reminders. Such experiences emerged throughout this dissertation process, which at times felt debilitating. However, something Dr. dickey stated about his experiences with mental health resonated with me, "And I don't apologize to anybody about that being part of my story...I'm somebody who needs mental health support, yet as a mental health provider, I'm not supposed to talk about my need for mental health support."

"I was tired of hearing horror stories"

Dr. dickey has been in the field for 15 years and considers himself an early career professional. He shared one of his main motivators for pursuing an advanced degree in psychology was to help the transgender community.

I went back to graduate school in 2005. I was already out as a trans person at that point and was tired of hearing the horror stories from trans people about the care they received from mental health providers. I said, "Well, you know the only way I know how to make change is to be part of the solution," and that was one of the main reasons I went back to graduate school to become a psychologist.

Something Dr. dickey encountered in his career was how divisions of organizations focusing on LGBT mental health often were not transgender inclusive.

I wanted to play a part in developing a tool that was going to, for me, make a difference in the ways that mental health providers, whether they're psychologists or not, are looking at how they work with the trans community. Because there still were people that were using horribly outdated resources. That was frustrating, made me angry. But I knew that the only way to change it was to give them a tool to be able to make that change.

Dr. dickey reflected on moments in his life where he has been haunted by thoughts of suicide and reminds himself of his purpose, which is to make the world safe for transgender people.

I remember thinking to myself, “You were put on this planet to do something important and you haven’t done it yet. And I believe I’m doing it now, and that is making the world safe for transgender people, not safer. Trans people are still at risk if the world is safer, it has to be safe.”

“You’re going to be a leading expert”

Although Dr. dickey positions himself as an early career professional, it is not without a doubt he has blossomed into a leading expert in the area. As a graduate student, Dr. dickey was actively involved in national organizations often times pushing the field to expand its inclusivity. This transition to leading expert began in 2006.

My first APA convention was in 2006 and I was part of a panel of the only symposia that was happening at that convention on trans issues. I was talking about my research from my master’s thesis, and I remember coming down off the podium and my advisor at the time coming to me and saying, “You are going to be an expert in this field when you are done training.”

From that point forward, Dr. dickey became one of the first and only student thus far to be appointed to serve on a guidelines task force and to serve as a co-chair in that effort.

I was very involved in Division 44, I chaired the transgender committee. I would say I was marginally involved in Division 17, I don’t know why I say marginally, I was the student affiliate for Division 17 for three of the years when I was in school...By the time I graduated I was clearly seen as a leader in the field because it is unheard of that a student would be appointed to serve on a guidelines task force and it’s definitely unheard of that a student would be selected to co-chair that effort.

“You’ll never make a career out of that”

As previously stated, Dr. dickey began this work in 2006 with his master’s thesis research. While attending his first APA convention, he was approached by someone considered big in the field who asked him about his research agenda. Dr. dickey reflected wanting to make contributions to the field to advance transgender inclusion to which the person retorted the likelihood of establishing a career in that area would not be plausible.

I met someone who, I don’t know how else to say it, was kind of a big deal. And they, you know this is my first convention, asked me what my area of research interest was, and I

told them work with transgender people. And they told me, "Oh, you can't do that. You'll never make a career out of that." My sense is this person likely heard the very same comment from somebody when they were a student, and said, "I want to focus on this." So you know, that was kind of my initial start around it was like, "Okay, people who kind of are a big deal think that there's not room for this work."

"I'm gonna prove you wrong"

Although Dr. dickey received this type of initial response, he did not let it deter him from continuing the work. He reflected how he pushes against those reactions and will prove others wrong. In fact, he often made it a point to conduct research on the trans community regardless of people's reactions.

But I'm the kind of person that if you tell me I can't do something, I'm gonna prove you wrong. I did a master's on the way to PhD and my thesis was on support group effectiveness with trans men. Then I did an extra research study because why not right? A qualitative study on sexual identity development in trans men, nobody had ever done that before. Whenever I had a research project for a class, I always focused on trans people.

In addition to receiving that initial feedback, Dr. dickey received some criticism when sharing his ideas for his dissertation. While rebuking the criticism, he was able to gather a rich sample size looking at self-injury in the trans community.

Of course, my dissertation looked at a topic that nobody had ever, well until I did it, nobody had ever looked at it, which was self-injury in the trans community. And I had people tell me, "lore, you can't do that. You're going to create a situation here trans people aren't held in a good light, and people are going to think that there's something wrong with trans people because you're going to show them how many people are engaging in self injury." But that didn't stop me...I had over 900 people participate in an online survey on looking at self-injury in the trans community. So, you know, at that point, certainly one of the largest sample sizes of trans people for something that was unfunded.

Dr. dickey's tenacity for advancing the field was evident on the job market and the feedback he received from deans.

My dean said, "You know, what I like about lore's research is he's got a clear research plan, a clear research question." And I looked at my research and said, "I'm looking at career self-efficacy, self-injury, support group effectiveness, and parenting." To me it

was all over the place except that it was with trans people. And that's what she saw is that it was all with trans people.

“We don't do this by ourselves”

When exploring what supports enable Dr. dickey to continue to do this work, he quickly identified the need for a consultation group. This consultation group was not solely focused on case conceptualization but support in continuing to engage in difficult work. Early on in his career he created a consultation group with people from the community.

When I was in Louisiana, I realized that I needed a consultation group...And for me, much of that was not just helping them be able to conceptualize the patients they were working with. It was also me having the kind of support that I needed to do the work I was doing, because I felt so isolated... You know having that consultation group was super important to me when I was doing the work by myself.

In addition to establishing a consultation group, Dr. dickey receives his own mental health support and shared challenges in locating his own provider as a transgender man and as a trained clinician.

My own mental health provider...that's why I ended up seeing the provider in Seattle when I went to North Dakota. I would use things like the WPATH directory of providers or the GLMA directory of providers to try to find somebody...It can be challenging especially for people who are in the field to find providers. Almost every single one of my providers has felt intimidated by my training, and I just keep telling them, “I am just another person who struggles with depression and anxiety and I need your help.”

Beyond therapy, Dr. dickey receives support from others in the field who he will collaborate with and sought guidance from throughout his career.

Robin Buhrke...she and I met through Division 44 stuff and she kind of became the sort of oopsie mentor to me, and I matched at Duke for internship and she was my clinical supervisor. She's been pretty huge in terms of helping me make decisions about what do in terms of my career...Duane Halbur has been a super, super important source of support for me personally and professionally. We've become close friends, and he has really helped me with the personal sides of things like, “How do I get the help I need?” and do the work that I'm doing. So there's a bunch of people, but you know we don't do this by ourselves. We really don't.

“Battle fatigue”

Although Dr. Dickey identified several sources of supports, there are considerable barriers impacting his work. The first barrier he shared was battle fatigue, which has been omnipresent since the 2016 presidential election.

Battle fatigue is what first comes to mind and that has been very present since November 2016. And hearing all of the bullshit our [then] president keeps doing... “Oh my god, what is he going to do that is going to make our life a living hell?” And that living hell, you know, kind of right now starts with his implicit support of white supremacy.

In addition to experiencing battle fatigue, he shared he lives with difficult chronic health issues that impede his ability to do work.

I’ve had some difficult chronic health issues that have gotten in the way. I remember when I first lived in Flagstaff, it felt like addressing my healthcare needs was a fulltime job and I was trying to work a fulltime job that required more than 40 hours a week to accomplish. And people wonder why I don’t have a life or don’t have a relationship or whatever.

Another barrier he encounters is feedback on his writing. Dr. Dickey shared he will continuously receive the feedback that his writing is not academic enough, feedback he received as a graduate student. He reflected it took him a long time for him to get his dissertation published.

I was invited with an award that I received from APA to write an article for American Psychologist and it was supposed to be in a special issue. But again, I kept getting this feedback, “Your writing isn’t academic enough,” and all these other concerns that you know, it was almost as if, “Well, you’re an early career psychologist you couldn’t possibly know how to write for this kind of audience.” And that was really painful to get that kind of feedback... They kept telling me I had to get a second author on this manuscript that I was writing. So that has been a barrier is, you know, what is acceptable writing? Which is a comment that I got an awful lot in graduate school, “Your writing isn’t consistent with what we expect out of doctoral level students.”

“I don’t think it’s happening”

When asked to elaborate on his thought about the current state of trans inclusive training in clinical graduate programs, he shared he doesn’t think it is occurring and has to be demanded.

I don't think it's happening. Yeah, I don't think it's happening. The only reason it happened at all in my life is because I just kept demanding it. I remember taking a gender class and we were supposed to read a book off of one of two lists. And I said, "We're missing a list." The course instructor said, "You know, create a list and I'll gladly send it out to students." I was part of a task group in Division 17 and one of the things we did as a group was create a toolkit for people who are training counseling psychologists that included articles for any class that would have been taught.

A barrier that prevents transgender information being covered in training programs is a lack of instructor knowledge and archaic approaches, such as assuming being trans is a pathology.

I think the most obvious one is a lack of knowledge. I think another is that people assume that that will be covered when we get trained in how to use the DSM because that's a diagnosable condition. And you know, if all somebody hears about in work with trans people is the pathology, they're not getting the kind of training they need to be able to work with in an affirming manner...And if a trans person came to seek counseling, the counseling center automatically assumed that that was a serious mental health concern. That student needed to be seen by the only psychologist on staff who held the assumption that if you were trans you had mommy issues that you needed to work out; a very dated, archaic, ineffective approach to addressing trans people's needs.

Dr. dickey reflected that when program accreditation standards are inclusive of addressing work with trans people and as more people receive training and become trainers themselves, we should see a change in knowledge level; however, that is still a decade out.

Even though I believe the accreditation standards are in a pretty good place right now, I don't think people have the knowledge for how to infuse that across curriculum. There shouldn't be a two day 16-hour seminar that's supposed to cover everything you need to know about how to work with trans people. I think the more people who get some training in how to work with trans people and then end up being trainers themselves that we will begin to see a shift, but I would guess that is still maybe 10 years out.

“There was no mention of transgender”

In the final interview, Dr. dickey shared he has seen a shift in the field, but barriers remain. He reflected back to 2005 when he was a student and attended the APA convention there was almost no mention of transgender people at all. Gradually there have been changes in division titles to include trans people, and yet it is often being tacked on at the end. Dr. dickey pushed back on the rebranding of division titles and advocated for transgender issues to be listed

first. He cited how the names have undergone numerous name changes throughout the years. As a trans clinician and scholar, Dr. dickey feels like a stepchild who remains unaccepted in their family.

There was no mention of transgender people in any divisions, any offices within APA. Eventually the Committee on LGB issues became the Committee on LGBT issues. Division 44 became the Society for Psychological Study of Lesbian, Gay, Bisexual, and Transgender Issues. And both of those organizations have switched their names to the Psychological Study of Sexual Orientation and Gender Diversity. I kept pushing back saying, "Why does sexual orientation need to come first?" At some point, people said, "Let's put the women first and the men second." Well, why don't we put the trans people first. Why does it have to be sexual orientation and gender diversity? On the one hand, I am glad that they did something that was broad enough that they don't have to change their name every time there's another letter in the alphabet soup. On the other hand, I feel like, "Okay, I will always be the stepchild in this organization. I'm not really part of this family."

Often times, Dr. dickey's pleas landed silent or were met with rebuttal. These rebuttals centered on two areas. First, how difficult it would be to change the name of a division because there would need to be a change of journals and listservs

"It's too hard to change the name on the listserv, so you have to stick with LGB issues." It's not that hard. Does it take some work? Yes. Is it impossible? No.

Second, the difficulty in establishing an annual award even though the division oversees other awards.

"Well, you know that's an awful lot of responsibility and it's hard to get people to nominate other people for awards. And you know, we don't do anything else like this in the divisions so why would we do this for trans people?" So Bisexual Foundation Award isn't something Division 44 created, but they manage certificates of appreciation, distinguished contribution to education and training, distinguished contribution to ethnic minority issues, distinguished scientific contribution, and now they have a student and early career psychologist engagement award. How can they say "we don't do that" when they've got science, professional, ethnic minority, and education and training? It took a very long time for Division 17's section to add T to their name.

“Have we lost true genius?”

With the hopes of clinical programs becoming more transgender inclusive, Dr. dickey shared heartbreak around hearing transgender students’ experiences within their programs and wonders how many true geniuses are lost.

I think seeing a trans person be elected to fellow, to APA, in both Divisions 44 and 17 helps people to see, “Oh, there is a path for me.” Then I talk to some advanced doc students and its horror stories about how they are being treated in their programs, and that’s even in counseling psychology. We’re supposed to be more enlightened or more in tune to social justice. It just breaks my heart because I think, “Have we lost a true genius, someone who could really contribute to the field?” because of the way they were treated in their academic program. And that also happens to young faculty.

In identifying recommendations to shift academia and training programs to be more trans inclusive, Dr. dickey presented these recommendations: more trans faculty, nondiscrimination policies, funding opportunities specific to people who are either representative of some minority population or studying that work, and appropriate training.

More trans faculty. I don’t know if programs necessarily have nondiscrimination policies, because I think that would go with whatever the university has. So, pushing the university to have nondiscrimination policies. And I actually accomplished that at the University of North Dakota and at the Morehouse School of Medicine...Maybe even some funding opportunities that are specific to people who are either representative of some minority population [that is broader than race and ethnicity] or studying that kind of work. The funding policy is hard because it really comes down to who is the university donor who is going to make that happen...Again, appropriate training needs to happen for folks.

“I should have rights in this country”

Because this is a contextually situated, narrative inquiry study related to a historically marginalized population, understanding the current sociopolitical climate is imperative to constructing a narrative. When presented with the question of what needs to shift socially and politically to support transgender affirmative practices, Dr. dickey highlighted that trans people by themselves can’t get the work done without help from others.

They [trans people] need allies who are willing to go to bat for them to be able to address all of the noise that's happening in the world today.

Further, he stressed it would have been important for APA to correct President-Elect Biden's statement on how many trans women have died this year.

I would love if APA had reached out to Joe Biden. And when he said 18 trans women have died so far this year, the woman he was talking to said, "It's more. It's more." I would love for APA to have reached out to him and corrected him, but I doubt anybody at APA knows how many trans women or trans people died this year.

As a trans man, Dr. Dickey stressed the importance of having rights and expressed the of being able to feel like his life is protected.

Yeah. I go back to what I think I said last time, and that is, I should have rights in this country because I'm a US citizen, not because of which state I live in. Like for example, we have a federal hate crime bill that includes sexual orientation. It's the Shepard-Byrd Hate Crimes Prevention Act. It was named after Matthew Shepard and James Byrd, Jr. But the state of Wyoming, where Matthew Shepard was murdered, doesn't have hate crime laws. How does that happen?...I should be able to feel like my life is protected because I'm a citizen of this country.

Dr. Dickey ended his reflections on what would need to change socially and politically to ensure transgender inclusion occurs with defeat.

I don't even know how to deal with the political issue. I mean, this country is clearly divided. There are clearly people who would shoot me without any provocation just because I'm trans. And because of where I live, nothing would happen. Nothing would change for trans people.

Dr. Lindsay Edwards

Dr. Lindsay Edwards has been in the MFT field for 15 years. She received her bachelor's degree in Family Studies from the University of Arizona. During her time at the U of A, she was interested in the clinical intervention aspects of what she was learning in her undergraduate. This interest led her to pursue a master's degree in MFT, which she received from Kansas State University in 2005. While at KSU, Dr. Edwards recognized there was a dearth of literature related to serving the LGBTQ community. This recognition propelled her to obtain a PhD in MFT. She received her PhD from the University of Connecticut. During her PhD, she was a doctoral clinical intern at an organization that primarily served the trans community. Currently, Dr. Edwards is an associate professor at Regis University and primary investigator of the Gender and Family Therapy Research Group (GFTRG). Her research agenda encapsulates three sub areas: 1) masculinity as an organization concept and system of dominance, 2) investigating practices in inclusive family therapy and effective training strategies, and 3) translating the experiences of TGNB folks into implications for clinical practice.

I first met Dr. Edwards as a master's student at NDSU while attending the annual NCFR conference in 2013. At the time, Dr. Edwards was a doctoral student, and I was captivated by her statistical prowess. When I had reached out to Dr. Christi McGeorge on who she would recommend I interview for this project, I was surprised to see Dr. Edwards on her list of potential interviewees. As I had previously known her, she was focused more on masculinity and LGB studies rather than the TGNB population. I never considered how her research agenda and clinical expertise could have evolved upon our first meeting 7 years ago. A major plot point in Dr. Edwards' story is her own evolution as a person, clinician, and scholar. Across the interviews, she continued to reflect she does not feel holding the title of expert is accurate. If

anything can be taken from her story, it is how expertise is an ever-transforming experience and not an achievable status.

“I cannot go back from this, I cannot”

Although Dr. Edwards became interested in queer scholarship as an undergraduate, her encounter with the TGNB community occurred during her doctoral internship. During her dissertation phase, she and her family moved to Colorado. In addition to completing her dissertation research, Dr. Edwards needed to complete her 500 clinical hours as required by COAFMTE. Through reaching out to people within the Colorado state chapter of AAMFT, she was connected to the director of a community center that served the TGNB community. It was through working with TGNB individuals, couples, and families that her dedication for advancing TGNB inclusive practice was birthed.

It changed me; it changed my direction and the direction of my career in many ways. Because I felt like I was simultaneously witness to the most profound resilience I had ever seen, just the most beautiful resilience and adaptiveness. It gives me goosebumps, I literally feel tears in my eyes thinking about it. The community of folks at the Gender Identity Center where some of the most beautiful people I've ever met. Couples were amazingly adaptive. And I was also witness to just constant transphobia that these folks were facing, not in the organization, the organization was like this beautiful safe haven. But even the building owners where we rented space at the GIC, the community members faced transphobia. I would hear the stories of folks that all they wanted to do was just live their life. And they were facing this discrimination constantly, and this oppression constantly. It just shifted my course, it impacted me to such a degree that I thought, “I cannot go back from this, I cannot.”

This impact has gone beyond her clinical work to her role as a faculty member and how she interacts with students. In her supervision process, she constantly invites her students to reflect on process and how power and oppression show up at the process level. In addition to clinical supervision, she openly centers TGNB experiences into the courses she teaches.

We talk about process and power in nearly every supervision session. The students who take my gender and sexuality or even my research methods class hear from me about process and power...I'm using my research and so they're being exposed to the statistics

of oppression, like they're being exposed to the experiences of trans folks as it relates to the U.S. Transgender Survey. But they're seeing that data and they can't unsee it. So, I'm going to teach them how to do a regression, but it's going to be a regression with variables that are about the experiences of trans oppression. So, they hear that from me and then at the end, we talk about how change happens, and I invite them to explore process research.

“Working Across Difference”

Another concept that has been important for Dr. Edward's professional development is the notion of working across difference. She reflected she has learned a lot from her colleague Dr. Luis Vargas in training students on process. She shared there are two domains of experience he trains students in: expanding tolerance for courage and expanding tolerance for anxiety. In doing so, he helps clinicians to sit with clients with differing backgrounds.

It doesn't mean you have to agree with it, but actually being able to tolerate differences is a critical point of training for family therapists who are going to work with clients of all different backgrounds. So, it has been wildly impactful for me. It definitely shifted how I think about training for sure. Especially training for inclusive practice. It kind of moved away from insight about power, insight about misuse of power and privilege to insight and experience and building your tolerance for difference.

Dr. Edwards shared a way of building those courageous muscles is to practice through playfulness.

So, Luis [Dr. Vargas] has students do that in these like fun kind of ways: skydiving, giving a speech in front of a bunch of people, what have you, whatever kind of stretches you. To do that in this realm that you're building your muscle for being able to be courageous in moments of elevated tension and anxiety in clinical practice, or in moments where you're across difference.

An important process in working across differences is increasing differentiation through examining your own worldview. Through this examination, remaining curious rather than disengaging invites the ability to discern what fits and what doesn't.

He has this other domain of essentially increasing differentiation by exploring your own world view. He tells our students to read about, to engage in literature, about like remote viewing, and aliens and the dark side of the moon. And these bodies of knowledge that are outside of the culturally sanctioned. And then in that investigation, notice for

yourself, do you foreclose yourself?...For me, it's just so crystal clear that that's what's needed. In order to engage in difference, I need to be able to know, for myself, what happens to me if something is outside of my worldview, so I can lean in and be curious about it, and not guess as to what parts of it are right or wrong, but actually take it in, and then decide for myself what parts feel true and what part's don't.

“They opened a door”

The opening of a door has been a powerful metaphor in Dr. Edwards journey. Across her academic careers, bachelors to doctoral, Dr. Edwards crossed paths with scholars who opened the door for her. Through these crossings, she solidified what could be her area of research and how she could make a career. As an undergraduate student she encountered Dr. Stephen Russell.

[Dr.] Stephen Russell started at U of A, as faculty while I was an undergraduate, and I took a class from him... Stephen [Dr. Russell] was talking about all this research. I think it was at UCLA. I'm not sure it just yeah, cracked the door open. Like, “Wow, I can do research and I can do this.”

As a master's student she encountered the work of Dr. Christi McGeorge.

When I first started reading Christi's [Dr. McGeorge] work, I saw someone doing what I wanted to be doing. So, I was like, “Yes, you can use research to effect change. Yes, you can.” I saw her and I was like, “Yes, this is exactly what I need to do.”

Beyond reading Dr. McGeorge's scholarship, witnessing her at national organizations speak out against injustice towards the queer community had a profound impact on Dr. Edwards as a doctoral student.

I think having her kind of be visible as an advocate in the field. That was really important. Yeah, I mean, I think my first thought is that. I kind of go back to like, this whole idea of narrative that it was a new story. It was a counter narrative to what the dominant narrative was, which was MFT's are perfectly fine how they are, and they're doing a fine job serving LGBTQ clients...She provided a counter narrative that I could latch on to...As a PhD student, you're actually pretty vulnerable, like professionally. I think it helped crack the door open for me to be able to say, “I'm a scholar and this is my specialty, this is my scholarship agenda.” I think that's what I mean when I say Christi [Dr. McGeorge] cracked the door open in many ways.

“I’ve had people challenge my use of quantitative research methods to study what I do.”

Dr. Edwards shared she has been challenged in the past by other scholars on her use of quantitative methodologies for researching systems of oppression. From the perspective of these other scholars, her use of quantitative data might be reifying systemic oppression.

It’s kind of the same principle of like this dominant strategy, this dominant research strategy. I’ve had people challenge the idea of using quantitative research methods to study what I do. “Okay, are you really? Are you really not just reifying the same thing by doing it?” I can hold that. I mean it’s quite possible. I know just the nature of quantitative research you have to look at averages. When you look at averages you miss intersectionality, you miss the diversity of experience within an experience. I can acknowledge that there’s the potential that my work to advance social justice reifies inequity. I’m hoping there’s more advancement than there is reifying.

Another concern Dr. Edwards hears about her research is based on her experiences as a cisgender person researching TGNB lived experiences. However, she sees this feedback as warranted and a critical point of self-reflection for her.

Yeah, most certainly. And it’s warranted. I mean that’s the thing, that’s the tricky part because it is warranted. I get a lot of folks saying, “Hey, we shouldn’t be studying trans folks, we should be studying why cis folks are so screwed up.” Then I’m like, “Gosh, you know you’re not wrong. You’re not wrong.”

Dr. Edwards often examines which part of the concerns are valid criticism while holding onto the acknowledgement that both things can simultaneously exist. She shared she feels she has to become comfortable with being a walking hypocrite.

I usually feel a little like, “I’m trying. I’m trying to do something here can’t you see this?” And then I realize I’m probably miss-using power, “Okay, well, what part of this is valid criticism?”...How else can I continue to contribute and move this forward in a way that I’m also not dominating. But it’s tricky business. It’s difficult. I think I have to kind of get comfortable being a walking hypocrisy. Like truthfully, I have to be able to hold both/and– I think of Ken Hardy, his article on both/and... – because both things can simultaneously exist.

“I appreciate being able to talk to people in a real way”

Dr. Edwards shared in her second interview having relationships with others where she can talk with them in a real way has been a major support in her endeavors. The first source of support she spoke about is her co-authors and the impact those relationships has had on her own development.

Well, I mean my co-authors, I so appreciate being able to just kind of talk to people in a real way. Like have these conversations that are really rich and generative. And like I said, it took us three years to write the ecological one, and it was so worth it because I was a different person by the time we were done writing it from when I started writing it. Probably the one that I'm most proud of, is that one. Partly because to me it's so rich. And I think it's rich because of the work that we did collaboratively.

Dr. Edwards continued by discussing how her colleagues at Regis have been sources of support.

I appreciate having colleagues that I can talk through. My colleagues at Regis are just really invested in equity issues in general. They themselves are kind of trying to figure out how to move a social justice agenda forward in a way that's respectful. It's really nice to have folks that I can talk with about that.

Finally, Dr. Edwards shares her family is a source of support. She indicated her partner can provide her with “reality checks” and it has been important for her to witness her children carry forward an inclusive stance.

I also appreciate my partner being kind of a reality check for me too, because I can get in my head. My partner will listen to me and we talk about both of our careers, and there are a lot of similarities and there's some differences. And he can tell when I'm getting in my head, so he can kind of calm me down sometimes, “It's okay Lindsay, if you said something that was experienced by someone else as disrespectful. That's okay. It's kind of messy.” I really appreciate that he can do that. Seeing my kids be who they are, that's helpful for me. I see the benefits that my kids are having from me being witness to others' expanded experiences, like expanding my own experiences, which allows me to then support them in having an expanded experience.

“We don’t have opportunities to collaborate with each other”

Although Dr. Edwards recognizes important sources of support, she has encountered some barriers. The first barrier she noted were the limited opportunities for collaboration in the field, especially within the realm of social justice focused scholarship.

We don’t collaborate in certain domains. I think about other areas of research in MFT that have been widely researched by teams of people, think couples’ therapy with heterosexual cis couples or common factors. If you study in these areas, you can essentially join a team and inherit a research agenda. When you’re a part of those teams, you are trained in all the skills you could possibly need in order to do that work. There’s not a similar process for people who are interested in studying queer and trans experiences, if that makes sense.

She continued to discuss how if someone is interested in pursuing a similar research and clinical agenda as hers, they have few options available in terms of mentoring and collaborating. In addition, she noted how the few scholars who do exist are often siloed.

This is true of my training, if I wanted a mentor, who already specialized in this area of clinical work or did this work and that would be willing to let me collaborate – I’d have few choices. I think about it. Like, we’re kind of all on islands; there’s a few faculty here and there...And it is usually like one faculty in a university, it’s certainly not a group of faculty that collaborate on the same general area and share information and knowledge...that’s what I mean when I say we don’t have opportunities to collaborate like we should. There’s not a network.

When offered to ponder what contributes to that lack of network, Dr. Edwards reflected on those who have tried to construct a network with the limited people power currently available and how gender dynamics play in that construction or lack thereof. These gender dynamics are important to note as Dr. Edwards reflected cisgender white women are most likely the ones advancing TGNB inclusivity in the MFT field.

I think it’s just people power, there’s just not as much people power in MFT for studying queer and trans experience. I mean, like I said, Christi [Dr. McGeorge] – what I’ve seen her do is try to build a network by training folks and then she publishes with them, and publishes and publishes, and they publish and publish...She’s the exception to rule. There’s a lot of gender dynamics at play in how productive someone is. This is another area that I’m currently researching – I’m looking at salary and equity between, I’m using

cisgender women and cisgender men as the markers, but looking at salary, different salary inequity and what we found is actually that publications and scholarship are related to salary inequity...But what I'm anticipating to find is that cisgender women publish less.

Another barrier impeding the construction of a network is lack of mentoring. Dr. Edwards shared from her own experiences as a student that it was impossible to find someone already researching queer and trans experiences at the time she was a student.

From a mentorship standpoint, there was no one out there. So maybe that's also what I'm referencing when I mean collaboration...It's also collaboration among faculty and students that mentorship is also somewhat missing...If I wanted to study, quantitative research, and specifically quantitative research as it relates to clinical work with LGBTQ communities, I had no options in that regard. Now there's Christi [Dr. McGeorge], but still, there's almost no one who is a tenured faculty member at an R1 university who takes doctoral students, that you can go study inclusive family therapy and quantitative research to study inclusive family therapy.

“This field is going to be antiquated unless we get our stuff together”

When discussing her current thoughts related to the current state of trans inclusive therapy practices, Dr. Edwards shared an article by Mizock and Lundquist. These scholars qualitatively explored TGNB folk's experience with psychologists. Dr. Edwards pondered what TNGB folk's experiences would be if they sought services from most marriage and family therapists.

And they asked them what was your experience going to see a psychologist and they heard all the terrible things these people encountered. It was awful. And I was thinking, this is psychology! APA has put out standards for inclusive work! What would this look like if it was MFT?...And nobody's done that research. Nobody's looked at how trans folks experience MFT. And I think a lot of it is because trans folks don't go to MFTs, because they want to stay safe. And just the name, Marriage and Family Therapist, I think folks are like, “No thank you, not going over there.”

Furthermore, Dr. Edwards elaborated that the field is further behind other mental health disciplines. She fears MFT is on the verge of being antiquated without making necessary advancements.

I've worried that our field is always two steps behind. I don't know why, because we are radical. I mean, we're supposed to be radical. MFT is a radical way to approach the world. So, I don't know why it seems like we're always two steps behind. Like I mean, go to the APA website, and search for inclusive therapy, there's going to be a massive amount of articles. Go to AAMFT's website, and search for inclusive family therapy, you're going to find almost nothing.

“We hear from the same people about the same things.”

Dr. Edwards shared her experience attending the national conference for MFTs and how it can at times feel like an echo chamber. Something she heard as a master's student but didn't recognize until much later into her academic career.

One of my mentors back in the day suggested I go to NCFR instead of AAMFT. Because I was asking them, “Which do you recommend?” This was when I was a new master's student. I asked them, “Do you recommend the AAMFT conference or the NCFR conference? Because I can't afford both...” They said, ‘The NCFR conference has a lot of really good scholarship. AAMFT is kind of fun, but I don't get a lot out of it anymore.’ And I thought, “Okay” I didn't quite understand what they meant. But I do now. I think what they meant was, that it can feel like an echo chamber at times. We hear from the same people about the same things.

When asked what contributes to the echo chamber, Dr. Edwards reflected there's a lack of transparency in how decisions are made in who is selected to present. She shared reputation often seems to be at play.

Some of it, I think, is a lack of transparency and how they decide who presents. Part of it is that we have our Masters, and we continue to operate from a reputation standpoint. It doesn't seem as though they invite presenters who are previously unknown or who are ‘out-of-the-box’ very often, which is one way to avoid an echo chamber. Also, sometimes it seems like AAMFT puts their conference together based on what's popularized by the news. I'm not sure this is the best way to create new knowledge.

In describing her concerns about presenters popularized by the news, Dr. Edwards shared how presenters will come and share deep meaningful experiences but there would be limited follow up on how it impacts clinical work.

I remember when Matthew Shepard's mother came and spoke to us. Her story was heartbreaking and I remember thinking, “What is this beyond heartbreaking? Is this

to raise consciousness about the effects of homophobia?” ...What I would have wanted is that the person who came on stage after her would explain how this is evidence of the effects of homophobia for everyone and how it’s relevant for us...So what we really needed following her presentation was some translation to clinical practice. And it’s never there. You never see anyone come on after any of these big keynotes from people who have been popularized by the news to say “Here’s what this means for you sitting in that seat, there, you systemic therapists sitting in that seat. This means you cannot be ignorant when it comes to homophobia.” No one has said that.

“Having an institution of queer research”

In the third interview, Dr. Edwards hopes to see an institution of queer research. A network of scholars, regardless of place of employment, working within a research agenda under the umbrella of queering family therapy.

I would love to have a network of folks, regardless of where they’re working – they could all be involved in the research. This is what I mean by having an institution of queer research. Regardless of where you’re working you can work with a shared research agenda –with the broad umbrella of queering family therapy. I would love that. If we could build a network like that.

To see that institution come into fruition, Dr. Edwards reflected it requires the field to return to its systemic roots in order to collaborate and involve PhD students.

By returning to our roots. Essentially, recognizing that good family therapy is inclusive in its nature, not a secondary thing. Good systemic therapy, if you’re doing it well, is inclusive...Maybe what we need is a small place where folks are starting to work together to collaborate and build the network that involves PhD and master’s students. Maybe UGA is the place. It seems to me like UGA is building faculty there that are invested in helping family therapy come back to its roots of being inclusive and process focused. They have PhD students there, like yourself, that are doing amazing work. So maybe it needs to start within an institution.

“Try to do the work to make the space inclusive”

A recommendation to help advance the field to be more inclusive for TGNB students, Dr. Edwards shared she has actively engaged in the university community to advocate for ways to dismantle cisnormativity on campus. She works collaboratively with the Queer Resource Alliance (QRA) on campus to address issues related to trans exclusionary practices (e.g., lack of

gender inclusive bathrooms, cisgender assumptions in clinical paperwork, and cisnormative policies).

I'm a member of the Queer Resource Alliance on campus. That's kind of a formal way that I've been working with others locally to build the inclusiveness of our university in general. So, we do brave space trainings and stuff. And our co-chairs communicate with the leadership of the college about cisnormative policies in the university.

She also works to create relationships on campus and to show her support of the queer community.

I try to just get to know people and get to know what their experiences are. I put my flags everywhere in my signature. I try to make sure that folks know that I'm someone that they can talk to, and I don't know how to say this, I try to let folks know that they can tell me whatever they want to tell me.

In her role of clinical director, she has reviewed documentation and clinical policies that are trans exclusionary.

When I took over the director role for our clinic, I thought it was a good opportunity to update the paperwork and make it more inclusive.

“I am a one trick pony”

When discussing what faculty and administrators can do to be inclusive, she shared being trained and engaged in systemic practice.

Being trained systemically. I wish I wasn't such a one trick pony. It all does come back to that for me. Being trained systemically. That's definitely helped me do relationships better.

Dr. Edwards reflected an important topic in systemic practice is an analysis of power and how it works within hierarchies. She shared hierarchies cannot truly be flattened and the most people can do is be transparent about how they are using power and ethical in their use of power.

I think we need some training for what power is and how it works. We need folks that have a clear meaning of what power is. And I say that because I've worked with some feminist supervisors who claimed to work collaboratively and were wanting to flatten the hierarchy. And I'm thinking all you're doing is sending this underground...I cannot truly flatten the hierarchy between myself and a supervisee. I can make it transparent and talk

about the ways that power organizes our experience and check in with them about it.

“We’re not a culture that creates people that connect well”

When confronting what needs to shift socially and politically to advance TGNB inclusive practices, Dr. Edwards discussed how our culture does not teach people how to be in relationships and value such connections. She shared this phenomenon is evident in intimate relationships and we need to recenter connection as a culture.

More broadly, we’re not a culture that creates people that connect well. It’s just the opposite...And some of it probably has to do with capitalist notions of self. In order to have more I have to be disconnected from the pain of knowing that my having more causes others to have less...I think I’m climbing the ladder on my own and I’m not noticing the people I’m stepping on while I climb up the ladder. So culturally, I think we don’t value relationships...we need people who do relationships well...We need those people to be leaders. My daughter and I were talking about this once and she said, so we need people who are connected but untangled? I thought that was beautiful and pretty insightful for a nine-year-old.

Livingstone Cox (ABD)

Livingstone Cox (ABD) has been in the field for 9 years. They received their bachelor's degree from a historically black university (HBU) in North Carolina. As an undergrad, Stone was a McNair Scholar, which poised and mentored them towards research and graduate school. Stone attended an MFT program in the North East that accepted McNair scholarships. After obtaining their master's degree, Stone enrolled in and are finishing their doctoral degree in Human Development and Family Science. Their research focuses on black trans masculinity and decolonizing the academy.

My interview with Stone was the first participant I interviewed who did not “meet” the traditional meaning of “expert”. If we are suggesting someone holding a doctorate with an extensive and prolific scholarship track record is an expert, how does that limit and silence certain voices. However, with the use of queer theory, I can unsettle this traditional (e.g., cisgender, heterosexual, White, educated) assumption of expert to include voices that are historically marginalized within the academy (e.g., transgender, queer, BIPOC; McDowell & Hernández, 2010; McDowell et al., 2014). Furthermore, researchers find higher education is more hostile towards TGNB students, faculty, and staff compared to their cisgender peers (Dugan et al., 2012; Rankin et al., 2010); however, there is a dearth in the literature related to TGNB faculty's experiences (Stachowiak & Gano, 2020). Given these findings, it is imperative that I challenge the influence of White cis-hetero-patriarchal assumptions of expertism in this dissertation and not reify the assumption that cisgender White academics are the keepers of knowledge. It became apparent in Stone's story about their experiences of the field includes that of exclusionary trans oppression.

“A Kindred Spirit”

Stone became interested in TGNB mental health as a master’s student. In their program, they were trained to specifically work with TGNB individuals, families, and couples. They shared as a “baby queer” it was important for them to be surrounded by as much queerness as possible. A highlighting moment for their decision to ground their clinical and research work in TGNB mental health was witnessing the experiences of their trans friends in college and experiencing their huge heartbreak with a trans partner.

I was a baby queer at the time. And Deb [Dr. Coolhart] was an out professor in the program, I aligned a lot with way that she saw the world. I think one day, she was like, “I have this team that sees trans folks...” I had a lot of trans friends in college. One of my first huge heartbreaks was with a trans person. I felt like, “I want to be over there.” I want to be helping queer and trans people...but before that I had not intentionally thought I want to work with trans people, but through that experience, and that team being available, and what I learned there, just fell in love with the community.

Overtime, Stone recognized they felt drawn to work with TGNB people because of their own gender identity.

Looking back on it, I didn’t know I was trans. And I felt a sense of kindred spirit with the client and with the team. I wanted to learn more. It’s kind of like when you know, you think you’re an ally to something else then all of a sudden, you’re like, “Fuck, I’m gay.” It was like, my people, but I don’t know that you’re my people...At that time, we did this assessment. It was like this written assessment that people had to do, and they saw us for like, a couple months before they were recommended to take hormones. A lot of those questions that we were learning, I was like, “Shit, I need to ask myself these questions.”

Stone recounted seeing others in their program were not actively pursuing the ability to work with TGNB client systems and reflected how it did not sit well with them.

I saw that a lot of people weren’t really jumping up to serve trans people. I hate that shit, regardless of the community. I was like, “Well everyone needs help. And honestly, the way this is set up, I don’t really vibe with the assessment process.” But feeling marginalized myself working with a marginalized community, I was drawn to it.

“My professional journey isn’t a super traditional one”

When asked to describe their professional journey, Stone shared it wasn’t a “super traditional one.” From experiencing otherness throughout their life and in academia, Stone is grappling with what that means for their career.

My professional journey isn’t a super traditional one. So, it [otherness] has shown up in embracing being different, taking different career paths, and making different choices. It showed up in my decision making... When I started my doctoral program, people were not studying trans people around me. I used a lot of my classwork and my time with professors there to really study black trans people. My topic right now is particularly around black trans men, and I haven’t really let go of that from the application process to dissertation. It was fairly isolating to the point where I kind of pivoted and said, “Maybe academia is not for me.”

In many ways, the otherness has shown up in the microaggressions Stone encountered during their program and how those instances have had a profound impact on Stone. For example, much of their career choices have been made on the basis of survival.

My time in the program has been littered with a lot of microaggressions, a lot of just trying to survive. Again, in another predominantly White, predominantly cis women, dare I say second wave feminist spaces... So, it was really a survival move.

With relation to the otherness, Stone shared they turned towards campus activism to resist the onslaught of microaggressions. They reflected the need to see other queer people and community. Stone took this desire into their own hands and created the space for the community.

For me to survive there and not to lose my soul, I turned to campus activism as a place to get that out that energy. I was doing a lot of work for free at the university and it literally was like, “Where are the queer people of color? I’m going to start this group. If I build it, they’ll show up.” Started bringing speakers to campus because I needed to see queer people who have come before everyone in the world... I needed somewhere to put that shit of academia that I’m experiencing and created a really dope community.

A resource for Stone to construct such community was their MFT skills to facilitate a support group for other students. Uncoincidentally, it provided Stone with their own “safe space” while pursuing their degree. Because of this opportunity, Stone was approached by a colleague who

shared they could be compensated for doing that type of labor, which lead them to student affairs.

One day, someone said to me, “You do know that people get paid to do this.” And I was really broke at the time. I was like, “No, I didn’t know people get paid to do this. It was around the time that my prelims were wrapping up, I didn’t have a reason to stay, which it was really hard to be black and queer in the rural South at the time, well I mean anytime. I wanted to get out...I know that in the space of higher ed LGBT centers could have been a second home for me.

“The first thing that came to mind was super negative”

When invited to explore sources of support, Stone shared the first thought that came to mind was “super negative.” They recounted a story of a clinical supervisor questioning if the field was an appropriate fit for them. During this time, Stone was navigating what it meant to be a clinician of color and how to deal with racism perpetuated by colleagues and clients. They reflected taking that feedback personally which prompted them to leave the field for the time being.

The first thing that came to my mind is super negative. I’m going to say this, but I think I have something positive to say...I actually took a pause because my clinical supervisor suggested that I was not a good fit for the field. I interpret that or read that, in hindsight, because I was pretty much advocating for more support around being a clinician of color. At the time, there was a lot of racism happening in the therapy room and I needed support around that. I was pretty vocal at the time around issues of identity and wasn’t getting a lot of support. That created a lot of tension. So, when I was told, essentially that maybe I wasn’t a good fit for the field, I took that hella personally.

Although Stone started with this reflection, they noted the capacity for the MFT field to be a source of liberation and how MFTs are at the forefront of the social justice movement. They reflected meeting Dr. Kristen Benson and Dr. Alex Iantaffi, who have been insurmountable sources of support that have allowed Stone to come back around 10 years later.

I think that relational and family and systemic therapy is truly a site of liberation. We are at the forefront of justice movements, if we can get people within their homes and relationships and themselves and at dinner tables advocating and treating people like people, then we have a chance as a society. I try to keep that in mind. Other things that

have really helped me in the past few years are the key people in the field who really are about this life. Kristen Benson [Dr. Benson] and Alex Iantaffi [Dr. Iantaffi], in particular, have been two people that have really kind of pulled me back in and shown me the heart of our field and the real intention behind it and reminded me of the purpose.

The relationship they have formed with Dr. Kristen Benson and Dr. Alex Iantaffi has invited warmth and excitement into their life.

Kristen [Dr. Benson] came to me and was like, “Do you want to help write this thing?” I was honored at first, I was like, “Whoa you want me to write something with you?!” Then I realized, “Oh, this is an MFT project!” I haven’t been in that energy in a while, and I missed writing. I haven’t been inspired from doing this heavy research. Kristen [Dr. Benson] has always been a huge advocate of me succeeding. I just needed a bit of that warmth you know; I’ll take on that project just to bring some joy into my life.

Being involved in such a project enabled Stone to remain in communication with Dr. Iantaffi.

They felt they finally had someone who shared similar personal identities and a real possible model for what it *can* mean to be an MFT.

I kept in touch with Alex [Dr. Iantaffi], who shared a lot of my same personal identities and I hadn’t really had a possibility model of, “Can I be MFT that is poly, kink, sex positive, and advocates for sex work and does all of the, you know, alternative things?”

Stone further elaborated they feel this might be the time for justice work to occur in MFT and being surrounded by the wrong people within the field.

Maybe I was surrounded by the wrong people. Or you know, I’ve read a lot about grad school and what it’s like for multi-marginalized people. And so it’s generally hard... What has kept me going is like a lot of the bullshit but also a lot of the good people really doing the fighting. I didn’t see those people and wasn’t in the position to see those people until most recently. Now I’m coming back around to “Oh yeah, I had a calling to do this thing that was justice oriented.” Maybe this is the time because people are now thinking about it and wanting to deal with it. But at the beginning of my career, that justice orientation is what kind of kicks me out.

“This journey has been a lonely one”

Stone shared they have done a lot of growing and noted the journey has been a lonely one in learning how to navigate White spaces. They reflected growing up in pro Black tradition, witnessing their parents fight for their rights, and attending in a HBCU helped them develop a

kind of tenacity that is challenged in the White academy. They shared never knowing academia's game and the rules of that game (i.e., respectability politics), which can be further compounded by their experience as a first-generation graduate student.

I grew up in a pretty pro Black tradition. My dad, I would say, he's a radical activist. He was in his country, someone who advocated for, people who were othered even there. He's very like, "Move out of the way, I'm fighting for my rights." I kind of had to develop that kind of tenacity, especially going to an HBCU. You learn about the value of our melanin, what we offer to the world, and what White supremacy is what we're up against. I went to South Africa and had this really, like African spiritual moment, I was really connected to the source of my own power... There's a game, there's a game that's being played... I didn't know about the respectability politics of academia. I didn't have a blueprint for that. I thought it was school. I'm going to school, I hear some bullshit in the classroom, I'm gonna say something... Another barrier is that as a first gen grad student. I wasn't used to the culture; I didn't know that there were politics and relationships and things that you had to maintain and consider. I thought I was going to class and doing my homework.

Although the journey has been lonely, Stone shared they have learned valuable lessons along the way. For example, strategizing is an important concept in disrupting power within academia and liberation is a marathon.

After a couple of systems that beat me up a couple of times, I've been humbled to realize, especially working at the institution I work at now, that strategy, coalition building, long term movement building takes time, patience, knowing how to communicate to the right audiences that can move things forward is super important. But the growing up I had to do, was to realize that liberation work is a marathon.

Unfortunately, Stone learned these lessons the hard way at the cost of their wellbeing. Stone shared burnout taught them those lessons.

I had an actual medical burnout. Because of all of the rage, systemic rage, I've been carrying all the doors that have been closed and who knows what it is all built up into my body. I had to go on FMLA for six months. And in those six months of wanting to be out there and wanting to fight like a machine, my body was literally like, "No, you cannot. You did all that you could." Really taught me. It gave me a way to think about what I had been doing, how I got there, what boundaries I wasn't setting. I learned the hard way.

“I don’t trust cis therapists”

In the second interview, Stone was asked to provide their perspective of where the field is at in terms of TGNB inclusive therapy. Their immediate response was “infancy?” Stone shared people are looking for good TGNB inclusive therapists, which makes them contemplate pursuing licensure. They elaborated they believe there are cisgender therapists who say they are advocates, but we lack many co-conspirators in the room. Stone further shared they trust when given TGNB inclusive readings cisgender therapists will do the readings but doesn’t trust the integration into action nor will they unlearn the programming of cisnormativity.

Infancy? There are so many people looking for a good therapist and good trans inclusive therapists...Great trans therapists are out there but we are scattered. And cis people say they’re about this life. There are people that I believe are allies, advocates, accomplices, we don’t have a lot of co-conspirators in the room...It will take a lot of learning for them to get there and accountability. I have faith in the trans therapists that are doing trans inclusive work. I know that cis therapists, if the books are written, they’ll read it. I don’t trust the integration into action. I don’t trust doing the work to unlearn the binary and the programming of cissexism for them to understand the nuances of when to refer when something’s not what you think it is.

I invited Stone to share what makes them hesitant to trust cisgender therapists to *actually* do the work. Stone reflected cisgender people have to take a risk to lose things because it’s not just a nine to five job. It requires people stand up and confront trans oppression perpetuated by family members. In addition, they feel cisgender therapists are unlikely to check their egos at the door nor to live both/and of celebrating transgender people and mourning the lost transgender lives.

To trust a cis therapist? I imagine being a dominant identity is comfortable. There’s so much that you have to risk to lose. It’s not just a nine to five. It’s a whole are you going to stand up to your family member in your home when they’re transphobic? Or are you going to let it go? I don’t trust the entire life shifts and mind shift that has to happen...And I don’t trust cis therapists to check their egos at the door and be like, “This is just my sacrifice for a community I claim to work with...” I don’t trust cis people will live in the rocky waters of that both/and with us.

“Who is shaping the culture of the field?”

I used the metaphor of infant and development with Stone to invite them to share what they feel would be necessary components for the field to grow. Stone first suggestion was a re-examination of who funds the field and what are their values. This re-examination extends beyond economic capital to cultural and social capital and who is shaping those domains. In their reflection, they see a lot of White people and cis people.

I think my first answer is the field needs to re-examine who funds it. What are their values?...So thinking about the economic influences of the fields. I'm thinking about capital lately, so capital being beyond economic but also social and cultural. Who is shaping it? Who do we actually listen to? Who has the social capital? Who has the economic capital? Who is shaping the culture of the field? I see a lot of White people. I see a lot of cis people.

In the third interview, I continued to explore with Stone how they felt the field was growing in terms of TGNB inclusive practice. They shared they are seeing clinical activists budding, which provides them with more hope. In addition, they are witnessing cisgender therapists taking initiative to make their practices more inclusive.

How do I see the field growing? Well, um literally you exist. I can only see it growing because I see clinical scholar activists budding. That gives me a bit of hope. In terms of trans competent care, I do see non trans clinicians wanting to take initiative to make their practices more inclusive.

In addition to witnessing the growth of clinical scholar activists and cisgender therapists wanting to take initiative, Stone shared they are seeing the larger organization is interested in continuing education that is rooted in realities of oppression and intersectionality. Furthermore, they are noticing larger institutions creating spaces of inclusion.

Seems like AAMFT is interested in continuing ed that seems to be more rooted in realities of oppression and intersectionality. The lineup for their continuing ed is getting a bit more inclusive. There is a CEO LGBT workgroup at AAMFT that seems to be getting there; that even the institution's creating space is promising.

“What is missing IS care IS compassion IS an unlearning of transphobia”

When I asked Stone to share from their perspective what is needed from the field, they recounted the experiences of two transgender friends of color. Their friends shared stories of “therapeutic trauma” and the choice to not return to therapy. What is often missing from care for TGNB people is understanding, care, compassion, and unlearning transphobia.

This is all anecdotal, because I have a couple of trans friends of color. I talk to them about why they choose not to go to therapy. They have so much therapeutic trauma. There’s nothing I can say, even though I still wholeheartedly believe in healing, maybe not in this traditional structure of therapy all the time, but I do have a quality therapist...The easy answer is understanding, but I don’t think you need to understand somebody to care about them...I’ll say what’s missing IS care, IS compassion, and IS a deep unlearning of transphobia.

Upon listening to Stone’s reflection, I was curious about what is needed for people to unlearn transphobia and cisnormativity. The first recommendation was a basic redefining of sex and gender and having an agreed upon definition as a collective, especially for those folks who are interested in this aspect of the field.

The first thing that came to mind is I want to start as basic as redefining sex and gender. Have we all agreed that it’s not how we’ve been operating around sex and gender identity as a collective? We’re clearly not on the same page about it and that might be idealistic, because I understand the basics. I understand the field. I’m learning more now being on this committee that there’s so many sub pockets of political leaning conservative folks and I’m sure those people choose not to see LGBT people. But for the folks that are interested, this how we’re defining gender. This is how it’s definitely different than sex, like really safe zone 101.

The second recommendation for unlearning is through decolonization. However, Stone was quick to situate it needs to be a basic application of decolonizing because the field wouldn’t exist in its current state if it was decolonized in its entirety. They shared people need to understand how things are rooted within White supremacist, cisnormative, and heteronormative ideas and we need to disentangle and heal from those roots.

I want to say the second part to the unlearning part is definitely a decolonizing part. But when I think about that, then the organization doesn't exist anymore, when I think through all of that. But just kind of like basic decolonizing practices is re-examining how we use the DSM as tool for gender dysphoria? Do people even understand what that is like? There's just certain things that I think are so rooted in White supremacist, cisnormative, heteronormative ideas that we haven't untangled and healed yet.

I became interested in what Stone imagined as part of decolonized field and they reflected communities having adequate funding to ensure people have their basic needs met. They further shared the person they would be working with in relation to their mental health would be someone who is familiar with their community context and take that into consideration when providing care.

I see communities funded...The society I would need to live in to help maintain my mental wellness would be one where my community is properly funded in a way that I have access to what I needed – so food, shelter, water, I knew who I could be in relationship...And it's kind of community care rather than like one person, that's super idealistic. I like support networks that happened to therapists in it, or healer in it rather.

The conversation shifted to recommendations for graduate programs to support TGNB students. Stone bluntly stated, “*They need to be admitted.*” Beyond admittance they need to feel like a human when they come into the door. When asked what cisgender students need in their programs, Stone shared they need the same things as TGNB students and need to be encouraged to interrogate their own gender, what that means, and how they support TGNB people.

Step one: Admit them. Step two: house them. Step three: feed them. Give them extra stipends, make sure they have access to mental health. Do you feel like a human that's coming into the door? Do you have everything you need?...A whole class on cissexism wouldn't be bad that trans people don't have to go to would be wonderful. Yeah, maybe like a program long so I'm just making people suffer at this point. But a program long project on like, what even is your gender? Have you thought about your gender? I would love to see it happen. Also, perhaps something service related. How do you support the real trans people in your life?

Similar to TGNB students, there needs to be more TGNB faculty who receive support to do their work and to train students. In relation to cisgender faculty, they also need to be encouraged to do their own cultural humility work and model for their students what an inclusive space looks like.

I would love to see more trans faculty members. I know there are a few in certain programs. They too need to be paid and fed and you know well compensated for their labor...I hope that faculty can do their own cultural humility work, I am doubtful. So that when they are thinking and structuring their syllabi and thinking about how they're going to frame the world and relationships and people, they're aware of all the systems and they're aware of all the people and they're aware of all the margins...So they're modeling what their students should be doing as well and how they should be thinking. I love a good inclusive classroom as much as they can be.

“This keeps me up at night”

The third interview ended with Stone reflecting on what needs to shift socially and politically to increase TGNB inclusive efforts. Stone discussed how they hope there could be a way for cisgender people to be honest about how they actually feel about trans people.

This keeps me up at night actually. What needs to happen socially?...I would love for there magically to be some way that cis people could be honest about and reckon with how they actually feel about trans. Because I think about all the majority of black trans lives that are lost in intimate, familial situations. Not often strangers, but that's increasing. So, when I think about the social climate, why can't we admit that we love trans people?

With regards to politics, Stone shared they are weary and fear we are moving in a direction where trans lives are scapegoated for political advantage. In addition, they reflected the importance having some legal rights for when TGNB people are violated.

But this, the political system as it is, isn't promising for me, I love Joe and Kamala. But I am deeply afraid that we are moving in a direction where trans communities are simply scapegoated for whatever political advantage is coming next. So legally, a shift would have to be made to actually submit the definition of gender and sex. Like we have to get some political wins just to have some rights when we are violated. Because right now, if I died, in whatever way, I shouldn't use myself, but like, what rights do I have if something happens to me?

Dr. Colt St. Amand

Dr. Colt St. Amand has been in the Clinical Psychology field for 15 years. He obtained his master's and doctoral degree from the University of Houston. As a graduate student, his research focused on the female-to-male trans population. He has served in leadership positions in national and international organizations such as APA and WPATH. In addition to leadership roles, Dr. St. Amand has an extensive publication and presentation record focused on trans healthcare. Although he is a licensed psychologist, his work has shifted from primarily psychotherapy to consultation, evaluation, assessments, and letter writing. Most recently, Dr. St. Amand obtained a medical degree to further his reach in trans health. Beyond his own edification, it is evident he wants to use his privilege to educate others. He is collaborating with others to create a certificate in trans affirming care, having already constructed a course on affirmative counseling for trans folks. This course counts for 44 hours of continuing education. What is most impressive is his breadth of experience within a seemingly short amount of time.

Prior to interviewing Dr. St. Amand, I had no knowledge of him. It was through interviewing another possible participant that a connection was made. In reviewing his CV and conducting the first interview, it became evident he has a true passion and dedication to trans health. It was also apparent he held a lot of expertise, which I must admit was fairly intimidating to me. If I were to place our knowledge and expertise on a continuum to novice to advanced expert, I would most surely be closer to the novice end and Dr. St. Amand would be closer to advanced expert. Although I felt that intimidation and realized how much more I have to learn still in this field, Dr. St. Amand was friendly, approachable, and humble. He was quick to share his struggles and own his privilege within the process.

“Well, I am here. Let’s see how I can help.”

Dr. St. Amand knew he always wanted to be a therapist, to help people. In addition to figuring out his career aspirations, he was cluing into himself to being trans. In figuring out what that meant for him and what that meant as a graduate student. He recalled asking faculty, as a prospectus student, what his experience transitioning might be like in their program.

I knew I wanted to be a therapist. And I figured out I was trans about a year before I entered grad school. So, when I was writing my application, I was just coming in or cluing in myself to being trans...I remember during the interview process, they always ask you, “Do you have any more questions?” It’s so important to have more questions. And every single one is awesome, because I just had to ask one question that lasted the whole rest of the time. I said, “Okay, so I’m transgender, and I will be coming out and living as a man during graduate school, and I’m wondering what that experience might be like here?”

In his first year of graduate school, he recounted his reactions to learning about Gender Identity Disorder in his psychopathology course and how awful that was for him. Over time, he routinely encountered disparities and the discriminatory lens used to research and talk about trans lives. At the same time, he knew others wanted to learn more but did not have access to beneficial reading material.

In our psychopathology class, first year of graduate school is when I learned about Gender Identity Disorder and read about it. I was like, “What? What is? Like this is awful...” I learned more about the disparities and the research that was done. A lot of the terrible things that were said about us, about just how misgendering was the way of talking about us, about how just because you are trans, you are crazy. This discriminatory language and lens about us were just wrong and not helpful. And there were lots of wonderful people in my life who wanted to learn more and wanted to help, but I didn’t have anything to give them to read because what they were reading was terrible.

In response to those experiences, Dr. St. Amand took it upon himself to do contribute to the field to make a difference. His thesis focused on examining differences between people who accessed testosterone and those who didn’t and how that impacted mental health. With his research, he

was able to sample 600 people, which demonstrated to his faculty his scholarship had the impact to make a difference and impact.

I just was like, “Okay, well, I’m here. So, let’s see, you know, how can I help?” I was like, “Well I can do a big research survey and this and that.” So, I did. My thesis was looking at differences between people who were accessing testosterone and those who weren’t and looking at mental health...I collected data from like 600 people. Back then if we had 30 people in a study, we were lucky, so it was huge. It really showed my faculty that I had really good potential to make a big difference and impact.

“The relational piece is important to me”

When prompted to share about experiences that have invited growth to him as a researcher, scholar, and scholar, Dr. St. Amand recounted a negative experience with an international expert in the field at his first WPATH conference. For Dr. St. Amand that experience helped him realize the title of “expert” does not always equate to expertise in the trans experience.

This is like weird. You’re supposed to be an internationally like renowned expert and you’re asking me something like you don’t understand. Because you don’t understand. You don’t understand...I think that was an experience, you know, just kind of realizing that folks who were touted as international experts had no idea about our experiences. And were very wrong.

Although this negative experience was one of the first experiences for Dr. St. Amand, he made it a point to attend to trans focused conferences to connect with other trans providers, especially folks in positions of power. It has been through those connections that have been turning points in his career. For example, forming those relationships enabled him to take on more leadership roles in various organizations.

I went to a lot of trans focused conferences like Philly Trans Health, Gender, Odyssey, and Spectrum, the one in the South, Southern Comfort. Connected more with trans people and trans people in the work as well as adjacent folks. More folks who are in positions of power within WPATH, APA, and started figuring out how to try to connect me in and include me on different things. That’s how I was able to work on the book for APA. That’s how I was able to be on the board of WPATH for a while as the very first student representative.

In forming those relationships, he had to be diplomatic in his approach. Is now a good time to speak up or to bite his tongue? However, navigating those decisions were vital in connecting not only with the community but those in powerful positions in organizations that make decisions about trans lives.

Through good relationships and keeping my mouth shut at the important times, you know, kind of weighing different decisions about when to say what... Those connections are super important, not only kind of with my own community but also with folks who are in positions of power within these different organizations who have access to things like the standards of care and publishing potential.

“It’s sacred to be trans”

In sharing what motivates his work, Dr. St. Amand reflected on how his privileged identities position him differently compared to other people. He shared a story in which he sent an email out to his department regarding Transgender Day of Remembrance to spread awareness of how trans violence impacts healthcare providers.

I didn’t think anybody in my family medicine department, at the Mayo Clinic, even knew what Transgender Day of Remembrance was. I felt it was my professional responsibility and personal responsibility to email and use words and phrases that would resonate with them about the epidemic of murder and violence, and how that impacts our health and our disparities. So, I sent them an email saying, “You know, so trans health epidemic of murders, I want folks to know that today, we remember our dead. Most of them are black and brown trans women. We have responsibility as healthcare providers to do something about this. And the fact that we don’t even know about it actually does have an impact on the community, because we feel that people don’t care if we live or day, that doctors don’t even care...” I am motivated to kind of use all these different identities to make change in my spaces where I’m able to make change.

Dr. St. Amand continued to reflect how his embodied experiences positions him differently for his words to be heard by those in positions of power.

If I was a trans woman or Black or brown person, people will blow me off easier. I’m trying to use my positionality and my privileges to get some messaging across that I’m hearing from my community, if that makes sense.

There have been many influencers and supports in his life that have helped him use his privilege for the betterment of the trans community as whole. One important influencer in his life is his friend Didi, who is a Black trans woman.

And my sister Didi and I are meeting next. She's a Black trans woman, so she's one of my greatest teachers. So, what she says, I figure out how I can pass that along in my kind of spaces in ways that people will find palatable, or whatnot.

Beyond important relationships with trans friends and colleagues, Dr. St. Amand shared prominent trans activists like Alok Vaid-Menon and Laverne Cox as highly influential and motivating. He reflected it has been beneficial for him to be open to different perspectives and voices within the community to better understand how healing can occur.

Alok is a poet and is a very much brown, visibly gender non-conforming person who gets hated on when they go out of their house, even though they are gorgeous and beyond creative and I think brilliant. They talk a lot about that experience and how actually that is part of our power is being able to elicit stuff in other people that they just can't handle, and they can't digest the fact that they might be attracted to us or jealous of us...Laverne Cox talks about how it's a revolutionary act to love the parts of our bodies that make us trans. I really think it puts a spin on a lot of societally driven gender dysphoria...I really kind of appreciate these different perspectives and these voices, especially of my Black and Brown trans siblings. They remind me of the power that is within our community for healing.

In addition to those in the trans community, Dr. St. Amand shared his parents and religion have been sources of motivation.

The other piece I'm motivated by is my parental support and my religion. What the hell was that? People don't get that, like, I have a charmed experience. I wish it that all people had that, because we can...So I want to do whatever I can to help more people have this charmed transition experience and to realize it's a gift and it's sacred to be trans.

“He helped open possibilities”

Near the end of the first interview, I prompted Dr. St. Amand to share what he hopes his legacy will be. He began by sharing he identifies more as a visionary and how he has visions of

“really cool things” that need to happen. In his vision, he hopes he helped open possibilities, decreased barriers, and elevated folks whose voices aren’t heard.

I identify more as a visionary...My legacy...He helped open possibilities. He helped decrease barriers. He helped uplift and elevate folks who were voiceless or whose voices weren’t listened to.

“I’m very much a collaborative person”

At the beginning of the second interview, I invited Dr. St. Amand to reflect on his experience in the field in relation to his work in trans health. For the most part, he shared it has been positive. For example, he completed in an internship where he was able to run a trans group, which he felt was a “well-rounded experience.” After his internship, he became a postdoctoral fellow focusing on LGBT health at the Veterans Affairs (VA). In this role, he ran groups and conducted evaluations for hormone therapy, which he had “a good time with.” Much of his experience has been trying to demystify the effects of hormones and filling up as much space as he can by publishing and presenting.

I also do a lot of workshops and education, and I offer that in terms of research. I’ve been pretty busy with research. I didn’t mean to be, but the research was really bad out there...Started mainly with looking at the effect of testosterone on mental health, because a lot of people just kept saying, “It could like give you roid rage and you could get arrested and go to jail.” I was like, “That’s not helpful. Like that is not helpful, and that’s not what everyone is saying that I’ve talked to that started.” So, we have to do something about that...I have a book on affirmative care of children, pre-pubertal children through APA. So just a lot of writing, a lot of publishing as much as possible, just to fill the space and take up space is really what I’ve been trying to do.

For Dr. St. Amand, taking up space requires collaboration. He shared prior to having connections it was difficult for him to do the work. In fact, it is easier to have people to bounce ideas off of, make plans, and remain motivated to finish things. Part of that collaboration is being intentional of whose voices are included in those works. Something he strives for is to be as inclusive as

possible because as “the most educated, Whitest person from all sorts of privileged backgrounds” he is more dangerous to the community when working in isolation.

I'm very much a collaborative person in general, for all sorts of reasons. When I was trying to do stuff alone, before I was really connected with folks it was hard. It's much easier to have people to run things by you and kind of make a plan and keep each other motivated to finish things. So, I've made a commitment to make sure that my collaborations are more inclusive, specifically of people of color and trans people...Any conference presentation that I do or with a group, it can't be all White people.

As Dr. St. Amand shared his experience with collaboration with others, I found myself wanting to know if he found it “easier” to work with other trans people in comparison with cis people. He reflected it is easier to work with other trans folks and over time he has found it easier to work with cis people as they listen to him more. He recounted it can be “annoying” when cis people question why he is present for certain projects.

Yep, for sure. I find that over time things are easier with cis folks, as people listen to me more. That's nice. I think it's still difficult. Like within WPATH, I'm the only person who's trans on our hormone therapy chapter for the standard of care chapter, the 8th version. And I'm the only person who is not an endocrinologist. Pretty much they're almost all White cis guys that are endocrinologists. I'm the only person who's a mental health provider, I'm the only primary care provider, I'm the only trans person. And a couple of them listen to me, but most of them are just kind of like, “Why are you even here?” and that's annoying.

“There's not much out there”

During the first interview, Dr. St. Amand shared his supports and those who motivate him to continue to do this important work. It was important for me in the second interview to really understand the barriers he has encountered, especially as he shared with me, he can be the “ever optimist.” The first barrier he discussed was the lack of adequate clinical supervision. He shared none of his supervisors knew much about working with trans people, so they often trusted he knew what he was doing. Although he appreciated that trust, he still desired education and instruction on working with his community.

Clinically, none of my supervisors knew how to supervise me in working with trans people. There's a lot of trusting that I knew what I was doing, which I appreciate, and would have loved some actual education and instruction, especially in working with our community.

Even though this barrier existed, he began to research on his own and found literature written by Reid Vanderburgh, a retired trans therapist. Reid's work and experience helped Dr. St. Amand fill in the gaps in his own training. For example, in Reid's book he recounts the commonalities he has witnessed over the years with his clients and what has been helpful in that work.

But my favorite book that I started reading at the very beginning was by Reid Vanderburgh. He's a retired therapist and a trans guy out in the west coast. I think it's called "Gender Identity and Beyond" or "Beyond Gender Identity," something like that. It was actually super helpful for counseling. Oh my gosh it was so helpful.

Beyond the clinical sphere, Dr. St. Amand shared a lack of mentorship. He reflected no one in his program worked with the population or were openly LGBT. The mentors he was able to locate were not focused on research, which is what he was needing.

Since nobody in my program worked with this population or was openly LGBT that was a barrier for mentors. And a lot of the mentors I found were not into research. They were into counseling, which is great, but I needed somebody in research. A lot of the folks who did more general research or research on borderline personality disorder, or like whatever domestic or interpersonal violence, etc. So, I had a lot of that, but I wish I would have had some both/ands...And a lot of the trans folks, I found their work good, but weren't into research or weren't trained in research as much. They were more focused on counseling and changing guidelines and things like that, which are all great and important.

In relation to research, another barrier Dr. St. Amand shared was related to publishing trans related scholarship. At the beginning of his career, it was more difficult for him to publish his work in "mainstream" journals, which led him to publish more in LGBT focused journals. Over time, more journal editors have called for trans focused scholarship but that has been its own barrier. He reflected a lot of cis scholars are publishing "a bunch of shit."

Especially in the beginning years, that was frustrating and definitely constituted a barrier. There was a lot of publishing in more specific LGBT journals instead of kind of

more broad ones. But now everybody wants something trans, and they're publishing a bunch of shit. Because everybody who is cis wants to do it on the trans. "And look how great I am helping these people." It's like "Oh my god, no sit down, just sit down."

The final barrier Dr. St. Amand shared was his own White privilege and lack of racial awareness, especially within the trans community. He reflected he appreciates those who have patiently sat with him as he navigated different things. He feels humbled and better equipped to engage in discussions and show up.

There are other barriers. I think my own lack of awareness about race and how that works in general, but especially within our community was definitely a barrier. I've been very grateful to have a lot of patient people walk me through some different things. And I've been humbled, and I've been better able to engage in discussion and show up. That definitely has been a barrier.

“There’s always a reason to invalidate someone, especially if they are trans”

After discussing barriers encountered, I invited Dr. St. Amand to reflect on how his embodiment shapes the professional and personal experiences he has been afforded. He noted it was not until he graduated from two doctoral programs that he felt people started listening to him more, even though much of what he says has been consistent.

I feel like it wasn't until I graduate. Until I graduated, frickin both doctoral programs, people started listening to me more. So that's been nice. It's also been annoying that it took this long because I've been saying a lot of the same things. But I feel like there's always a reason to invalidate somebody, especially if they're trans.

In addition to lack of being heard, he shared families do not seek therapy from him because he is trans and experiencing anger when other therapists point out that microaggression with him.

I think there are some families who do not come see me because I'm trans. And it's interesting because some other therapists have told me, "Well, they didn't want to come see you." And I was like, "Why do you even have to say that? Why do you have to say that? Why? I know that about people. Why do you have to tell me that microaggression is happening?" So, I get pissed off about that because I already know that.

However, there are some families who seek his services because he is trans and how that has been impactful for trans youth in his care. In addition, him being trans has opened possibilities in his clinical work.

There are some people that bring their kids and teens to me because I'm trans. So, you're gonna get that as well...I think there are opportunities that come up that are very helpful. I think it's so much of the clinical work, you know, me just disclosing from the beginning is so helpful people's guards go way down.

In relation to his trans identity, Dr. St. Amand encounters a challenge in being seen as an expert because of the degrees he holds. He seeks to disrupt people's assumption of expertise by advocating for the importance of folks who have lived experience. For example, different companies are used to hiring doctors or PhD's to give presentations and it is difficult to help the organizational leaders understand the community has lived experience and expertise that is invaluable.

The most educated person and I had to do it all by myself, in addition to all the other crap that I got taught. A lot of what I know is not from my formal education, right. So that's what I try to advocate for is the importance of folks who have lived experience for their expertise. Because it's not like me having two doctoral degrees...There's plenty of people who know more than me and who have no degrees...But when you're talking to different companies who are used to hiring doctors to give presentations, or PhDs or this and that, it is hard for them to understand that our community has lived expertise and experience that is very valuable and useful, if not more than me telling other people's stories.

“We are at the beginning”

The second interview concluded with Dr. St. Amand sharing his thoughts regarding the current state of trans inclusive therapy practice is at within the field. He reflected people have heard of the word “transgender” and are starting to talk about it. Although the conversations have only started, he shared people overestimate their knowledge, which results in outdated practices to be taught and passed down.

We are at the beginning. People have heard of the word transgender – AH! People are beginning to start to talk about it. But what I find is that knowing a little is dangerous. So, we're in this place where a lot of people think they know a lot more than they actually do and are teaching and passing along old practices. There's just going to be a lot of catch-up work.

To address this cognitive dissonance, he helped create the Gender Education Network (GEN) as a way to centralize trans people as the educators. The mission of GEN is to provide a standard of education, which he shared has been going fairly well and hopes the organization launch a certificate in the next couple of years.

So, part of why I helped start them growing Gender Education Network is so that we can centralize ourselves as the teachers. You know this is the standard of education and information. And it's going pretty well. We're working on having a mental health certification probably in two years from now.

Dr. St. Amand was quick to discuss the overestimation of knowledge and assuming certain people know best is impacting the amount of progress that can be made. He shared leaders of organizations are not always aware of the impact of problematic literature and statements and are often removed from the real problems the trans community faces.

Oh, and also people assume that certain people know more, right. For example, someone who, at some point was the president of WPATH...came up to me and he's like, "Colt, why do you think I heard that you know, somebody was talking about there's this one research paper on rapid onset gender dysphoria and why are people up in arms about this? Like it's just one research paper and it's not even good." And I'm like you are so removed and you're the president of WPATH. We can't afford that, that's dangerous. That level of disconnection from community, especially at this time, is dangerous.

He was adamant to state until we, as a field, learn how to center the most vulnerable in the community and listen to them we will not be able to get real work done. He further shared we are not at a place to help trans people thrive, we are at a place to help them survive. Basic needs are not being met for the trans community.

I think once we learn to center the most vulnerable in our community, and listen to them and empower them, then we'll be able to get some real work done...We are not in the place of helping our community to thrive, we are in the survival super disparities. We are

in the helping keep our people alive place...Because literally people don't know that portions of us are being hunted and killed and there's no justice and kids can't be at school and like basic needs – survival, urination, food, jobs, are not being met.

When offered to share what a general mental health provider thinks of when they hear “transgender inclusive therapy practices,” he struggled to answer. He reflected it really depends on their learning experiences, social circles, political affiliations, their religion, and their families. He hopes that those who have limited knowledge on trans inclusive practices know someone who does who they can get support from.

I have no idea. I think it's so dependent on their learning experiences and their social circles and their political affiliations and their place of worship and their family structures and families. If you're connected to one of us, you're more likely to have a different idea or more ideas or think you have more ideas, or maybe you have some resources. But I hope at minimum, you think about the average person who doesn't have expertise in this and who's not regularly seeing trans clients, I hope they have somebody who knows what they're talking about and then consults with them or refers patients to them. That is my hope.

“When cis people are willing to step aside”

The final interview began with me asking Dr. St. Amand to share his thoughts on how he has seen the field grow. He discussed growth depends on when cis people are willing to step aside and allow trans people to take the field and lead. He noted he has seen some shifts over time, and it is a slow struggle, which has left him jaded.

I think that really depends on when cis people who build trans health are willing to step aside and allow trans people to take the field and lead, like truly lead the field. We've seen some shifts in that over time, but it's a slow struggle and cis people really love to tell trans people about themselves and how things were...I definitely have a jaded perspective on that.

In addition to seeing gradual shift in who is dominating the field, he shared he is seeing more and more trans clinicians in positions of influence. These individuals need to be forceful and be careful in how they compromise with cis providers.

So now that there are more and more of us, you know, in positions to influence the field, we have a responsibility to be very forceful with our opinions, which is not my style...I have a really good friend and colleague who is openly intersex and a physician and she happens to be on a big board of things that's making guidelines for the next decade on intersex care...We had this conversation because there's arguments over infant genital surgery within the members of that group...She's talking about compromise and stuff. I was like, "No ma'am. Like, no, we have to stop that because then you have 10 more years of suffering..." What are our minimum standards?

“Treating cis anxiety is a big part of the field”

Dr. St. Amand was quick to discuss how naming and deconstructing “cis anxiety” needs to happen in order for the field to grow. He reflected at least 50 percent of his work with families, partners, and other providers is providing information and answering questions to alleviate “cis anxiety” related to the trans experience. Once we have better named the process, then the field can focus on trans care.

A lot of what we do, at least half like we talked about, is treating cis anxiety. And really with information and answering questions, and also helping people be okay with the unknown and the unknowing and relearning that comes along with this population...You can name more, but I think that once we get better at naming that, and we can then be like, “Okay, why don't we focus on trans care?”

In addition to naming cis anxiety, humility is an important remedy to the process that is currently plaguing trans care. He shared humility is knowing you could have done better or unintentionally harmed somebody by doing a practice you thought was right. There is a need for clinicians to be vulnerable and open to learning even when they “know more than 99% of their colleagues.”

I really think it's about humility. And I think, you know, I needed it too, it's not just everyone else. But having that humility to realize you could have done something better, or that maybe we unintentionally harmed someone by doing a practice that you thought was the right thing to do. And just being very vulnerable and open to these things and humble...But I think it's going to take that humility for people to be able to acknowledge and shift, and for the people who are learning to kind of keep that humility, even once they know more than 99% of their colleagues.

“They need support”

Once Dr. St. Amand had elaborated on where he feels the field is at and how it’s grown, we switched to discussing what needs to happen within programs for TGNB students. He reflected he would have liked to have had a trans mentor, inside or outside of the program. In addition, students need to feel supported by the faculty. For example, they need to be able to fully present and recognized as themselves. They need faculty who will consult with others before going “off the cuff.”

That is big. Everybody need somethings, right? I would have loved having some sort of mentor, trans mentor that would have been really cool. Inside or outside of my program, whatever it was. Somebody who was a clinician and somebody who was already there, somebody who had made it through. Mentoring is useful...I think making sure, just like in undergraduate programs, that they person is able to fully present as themselves and be recognized as themselves and access care that they need. Sort of the basics to thrive, survive/thrive in a program. They need support. They need supportive colleagues in their program, in their faculty. They need supervisors who are willing to consult with people who know what they’re talking about, instead of just sort of going off the cuff.

“Do your own gender work”

When asked to explore what needs to happen in clinical programs to be more trans inclusive, Dr. St. Amand first shared, “[Gender work] has to be done in school, at the graduate level is a little late, but better than never.” Faculty and students need to engage and be encouraged to do their own gender work and reflect on how they first learned about gender.

Reid Vanderburgh is the first trans therapist book that I read. He says that you’re not qualified to sit across from a trans person until you’ve done your own gender work...That’s part of what I do, and in my course, is make people sit down with who first told you, you were a girl or a boy? Because usually had to be told, and what was that context?

He further shared he questions whether this should be a specialized and should people receive specific training to work with us. He elaborated that is a difficult spot for him to be in because trans people need access to care and trans people need people who will not hurt them.

I think the question always becomes like, should this be specialized? Should people have specific training to be able to work with us? And then like, we need people to work with us. That's hard. At the same time, we need people to like not hurt us.

He ended his reflection on hoping people realize they need more training than what is being offered, even from larger organizations.

I think it's hard because you have giant organizations like WPATH are doing theirs. And you know that two co-chairs who created that are White cis women, surprise, who've been in trans care for like 30 years each. They do have that you know and neither of them have a relational connection with the population besides doctor-patient. Hopefully more people realize they need more training and the trainings that people get are beyond 101.

“People need to know our histories as healers”

The final interview concluded with a discussion with what needs to happen socially and politically. Dr. St. Amand reflected the entire system needs to shift. From policies to seeking a trans therapist as desirable rather than weird.

So many things need to change, like we had so much progress with the Obama administration and the federal stuff for schools, I think that all needs to come back and be even better than it is. I think we need to clearly get gender identity is defined as a biological part of someone's sex. So that the legal term sex does include gender identity as well, even though we tried to separate it...I think we need to not have a diagnosis for being trans. I think we need to figure out how to still get things covered, and how to, I think our whole fucking...our whole medical system, health care system needs to change in general...I think people need to know about our history as healers. And so, the idea of going to a trans therapist wouldn't be so weird, I think it should be desired.

As he shared what he sees as needing to shift, I offered a statement of decolonizing everything to which he responded, “That sounds good.” He ended by sharing a conversation with his two-spirit mentor and how many of the medicine people and healers were two-spirit.

I mean, Native folks did really well with trans folks. I'm learning spiritedness through my two-spirit mentor, Kelly, who's in Oklahoma. And so many of the medicine people and healers were two-spirit, right? There wasn't an issue, so they know and know what's going on. So, I feel like that's definitely something to learn from.

Dr. Alex Iantaffi

Dr. Alex Iantaffi has been in the systemic therapy/marriage and family therapy field for 20 years. Their journey into the field began in the UK where they obtained their PhD, and their MSc in systemic psychotherapy. In that context, they practiced in a range of clinical settings (e.g., school, national health service, in-home, and private practice). They moved to the US and worked as a postdoctoral fellow at a Midwestern university studying human sexuality, specifically studying TGNB folks and HIV. Although they were hired as a postdoctoral fellow, by that time they had already had their PhD for 9 years. Given that they already had nearly a decade of research and teaching experience in the UK, they originally had plans to secure a tenure track position at that university; however, they encountered countless instances of trans oppression, including discrimination and harassment. They were eventually able to secure a green card, independently from the higher education institution they worked for, as they kept postponing their support for a more secure immigration status. They started a private practice, which has transformed into a tiny agency. In this practice, Dr. Iantaffi works with clients, supervises pre-licensed MFTs, including practicum students, and provides consultation to other clinicians. Since leaving academia, they have become more involved in AAMFT serving on the Queer and Trans Advocacy Network (QTAN) first as chair-elect and currently as chair and have written numerous books, chapters, and articles related to clinical work with the TGNB community. Their most notable recent work is the sole-authored text, “Gender Trauma: Healing Cultural, Social, and Historical Gendered Trauma.”

Prior to conducting this study, I was aware that Dr. Iantaffi existed in the field. I had met them through Dr. Kristen Benson at the AAMFT conference when I was master’s student at NDSU almost seven years ago. As a member of QTAN, I have been able to stay up to date with

their work. I am always so impressed with how quick they are to provide assistance through the QTAN listservs and how they do not shy away from offering criticism and cautions to other providers. These criticisms are rarely harsh or combative and come from a deep care and desire to transform the field and how MFTs practice, which was evident across the three interviews. Dr. Iantaffi was open with their concerns and ideas for how to engage in transformative action.

“I never intended to be an expert in trans mental health”

Although Dr. Iantaffi was interested in systemic practice and academia, it was never their intention to become an expert in trans mental health. They were influenced by second wave feminism and aware of the trans exclusionary rhetoric. However, their area focused on gender dynamics at the intersections of queerness and disability. In fact, they imagined they would end up in Deaf education or advocating for disabled students in education.

I mean, honestly, I never intended to be an expert in the area of trans mental health...Honestly my expertise was on disability and gender. When I started, I thought I was going into the field to be somewhere in deaf education or kind of advocating for disabled students in education.

They described their elevation to “expert status” as serendipitous. They shared TGNB people often sought out their services and in order to competently care for these clients they began to do their own research. At some point, the work they were doing positioned others to see them as an expert in TGNB mental health.

I think because of my own identity, trans people kept coming to me. It just happened to be honest...It just happened like because trans people come to you and then I wanted to be competent and I'm immersed in the community. Before you know it, it's like, “Oh, you're a trans mental health expert now. Congratulations!”

They described their path to ‘expert’ status as doing their own learning, doing their own “fucked up” things along the way, and the bar being very low in the field in terms of what constitutes an expert in TGNB mental health.

I did a lot of reading. I wanted to stay up to date and listening. I've done some fucked up things. I used to say female-bodied and male-bodied because I didn't know any better until someone pulled me aside and said that wasn't okay and here's why...I'm making sure that I'm not just reading academic books, that also reading and being in relationship with activists and community organizers. That's what has been very powerful for me. Now I feel there is a body of work where when I was coming into the field now, I wouldn't have to do so much piecemealing...I guess the bar was very low when I entered the field. The bar is pretty low to be honest. I've been trying to raise it slowly.

“I have a lot of gratitude for trans community”

When prompted to explore their biggest influences, Dr. Iantaffi shared the trans community has been a major influence. If not for the community, they would not be where they are at today. They have been able to do so much learning about themselves and others and healing through the community.

I have a lot of gratitude for trans community. First of all, without community, I would not be here. Growing up in the early 70s in Italy, it's not like the world was abundant with trans role models or opportunity models. I didn't even know what a trans person was until my late 20s to be completely honest. I only knew because I was in queer community and I was like, "What is happening here? I'm interested..." Community was the first place where I first saw possibilities for myself, and my own identity, but also community has been a place where I've been able to learn and be validated.

Another influence has been important friends who have provided Dr. Iantaffi with language to help understand their experience. Learning and understanding the influence and impact of cisgenderism has allowed them to critically reflect on their experiences.

I think Gavi Ansara has been a big influence with his work on cisgenderism. Especially, that's been helpful for me to really, it was just that extra step in realizing, "It's not just transphobia." Yes, transphobia is a huge issue, but it's bigger than transphobia, right? Cisgenderism is its own thing.

The last influence to be named by Dr. Iantaffi was their trauma training. Trauma was never an area they would set out to be an expert in but working with a historically marginalized community requires trauma informed care.

And then the other piece is my trauma training, because of my own healing journey and then honestly because if you work with minoritized communities you're going to work with trauma. That's another area where I didn't set out to be an expert, but now I am a trauma expert because I had to gather the tools for myself, for my community, and as training and putting that together with a more kind of social justice, systemic understanding, which is often lacking in the trauma world.

“Rage”

During the first interview, I invited them to share with me what motivates their work. They very quickly stated, “Rage.” They reflected how their own childhood and teenage years were filled with violence and abuse and wanting to resist being reduced to a statistic. Even though they lacked the language as a teen, they always felt like the solution to issues required systemic intervention.

Rage. I think that's it, actually. Because when I think about it, even when I came into the mental health field, this is actually another strand. I come from a family where there was a lot of domestic violence and abuse and I'm a survivor on multiple levels, both as a child and adult. I remember even as a young person reading studies where basically they were like, if you're abused too early, you're fucked up and you might as well be on the reject pile of society...As a teenager, I wanted to not be a statistic...I think rage has been a big motivator, rage and compassion at the same time, right?...I always understood that even the individual abuse that I experienced was a systemic issue if that makes sense.

The rage invites Dr. Iantaffi to co-create a world they would like to live in and to act as if the world is already how they envision it.

It's rage, but then it just always been about how do we challenge systems of oppression? And I'll do it, how do I co-create the world that I want to live in every day. That's been my motivators. I remember that time might be my first clear thought of, “This is what's worthwhile doing every day, trying to push for the world you want to live in.” Or as my good friend and elder Donald will say, “We just decided to live as a revolution had already happened...” When they said that I was like, “Oh” that resonated with me.

“God. I don't know.”

Near the end of the first interview, I asked Dr. Iantaffi to reflect on their contributions to the field and their legacy. Their reflection started with them sharing how within the last few years people have approached them about the impact of their work, and not really being sure

how their work has impacted others. They shared perhaps an area of impact has been being a visible older, openly trans, fully licensed, senior person.

God. I don't know. It's been weird to think about. It's been weird in the last few years to have some folks talk to me about the impact that some of my work has had on them. And having this feeling of legacy for want of a better word. I guess what I think my impact in the field is at the moment, I think partially is honestly being an older, openly trans, a fully licensed therapist, kind of more senior if we want to use that language, being a senior person in the field like that has its own power, I think.

Another area they try to make an impact in is therapists becoming more vulnerable with their own struggles, especially for minoritized therapists.

That's one of the reasons why I've been really moving a lot more towards supervision and mentorship because I feel like there's such a need for therapists with minoritized identities and experiences to have that support. I do feel that's its own level of vulnerability to be like you can really struggle with your mental health and still be of service as a clinician, in fact it might help you.

“Things clinicians thought was affirming was actually not”

The second interview started with me asking Dr. Iantaffi about their experience in the field related to their clinical and research work related to TNGB inclusive care. They noted they have worked with TGNB people early on in their career and received additional training in sex therapy. As they were developing their own understanding of TGNB care it became evident that what clinicians thought was affirming actually was not.

In terms of clinical experience, I started seeing trans folks pretty early on in my career...Then when I moved to the US I got to experience working in a gender based identity clinic and got a lot of training in a more traditional kind of medicalized model of sex therapy...At the same time, I was very steeped in community, I was doing a lot of volunteering with our local trans health coalition...I think it became increasingly clear that a lot of the things that clinicians thought were affirming were actually not really affirming at all.

During that clinical period, they were engaging in research that included some TGNB participants. This research focused more on HIV education and prevention. They eventually received a small grant to look at PrEP, pre-exposure prophylaxis, and trans folks.

Also, at the same time, I was doing research, and some of this was with trans folks as well. So that contributed to my experience as well. A lot of the research focused on HIV education and prevention, so more kind of sexual health kind of area. I even did my small grant at one point to look at PrEP, pre-exposure prophylaxis, and trans folks because there wasn't very much data.

“A good reputation is important to me”

When asked to describe sources of supports for Dr. Iantaffi to do the above-mentioned work, they shared that community has been a big source of support. It has been important for them to maintain a good clinical reputation within the community.

I think community has been a big source of support for me, just knowing that I have a good reputation as a clinician in the community is really important to me. Not because of like, “Oh what do people think about me” but it's like, “Okay, means that I'm not doing harm, at the very least.

Community involves more than the TGNB community but also the larger clinical community.

Through connecting and creating relationships with other clinicians, Dr. Iantaffi has been able to collaborate on projects. Although these supportive colleagues have been primarily trans, there have been some cisgender folks who are good allies.

So there's trans community, but also clinical community, you know. I've overlapped with really supportive colleagues who have given me opportunities to write or research with them, or I've really supportive colleagues who have been in communication with me over the years, not just in the US but back in the UK and Australia...In terms of clinical and research community has been mostly trans folks and some cis folks who are really good allies.

A final source of support identified was family. Dr. Iantaffi shared their family provides an insurmountable wealth of support to them, especially on days when clinical work has been extremely taxing.

And of course, my family, I think if I didn't have a supportive family, it would be really really hard to do the work I do...And you have really hard days, especially when working with families of youth and if transphobia comes up, it kind of impacts us, I think in a different way then it impacts cis clinicians and so to be able to go home and have a really supportive environment...is really important to me.

“I don’t care if people think it’s sour grapes”

After identifying sources of supports, I inquired about barriers to being able to do their work. Dr. Iantaffi shared barriers related to both their clinical practice and their academic journey. With regards to their clinical practice, they reflected parents who differ in their level of support for their TGNB child will seek a second opinion and, in those moments, they are aware what they really mean is consulting a cisgender therapist.

It’s a little easier now that I have my own practice, because I don’t have to put up with some systems...So currently, I think it’s more kind of if you’re working with young people and the parents or caregivers are really struggling to accept the young person, it can be really hard sometimes. Maybe one parent is supportive of their kid having a trans clinician and the other is not. And so, you can get things like, “I want a second opinion.” And you know, as a trans clinician, what they mean is that they want a cis clinician’s opinion, it’s not a second opinion, you know.

Even when parents are accepting of their child seeing a TGNB clinician, Dr. Iantaffi shared it can be difficult to help the liberal progressive parents to be aware of their own internalized transphobia.

The good liberal parents who are super supportive of their kid, and also don’t understand how transphobic they really are. Those are a tough nut to crack usually, and that’s another very common scenario. And actually, they’re making an effort. They want their kid to see a trans therapist and they want to provide them with the best care. And they’re really not looking at their own kind of internalized transphobia versus cisgenderism and all of that.

In terms of academia, Dr. Iantaffi started by reflecting on how they never received a tenure track position even though there were conversations about being offered one and the difficulty in watching cisgender colleagues sail ahead.

Oh, academic and research world? That’s great. Well, I never even got a tenure track position, and I don’t care if people think it’s sour grapes. But yes, I do resent that. So, one of the main barriers is just seeing all the cis people sail ahead. And for a long time, I internalized that, “Well, I’m not good enough. It’s me, I haven’t made the right choices. I haven’t made the right moves.

They continued by sharing how another barrier is not having the same access to opportunities compared to other students in their PhD program.

While my colleagues who finished their PhD at the same time were getting interview after interview after interview, I was getting no interviews outside of my own institution...That was like the first barrier, not having the same opportunities to start with, for sure.

Another barrier within academia is the tokenization and exploitation they experienced at the hands of their cisgender colleagues and when attempting to speak out about the systemic injustice being labeled “hostile.”

Kind of tokenizing in an exploitative way, sometimes by colleagues, like wanting you on their research team or their thing because you're trans, but they're not really giving you the recognition sometimes, not always. I think I talked last time about being put on an NIH grant and then being taken off it. So being told I did not have enough NIH experience and at the same time I got invited to be a review member on a special panel by NIH...It's also the continuous invalidation and also a sense of, “Why aren't you grateful for what you have and the opportunity that you have and why are you being so “hostile?” In air quotes which again right there you become the angry, hostile trans person.

Another example of tokenization is cisgender colleagues acting surprised when seeing their curricula vitae because they have assumed Dr. Iantaffi was invited because of their trans identity. They expressed how exhausting the experience of people seeing their identity before their competence can be.

I think the last piece I will say is that sometimes similarly to the clinical stuff that I was saying earlier, people look at you and they are like, “Oh you're here because you are trans.” So, we need to tick the trans box, right? Then they're surprised that you actually know shit or have an education, you know the number of times I send my CV to people and people are like, “Oh, wow.” And I'm like, “What, did you think I was sitting on my ass for the last 25 years?” ...But it's exhausting, so I would say that's definitely a barrier because it kind of wears you down and people see your identity before they see your competence and your experience.

A final barrier Dr. Iantaffi discussed was people, often cisgender, self-declaring how incompetent they are. They shared a story of them being at an international conference and a

scholar presenting on TGNB people while self-proclaiming they knew very little about TGNB people and how colleagues who are supposedly allies will make excuses for those scholars.

Oh yeah, that's another thing of more barriers. Conference presentations where people are self-declaring how incompetent they are. International Academy of Sex Research Prague. I can't remember what year it was; it was sometime in late 2000s. Lisa Diamond is keynoting...I don't fucking care, I can name names, and I don't even want an academic career anymore anyway. But so, Lisa Diamond is giving a keynote on trans folks and goes, "I don't really know anything about trans people." Like she's straight up saying this to the crème de la crème...and this should be fucking public. This kind of shit. So, she goes, "I don't really know about trans people. I know there's a whole field out there." She's literally this dismissive and then proceeds to give this terrible talk about how some of the women participants in their study have started to transition. So, she got interested and did some qualitative research with them...I don't fucking care if it sounds like sour grapes. But this is one of my pet peeves in the field when I was trying to have a career you have to play along with all these people...I don't want to be around transphobic people, you know? I would talk about that with some of my cis colleagues and it would always be like, "He's [Ken Zucker] not that bad. He's a nice guy..." And that's exhausting too because you get to see all the people who you thought were good colleagues and even you know friends...and some folks I'm not surprised, but other folks I'm like, "I thought you actually were a decent human being and a friend and you are supporting this person who's actually like, really made their career on hating queer and trans folks."

Additionally, Dr. Iantaffi often feels when cisgender scholars present on TGNB topics they receive applause and gratitude from attendees; however, when TGNB scholars present on a similar topic they often experience greater scrutiny.

If it's a cis clinician that does something, they're gonna be uplifted and elevated. "You should write a book or make a presentation." It's like, "Yay, cis people doing trans things, you're awesome." And then if it's the trans person it's like, "Is that really good? How good is this? And isn't this a little bit biased? Okay, that's what you did? That's nice."

“Everyone wants to be trans affirming now”

When asked to share their perspective on the current state of TGNB inclusive therapy practices in the field, Dr. Iantaffi expressed, “I think that everybody wants to be transgender affirming now, and that’s nice.” They reflected their hope that the field will eventually reach a

point where it embraces gender affirming rather than TGNB affirming and really root efforts in dismantling cisgenderism.

I feel that first of all, I wish it was gender affirming, not transgender affirming, like really what we're talking about is affirming people of all gender identities and expressions and roles and experiences. And once again, we are making it about trans people. This is not about trans people. This is about cisgenderism impacting everybody...My pet peeve is this should not be about trans folks, or being nice to trans folks, or being affirming of trans identities. This should be about dismantling cisgenderism.

In addition, Dr Iantaffi shared the current models of TGNB affirmative care need to be conceptualized through an intersectional lens to address how experiences of racism, classism, and other systemic oppressive forces intersect with the experience of being TGNB.

I also think a lot of the models for transgender affirmative care are very white, they don't really take into consideration intersection of gender and race. They don't take into consideration any other intersections, right? They're very ableist...Like I said, no, I think it's great that we have a gender affirmative model, and we need it. But I think it needs to be expanded. And also, that it shouldn't just be about how people's practice but the reflexivity and clinicians having done their own gender work has to be an integral part of this.

Lastly, Dr. Iantaffi reflected gender affirmative practice needs to be a core competency and that TGNB people should not be a special subject.

It shouldn't be an add on, it shouldn't be like, "Oh, you want to specialize in this, let's add it on." This has to be kind of integrated into all curricula, it should be a core competence, to be able to work with people of all genders, all gender identities, experiences and expressions, because we shouldn't be a specialist subject.

“Slowly and painfully getting kicked into it”

At the beginning of the final interview, Dr. Iantaffi was encouraged to share their thoughts about how they see the field growing in terms of TGNB inclusive practices. They shared the field is changing and it has been a slow and painful process, and the field will evolve to a state where such a question does not need to be asked.

Oh god. Yeah, no, no. I mean the field is changing, but slowly and painfully getting kicked into it, I feel for some of us. I feel like eventually I would like to see the field be in

a place where we don't even have to ask that question, right? This should be moot and unnecessary...I don't want folks to have to need trans competence because it's so embedded in curriculum in the same way that I don't want them to have to take special courses on intersectionality.

In addition, Dr. Iantaffi stressed the field needs to wrestle with the impact of colonialism because we cannot talk about gender without examining that, which also requires dismantling capitalistic notions of binaries.

We can't talk about gender without talking about colonialism, without talking about how dehumanizing Indigenous and Black and Brown bodies was allowed for the ongoing colonial project to thrive. And part of that is creating this binary system of gender, which is also linked to capitalism, and the idea of property for land or people, right?

To be able to engage in such practices, clinicians need to be trained in *true* systemic practice and thinking, and MFTs should be leading the broader mental health field in systemic practice. Dr. Iantaffi reflected how even in social work students are trained to either intervene at the micro or macro system without understanding how systems operate.

Basically, what I would like to see is the field grow in much more complex understanding of systems of power and oppression. I'm like, "Come on, if anybody can do it, it should be us, as systemic psychotherapists..." The saviorism in social work is so rife, not all programs do a good job training people for clinical work, because again, it's like this, "Am I gonna be out there changing the microsystem or the macrosystem?" while not understanding systems.

Dr. Iantaffi feels like in some ways the MFT field has gone sideways because of the medical model's influence on the mental health field. They elaborated the western medical model splices people up into specialties, which is occurring within the mental health field.

It doesn't serve the western medical model of hyper specialization. We know western medicine cuts people up, and we're doing the same thing in our field cutting people up by population, by specialties. We shouldn't be cutting people up by specialty. It shouldn't be like, "Oh well if you're trans, you get shipped to the gender specialist..." If anything, I think we've literally gone sideways in our field.

"A complete overhaul"

When asked what would make the future of the field embracing *true* systemic thinking,

Dr. Iantaffi reflected there would need to be a complete overhaul of graduate training programs.

They stressed the importance of master level trainees understanding the historical roots of the field and how interdisciplinary the field is.

A complete overhaul of our training programs to start with...So, sure people need to know what to do when they're dropped in a room with a client, and also people really need to have an understanding of the historical roots of the field. Very few courses really do kind of a historical theoretical development in the field of family therapy. For example, a lot of folks don't even know or might passingly know what I mean by second order cybernetics or things like that...I think our curricula do not serve our students.

In addition, they stated MFTs need to stop trying to mimic psychologists, which does not make MFTs any less than and to truly embrace the systemic prowess MFTs hold. They emphasized MFTs need to be advocating for systemic codes to be reimbursable by insurance companies.

We should also stop trying to mimic psychologists because we aren't psychologists. That doesn't mean we're less than, I think we're actually more than and we are the future, like systemic thinking is the future it is where the field should be going. We should be leading rather than following all the other professional fields that quite frankly don't have the same foundations we do...So you know just tiny changes like we need to overhaul the insurance system and we need those if we are going to keep using the ICD. We need those z codes to be recognized because those are the systemic codes that are billable, which they should be, in theory, but insurance pushes back on them a lot.

Lastly, Dr. Iantaffi reflected MFTs need to become comfortable embracing a political identity not rooted in conservatism. In addition, they noted the field has been historically political and systems requires political intervention for transformative justice to occur.

Systems thinking is inherently political, if we want to think about it that way. Because if politics is a system, that's what we do. We work for systems and so inherently we're gonna be political in our intervention...but if there isn't systemic change, just adding diversity to the same formula is not going to do it. And we know that this whole diversity/inclusion model still supports the system as is.

“Some things are happening”

I then asked Dr. Iantaffi what they see happening in the field that makes them hopeful the

future they described is happening. They reflected they have been movements in the larger organization to include keynotes that have been great and conversations about changing the name from MFT to a systemic psychotherapy direction. However, there remains some resistance to those types of changes.

I've seen one or two keynotes talk about that over the years which is great and exciting. I believe there's a conversation about changing the MFT name to a systemic psychotherapy direction...But there is resistance and reluctance from many members.

In addition to witnessing exceptional keynotes and hearing rumblings of change, Dr. Iantaffi shared they are seeing programs do the work to restructure their curricula to be more inclusive and systemic.

I know the program at Stout tries to have kind of like LGBTQ folks embedded in the curriculum...And interracial relationship was embedded in the curriculum, right? So, I think some things are happening, they're just happening slowly in a very discreet level.

Dr. Iantaffi continued to reflect on how social justice topics are becoming more popular and people are engaging in transformative research, and there appears to be a different type of openness and willingness to not pander to the conservative membership.

You know, you're doing research projects like this, I think there is an interest. But it also feels like a vast undertaking, if that makes sense...I do see a different openness, a different willingness to not just pander to the most conservative common denominator. And just even things like the popularity of something like the Queer and Trans Advocacy Network, I think we're the second largest topical network.

“Know your rights”

As the conversation shifted to what students need, Dr. Iantaffi shared students need to be aware of their rights. They encouraged students to unionize to garner more power within the system to better advocate for themselves.

At the student level, maybe just kind of people knowing their rights? But also some organizing, especially for graduate and postgraduate students...Students should unionize right?...Because then they can represent the interests of the students...They're also

exploited for their labor, often, you know...So I think students should unionize first of all, at every level, and understand the power they have within the higher education system.

Dr. Iantaffi reflected students from privileged backgrounds need to be aware of and check their entitlement. They continued to elaborate these students are often incredibly demanding and pushy in the system because they know they have power within the system.

For some students, and this is more for the students from a privileged background, there needs to be less entitlement honestly...Then there is this thin layer of super privileged students who are like, not doing all of that [working numerous jobs] and being incredibly demanding and pushy in the system because they know they have power in the system, right? So you're getting actually a few students having a lot of voice in the system where a lot of other students don't have the strength or time, or knowledge of the system.

“Academia should be an educational establishment”

When prompted to discuss what they think needs to stir up the academic system at the faculty and administrative level, Dr. Iantaffi reflected capitalism is ruining the institution, especially at the administrative level. Students are often seen as clients and consumers, which influences how students engage within the system and how the system engages with the student. They situate academia as a place where radical thinking needs to happen.

Well, capitalism again, and capitalism is killing us all. Administratively it's capitalism because they're like, “Well, we need to make money” students as clients, all that kind of stuff, right? We need to change that mentality like it isn't. Academia should be, in theory, an educational establishment, in theory, where the most radical thinking happens, right? There's a reason that when dictatorships takeover countries, often academics are the ones who are persecuted...It shouldn't be a money-making thing. Academia should be a service to the community.

At the faculty level tenure needs to change and the scarcity mentality needs to shift. Dr. Iantaffi shared how many of the classes are being taught by underpaid adjunct faculty because the system currently operates in a way that situates a lack of available tenure track positions.

There aren't enough jobs, so folks then go after adjunct jobs to stay in academia, they get royally underpaid and live kind of below or just above the poverty line while working really hard, because you create a scarcity mentality in academia...I want job security for everybody, but what systems are getting reproduced for the job and whose job security

really is guaranteed? Because somehow you know if you're a minoritized person tenure can mean something up to a point. Also, most states have really dismantled how firm tenure is anyway. You know tenure doesn't mean what it used to mean, and also created a lot of issues like professors have sexually harassed and assaulted students who are still in their jobs...It's not without its problems to give somebody a job for life.

In addition to the changes in tenure and scarcity mentality, faculty need to be aware of the pressures students are under, especially lower SES students. Dr. Iantaffi shared it's not uncommon for lower SES students to work multiple jobs and have various demands on top of their coursework. They suggest faculty should be accommodating on due dates for assignments and not penalize students for turning in work "late."

Faculty need to understand that some students are working their asses off, have families, are working two jobs and coming to university...That's where faculty come in, they should have an understanding that some students are under incredible pressure, you know, and they're actually juggling 300 things. I'm like, I looked at some syllabi and I was like, "Why do you do all that? Why so many assignments? Is this really necessary?" I don't think so. I've always given far fewer assignments and I'm very flexible, I don't ever penalize people for turning in their work late, as long as they talk to me. I always let people know, "Hey, this is the very last date by which I need assignments because then I have to grade them, and this is when grades are due, so I do actually need those assignments in by this point." This is where there's a synergy between faculty and student, right?

"SO MUCH!"

The interview ended with a discussion of what needs to happen socially and politically. Dr. Iantaffi was quick to situate that a lot needs to change. Ranging from systemic codes needing to be reimbursable by insurance companies to basic human rights for ALL people regardless of gender, sexual orientation, relational configuration, and citizenship status.

So much! Well, in terms of the political arena, I think we touched on some of those things already. I mean our license should be recognized by Medicare, like yesterday, universal healthcare on a social political level. Basic human rights for all people, people of any gender, sexual identity orientation, relational configuration, citizenship status because many people don't realize that non-citizens don't have the same rights.

Other political changes included de-privatizing systems connected to policy and social systems (e.g., healthcare, education, prisons, immigration centers).

So, on the political and social level, not privatizing systems that are connected to policy and social systems, if that makes sense. I mean, healthcare, education, prisons are

complicated because they shouldn't exist, immigration centers shouldn't exist. I mean I want to abolish borders and always have since I was like in middle school.

In terms of MFT education, Dr. Iantaffi shared the licensure process should be altered because the national exam is a barrier for people.

Really changing how the educational system works in terms of training therapists, changing the way we access licensure. I think it should be much more portfolio based and relational. Because taking a computer test is not relational, it's just taking a test, and it doesn't say if somebody is a good clinician or not. At least at the state level, like the oral exam, that's relational and conversational, I can go with that. But that national exam seems like such a barrier. I think people should finish their masters and either can go into the pre-licensure route or not based on their portfolio and performance in practicums, and things like that, which would be a huge change to the system.

In order to make all of these changes, they stressed the US would have to shift away from capitalism, which also means moving socially away from a sue-based, fear-based response.

But that would be moving away from capitalism, right? Because then people would be mad and sue universities and all that kind of stuff. This fear based, legally based kind of way of operating needs to go away, the suing people thing is weird and needs to go away. I don't know how we make that go away.

Lida Vala, LMFT

Lida Vala obtained her bachelor's degree in electrical engineering from California Polytechnic State University San Luis Obispo in 2001. During her undergrad career, she started to explore then question her gender identity which led her to recognize her career identity did not align with being an engineer but being a therapist. In consultation with a psychology professor, Lida decided to take additional psychology courses without changing majors to help prepare her for graduate school. Upon graduating, Lida provided direct care to "severely emotionally disturbed children" social services in a residential setting from 2002 to 2012 as a residential counselor. In that time, she obtained her master's degree in 2010. As an early career professional, she started to work more with TGNB clients. In 2015, she received her full license as a marriage and family therapist. Since 2015, Lida has been active in conferences, consultation groups, and larger organizations (e.g., WPATH, TPATH, UCSF). Because of her active participation in these organizations and being recognized as an expert, she earned a role as a workgroup member on the SOCs Version 8. In addition to these roles, she maintains a private practice and serves as a county consultant to help train and educate others on TGNB inclusive practices.

Lida was the second participant I interviewed who did not "meet" the traditional meaning of "expert." I remember Lida reaching out to me and wanting to hold a meeting before the scheduling the first interview to be sure she qualified as a participant. In that meeting, it became apparent how much of an impact Lida has had in the mental health field. She is only author on her chapter of the SOCs Version 8 to be a full-time practicing clinician who does not hold an MD nor PhD. In addition, Lida sees her role more outside of academia and wants to directly

influence clients and other clinicians through consultation and advocacy. She is active within the film industry, writing screenplays that accurately represent trans lives.

“Really just by being trans”

At the beginning of the first interview, I asked Lida what led to her interest in TGNB mental health. She reflected her own identity as a trans woman and how seeing other TGNB colleagues helped her craft an idea of what healing looks like for the community. She shared healing goes beyond the transition process because of how some people still experience depression after surgery.

Really, just being trans. It was that, and as I saw more trans and non-binary folks, in conjunction with consultation groups and communicating a lot more with trans and non-binary providers, colleagues of ours, I started to craft this idea in my head of what healing really looks like for our community. When I say that, I mean the healing beyond transition, you know...like the things that feel like they need an end point...You see those articles about still depressed after surgery, or I'm still this and that, and I just wonder a lot about it.

She shared how trauma informed care and narrative therapy have been helpful for her to articulate how healing needs to include cleaning out the internalized gender toxicity that often remains for TGNB people.

Trauma informed care is an approach, it's not like trauma focused CBT, it's really to recognize that the experience of not being witness not being seen, and in my case, think of trans people not being accurately witnessed constitutes a lot of built up gender toxicity, when you think about the oldest stuff it's the stuff that hardens...If you have toxins that are like 20, 30, 40 years old those are going to be hardened and ingrained...And I've liked narrative therapy, I don't feel like I've really learned enough about it in grad school to get the whole practice, but I apply some aspects of it...What the work entails is meeting with my clients, first finding out where they are in their process, helping them uncover the past, then inviting them to revisit the past. And we review their narrative.

“A spiritual kinship”

When prompted to share what has contributed to her growth as a clinician, Lida reflected her own personal therapy, which began when she was in graduate school. She then reflected on supervisors who invited her to find her own way having led to a lot of growth.

I would say it's number one, my own personal therapy, which I started when I was in grad school... [T]he second thing was supervisors who allowed me to find my way.

With regards to supervisors, she shared a story of a particular supervisor with whom she shared a spiritual kinship and how that relationship had a profound impact on her.

I mentioned kind of like just a spiritual kinship I have with her were like I just looked into her eyes, we did this exercise in group and she had us partner up and I came late, and I was partnering with her. We did this thing where we hold hands and then look at each other. There's just something about the look in her eyes, just so familiar, felt like family. It just brought out a lot for me.

The final contributor to her growth would be TGNB colleagues. Lida noted she feels like having TGNB colleagues has opened her eyes up to things she was not aware of before. For example, at first being an apologist for cis people and then recognizing how things that did not irritate her before became irritating.

[T]hirdly, I think just my trans and non-binary colleagues. I feel like a lot of them opened my eyes to a lot of stuff I didn't see before. I don't want to say apologist like it's a bad thing. Like I was the apologist, “No, cis people can do therapy for trans people too, or just as well, and that shouldn't matter.” But I started to realize and recognize certain things that irritated me that didn't irritate me before.

Lida further shared how she has learned much from her non-binary colleagues and clients about how marginalized non-binary people are because of the trappings of the binary.

I would go further; I think I'm a better clinician because of non-binary folks. I feel like non-binary folks and hearing their stories, whether colleagues or clients, started mostly with colleagues, it really helped open my eyes to a lot of the trappings of the binary being a binary trans person. It started getting me to realize how much further marginalized non-binary folks are.

Lastly, Lida reflected how she has needed to expand her work to be inclusive of neurodivergent clients. For example, deconstructing and questioning what communication is and how it operates.

[M]ore recently, it's been neurodivergent folks. Almost, I mean, I'd say the majority of my trans clients show some aspect of neurodivergence in terms of communication or processing or attention or memory...Like one client, who originally started off with talking about, "Well, you know, this is kind of what I need in terms of questions that are too vague or not good for me." I go, "Okay, that's good to know. I will keep that in mind. And please keep in mind that sometimes I will ask a vague question, not to challenge you, not to grade or evaluate you, but because it's really important that you allow yourself to be okay with whatever comes up in that moment."

"I feel the personal and professional"

Following contributions to her growth, I inquired about Lida's biggest influences in her professional journey. She started by noting that she feels the professional journey is a combination of "the personal and professional." Because she is active in the film industry, she has had the opportunity to work with trans directors, producers, and actors. One actress in particular who has pushed and challenged Lida is Harmony Santana. Lida shared how she was able to talk with Harmony and noticed how much less gender toxicity Harmony had compared to Lida.

[T]his director knew I wanted to connect with Harmony on a personal level as well and did this shoot in a way where the Harmony could have some time with me. So, she came over and spent the night and there was some stuff that she challenged me on...[A]t the time I was 38 and she was 26 or 27, so it was kind of like, okay these younger trans folks, maybe they have less of that toxicity that I have going back to that whole residue build up, like I just probably have a lot more built up, just based on the times that I grew up in.

The other influence Lida discusses was joining the Gender Diversity Consultation group. She has been an active member in that group and was recently asked to join leadership. In this group, she has been able to engage with other clinicians who provide her with other points of view.

I think I mentioned Santa Cruz, Gender Diversity Consultation group...It's been four years coming on to five years and earlier this year, during the summer, I got asked to join

leadership, so now I'm part of leadership...I think I give these other points of view and I get other points of view from them.

“What kind of transcestor do I want to be?”

When invited to describe what motivates her work during the first interview, Lida shared she spends a considerable amount of time thinking about what kind of transcestor she wants to be. She has connected with elders in the community to involve them, hear their stories, and to provide support.

More recently, it's been thinking about my transcestors and asking myself, “What kind of transcestor do I want to be?” To what degree am I gonna play a role and influence future generations? So I think that's the big thing these days, I'm really reaching out more to elders and trying to involve them and hear their stories and help them.

She shared she is working with a Black trans woman, who is her trans mom, and they are working together to create a scholarship to help Black trans women to attend university. The aim of the scholarship is to provide the recipient with enough money that they do not have to worry about surviving so they are able to focus on their education and to have a group of mentors they can lean on for support.

She's a Black trans woman and I love hearing her stories and trying to help her with her projects. One of the things we want to do is create a scholarship for Black trans women to be able to go to graduate school, and the concept is, all the money that person needs, it'll probably be a public university is my guess, because the other aspect of funding is paying for a cohort of mentors, essentially others particularly if they're Black trans women, but it can be Black trans men or non-binary folks who are therapist, it can be Black trans folks who are professional in the field of trans health...But having a group of folks as a cohort that the awardee of the scholarships can lean on during tough times through graduate school.

I followed up with Lida about how she would know she accomplished her goal of being a good transcestor. She shared although she would not have evidence for it, it would be her trans daughters continuing to pass on the lessons and messages they were able to embody during their time with her. She reflected she does not need a book nor does she need one of her screenplays to

be a blockbuster movie unless it allows for more people to be able to see a more nuanced trans storyline.

That's a question I actually have an answer for directly. I won't have evidence for it. But it's after I'm gone, that my daughters continuing to pass on some of the lessons and messages that they were able to embody during their time with me. So, if that happens, that's all. I don't need a book, I don't need to have my screenplay turned into a blockbuster movie, it'd be great. You know, if it meant more people got to see it, and more people got to see a nuanced aspect of the trans experience.

“I've helped other providers learn”

The first interview ended with Lida reflecting on her contributions to the field. She began by sharing she feels she has been able to help other providers learn. Through her involvement in consultation groups as a member and a leader she has been able to educate other providers.

Beyond education, she shared her existence as a trans woman therapist is a contribution to the field.

I feel like I've helped other providers learn, so they could do better with their clients, which kind of suck in a way sometimes because it's like, “Well, they get paid and I'm giving them free help...” If I feel like I'm teaching in these consultation groups, then I'm leading the consultation group... I've lead consultation groups that felt unhelpful, I'm primarily giving. I think I'm also helping just by existing, I come up with these different concepts that I share.

“Very much a token”

The second interview started with gathering Lida's experience in the field. She shared how clinically she has worked with a vast amount of TGNB clients and clients who are starting to unravel their own assumptions of gender. These clients have either sought Lida out for providing letters for gender affirming treatment or for mental health issues.

My experience has really gone towards the balance of people seeking me out for letters, people seeking me out for mental health issues, and kind of as they package themselves, they package themselves as this is what it is, this is what it is... And recently, I think I'm had an influx of clients who on the outside they appear to be straight men and they affirming an identity now asserting it. One of the four has socially transitioned and just

started medical intervention. The other ones are accessing the risks and damages in terms of relationships in their life.

Because of Lida's identity as a trans woman in the mental health field, I invited her to share with me the experiences she has encountered. She reflected having to set boundaries with others and to not engage in free labor related to tokenization.

I think also as a trans woman, very much seen as a token. At times, you know, the trans person do this for free, do that for free, it took me a while to go, "No, we need to get compensated." Where at first, I was doing it to get my name out and then go, "No, I actually do."

Lida shared she also receives unwanted "compliments" from cisgender colleagues about her appearance and how she did not even "look" transgender. When these moments happen, Lida is reminded of her clients that will not be perceived as cisgender.

I get a lot of "Wow, you look good, you look beautiful." Like when I used to dress up or like a lot of times I go to conferences and stuff like that. And I'm just like, "I'm not doing this for you." I feel uncomfortable. Why are you commenting on my looks? And then every time he goes, "Oh, I didn't know you were trans." Like, that's not a compliment. All that does is remind me of all the people who come into my office who will never be perceived as cis. Like that is so fucked up.

"Helped me love myself more"

During the second interview, I prompted Lida to share the sources of support that have helped her continue to do the clinical work. She immediately listed personal sources of support that have helped her love herself to be the best version of herself. These include her daughters and godparents, Jane and Ernie. For Lida, Jane and Ernie feel more like parental figures than her own biological parents.

Right away I think of sources of support that are more personal that helped me love myself more and to be the best version of myself. I keep saying my daughters, of course, but I want to go back to earlier, you know my godparents. They were two elderly White cis husband and wife, Ernie and Jane...I eventually asked them, "Can I adopt you as my godparents?" Yeah, we had some really lovely times together and Ernie passed away four years ago, and this month actually, so they were really big, strong pieces of support for me, and just the relationship, you know, what I probably didn't get with my own

parents. And to this day, they feel more like my own parents emotionally. Where I can, I don't feel like I have to censor anything, I can just be myself in any way.

In addition to these important people, Lida identified community as a source of support. This community includes capoeira and basketball. She reflected the people in these communities treated her with respect, love, and compassion.

Community in different ways. So there's a good chunk of four years of my life where I used to do a Brazilian martial arts called capoeira and the way the school was run the [instructor] felt like an uncle figure. I look back and I stuck out like a sore thumb. And you know, so masculine, I hadn't had any surgeries, maybe just some hormones, yet still people treated me with respect...I found out because the [instructor] treated me with respect and love and compassion, it's like everyone else, everyone else followed along...But I went back to my old love of playing basketball, pickup basketball, and I was scared for so many years, "Oh my god, they're going to tell I'm trans," or "They're going to be mostly guys and hypermasculine, mostly Black guys and if I play well, they know I'm playing like a guy, like, what do they expect cuz I play kind of better, more athletic and limber." You know all these things in my head. But I still went and with time, I went repetitively, people were accepting and knew about my transness or some didn't...The more I went to basketball the more empowered I felt.

“We fail in mental health”

After exploring sources of support, Lida shared the barrier she encounters in her work. She reflected people who are wanting to work on gender related things often cannot afford it. To help reduce that barrier she works on a sliding fee scale rather than taking insurance.

I think most people who want to work gender stuff can't afford it. I don't take insurance. I'm not on any panels, I'd rather slide my fee.

Other barriers she encounters relate to society. These barriers include the lack of legislation that protect TGNB people and TGNB people lacking social support. In addition, trauma, including gender-based trauma, is often a barrier because it can go unrecognized.

Not enough laws protecting trans people. I mean, it's all societal stuff...They don't have the social support in their environment...I see the barriers being a lot of things, trauma, unresolved trauma, that maybe gender-based trauma might be other types of trauma that's just unrecognized.

Beyond inability to access services and societal barriers, Lida shared that she feels we fail in mental health. She discussed how Gender Dysphoria is not a diagnosis, it's an experience. Moreover, she elaborated people often are not trained to differentiate lower case "gd" with uppercase "GD." She reflected how the checklist for the diagnosis is more of a checklist for transness (ultra-binary stereotyped version) rather than dysphoria.

I think we fail in mental health. Gender Dysphoria is not a diagnosis. To me, it's an experience. And I think that people don't distinguish enough between lowercase GD and capital GD. I don't even touch capital GD. I don't care. I go through that list; it almost looks more like a checklist of being trans than about being dysphoric. And so, to me, I think that's a big hurdle.

Lastly, Lida recounted how poorly trained clinicians are to work effectively with TGNB people and make money providing "shit" services to the community. She noted the California Association of Marriage and Family Therapists wants to update their ethics and Lida would like to add how more specific training, beyond 101s, before they work with TGNB people.

I think our ethics board or ethics organization, California Association of Marriage Family Therapist wants to update their ethics. Like, can we put something in there? Like you need training to work with trans and non-binary people, like specific training. There's specific training out there, but people go for the little 101, this and that you know... You need to go get training and you're making money off our backs. Like it's bullshit.

"It's performative"

The second interview concluded with Lida sharing her thoughts on the current state of TGNB inclusive practices in the mental health field. She discussed how people join TGNB specific consultation groups and bring unrelated cases for feedback and assistance, or people will attempt to seek information for colleagues who are not part of the group. She continued by reflecting how people do the bare minimum with no intention of following through.

I see people like join the consultation groups, and we have these listservs to post stuff. And people are like, "Oh this is a non-gender case." No, no, no, this space is specifically for this, you don't get to use this as an opportunity that you joined and have access to all

these people to then post things like that...That feels like exploitation...Also a lot of people go, "I'm asking for a colleague." No. That colleague needs to join this consultation group and ask for themselves. Don't interpret their stuff. And what you're going to get an answer from us and pass it on to your colleague? That client is fucked...They just do the bare minimum, you know, it's just like, at this point, you know, they put the Black Lives Matter thing in their window. And that's it, you know. People don't actually follow through it's performative, so performative.

When asked what needs to happen to see follow through, Lida shared people need to be willing to take risks and not worry about the cost. In addition, cisgender people need to act with humility and sit with their own gender work.

It costs. It costs in so many ways, financially, time...They [cisgender people] need to shut up, they need to stand back. They need to be humble. They need a lot more self-exploration around their own gender, they need to examine their gender journey.

“I see a lot more trans and non-binary folks getting involved”

At the beginning of the final interview, I prompted Lida to share her thoughts on how she sees the field growing in terms of TGNB inclusive practices. She reflected she sees a lot more TGNB people getting involved and want to play a role in shaping things. She shared she feels that desire comes from people pushing for experiences they did not have.

Well, I see a lot more trans and non-binary folks getting involved. Even like folks who've, beyond like college years, are returning to school, who want to play a role, you know, have a hand in shaping things. I feel like a lot of it does come from what people wish they had or wanted.

Although there has been some progress made, Lida shared until TGNB people have a voice in their care, advancement will likely halt. She shared she senses fear among some cisgender providers that impacts how they conceptualize and engage in TGNB care. She ended with noting the veil of allyship will have to be lifted for things to shift.

It's my assumption, I don't know...They [cisgender providers] experience a lot of trans clients or patients who get obstructed systemically by things and so they're afraid that's going to continue. I think they come from a position of fear and weakness...They're playing the game, the "Let's not disrupt too much..." I feel that there's gonna have to be

a separation of who are truly allies, and what allyship really means in the professional realm.

“People voting for the trans and non-binary professionals”

When prompted to reflect on what she is seeing that invites continued growth in the field, Lida expressed how she has seen a lot more visibility of TGNB people in leadership roles and in media, specifically meaningful films.

I see it with elections, a lot of people are voting for the trans and non-binary professionals. I am seeing increase in media, and I want to be specific more to films: short films or feature length...But yeah, actual meaningful films that challenge stereotypes about trans people...[E]nd of the day, all professionals are people too, so they consume a lot of that stuff.

Meaningful media representation is important because people can begin to lessen the grip on limiting narratives of TGNB people’s lives. For example, a prevailing discourse involves TGNB people being born in the wrong body creates a constrain for the community to access care.

So many people consume the “born in the wrong body” narrative for so long. But no one understands that it was based on, like, if that wasn’t what you reported, you weren’t going to get care.

Lida shared in order for the field to continue to grow the TGNB community needs to have greater access to higher education. She reflected the field lacks diversity and desperately needs it.

I think right now, definitely having diversity because I do see more and more people gaining access and getting into it. I just feel like it’s not diverse enough.

“More trans and non-binary stuff infused”

As the final interview shifted to recommendations for the field, Lida noted TGNB students need to have access to each other. In addition, she reflected there needs to be greater incorporation of TGNB people in the classroom (e.g., case vignettes) beyond diagnosis.

Access to one another, you know, kind of having cohorts in community...Okay, let’s take, you know, like the vignettes are always about a cis person. The trans vignettes only come up, it actually never came up for me, but if they’re gonna come up, I guarantee you anything it’s just about Gender Dysphoria.

Similar to the needs of TGNB students, Lida discussed how cisgender students need to have TGNB topics immersed across the curricula and learn from TGNB instructors.

Trans and non-binary instructors, for sure. I think that more TGNB stuff needs to be infused into their curriculum, you know.

Lida cautioned the addition of TGNB topics into coursework needs to be focused on quality not only quantity.

I don't think there anything else more. I think it's the quality of it. It's not just the presence and absence, it's the quality.

“They need to be devoted”

Shifting the focus to faculty and administrators, Lida stated they need to be devoted and demonstrate that devotion. She continued to stress the importance of faculty integrating gender diversity across the curriculum and administration needs to construct and clearly state TGNB inclusive policies.

They need to be devoted, they need to demonstrate that, you know. It's the quality of the instruction from the program, it's going to be infused with gender diversity being part of it, not its own class, its own workshop, you know. It's something they need to state.

She shared she does not feel like academics truly care about the community. They are only focused on doing things that they will profit from. She shared she will read literature to find the holes and problematic assumptions.

I feel like most studies about trans people these days, I don't even care what the conclusion is, I like to go through it. I'm like where are all the false assumptions, I want to find them all because I want to pick them apart...But sadly a lot of people just want to get something out and have something attached to their name.

“Power and influence”

The final interview ended with Lida reflecting on what she thinks needs to shift socially and politically to be more TGNB inclusive. She noted TGNB people need to be in positions of power to influence change.

We just need more trans and non-binary people in positions of power and influence. So, when I think of socially and politically, there is a part of it and I think we've kind of gotten to that point, now it's about actual influence.

However, Lida stressed motivations for TGNB leadership and political involvement must move beyond presence and absence to how people are using their influence. She shared a story of a White trans woman will critique a cisgender queer Latinx colleague because that colleague centers BIPOC people first.

Again, their presence or absence is just like the minimum, it's what they do once they're there, the way that they wave their trans wand and prioritize certain things. I know a colleague of mine, in our county system, who while this person, she's a cis queer Latinx person, she gets constant criticism from someone in the community who is a White trans woman. Who gets upset with this other colleague of mine because she's always putting BIPOC first. And this White trans woman is like, "Bah, bah, bah, this isn't that." And doesn't get the notion that when you raise people of color, everyone else who's already above is gonna go up.

Lida ended her discussion by sharing she feels like she has moved towards trans centrism regarding leadership, education, and clinical practice. She has noticed since making that movement she has distanced herself from cisgender colleagues. She concluded by saying she's done trying to please cisgender people.

I've noticed too the more I've developed this trans centrism around leadership, around education, around even clinical practice, some of my cis colleagues I've just naturally distanced from. Even when I emailed them out and am like, "Hey, let's get together. Reconnect." This and that. And they respond, "Okay, we will." I never hear from them...I'm done trying to please cis people.

Dr. Susanna Moore

Dr. Susanna Moore has been in the clinical psychology field for 27 years. She obtained her doctorate from the Wright Institute. Her dissertation focused on gender nonconforming children under the mentorship of Dr. Diane Ehrensaft. Post-graduation, Dr. Moore has been primarily engaged in clinical practice working specifically with children. For eight years she worked in a clinical agency that served children in foster care. She then worked a year in El Salvador. When she returned to the US, she worked with an agency providing services to lower income families, which she had done for about 17 years. Currently, she works in private practice serving transgender youth and their families. She is an active member of the consultation group, Mind the Gap. Mind the Gap promotes the healthy development of gender expansive, gender creative, and transgender children and their families by providing affirming mental health services. In addition, she engages in WPATH and or conferences specific to the TGNB population.

Although I was familiar with Dr. Ehrensaft's work, having cited her in my master's thesis, I did not know Dr. Moore prior to the interview. One of the potential participants I had contacted forwarded my announcement out to other clinicians who held expertise in TGNB mental health. I received an email from Dr. Moore expressing interest in the project and outlined how she felt she met the criteria. Because of her research, clinical practice, and professional involvement, I felt confident she could adequately speak to the topic.

“I had never, I thought, met any transgender people”

The first interview began with Dr. Moore sharing how she became interested in TGNB mental health. Prior to determining her dissertation topic, she had spoken to an attorney for the National Center for Lesbian Rights (NCLR) in San Francisco. During their conversations, the

attorney shared how a lot of queer youth were being sent to psychiatric institutions against their will and received a diagnosis of Gender Identity Disorder. Dr. Moore reflected at the time she was unaware of the diagnosis and reviewed it. She realized as she was reading the criteria that had her parents been different, they could have hospitalized her because she fit the description. This experience was the impetus of her dissertation which sought to critique the diagnosis.

Right around the time I was at West Coast is when I was figuring out my dissertation topic, and I had been a donor of an organization, which was then called the Lesbian Rights Project, which is now the National Center for Lesbian Rights (NCLR) in San Francisco, and I was talking to one of their attorneys. She was saying that she was someone who talked to youth a lot...She was saying how there were queer kids who are begin sent to these like tough love schools not schools, it was like psychiatric institutions against their will and the diagnosis was something called Gender Identity Disorder...So anyway I went to the diagnosis and I read it and was like, "Holy shit, this is a description of me when I was a little girl. And if my parents were different, they could have dragged off to the doctor...So that became the crux of my dissertation, which was a qualitative study critiquing Gender Identity Disorder.

During the time of writing her dissertation, Dr. Moore shared she thought she had never met a TGNB person before, including children. For her it felt all theoretical because she was relying on books and journal articles. However, her education felt incomplete, so she reached out to different media outside of traditional academia.

How to say this succinctly, at the time I wrote my dissertation, I had never met, I thought, any transgender people, including kids. So, it was all theoretical, it was all books, articles. And then after a while, I was like, "This is really incomplete." So, I read memoirs and poetry and novels and movies.

“Crisis of provider”

Dr. Moore described her dissertation as a crisis where she had to wrestle with and unlearn what she thought it meant to be TGNB. For example, her understanding of being a transsexual person was only associated with surgery and not about the person. Being able to hear and witness people’s stories helped her navigate her crisis.

When I say reading people like Leslie Feinberg or knowing people like Shannon Minter, basically it was hearing people's stories, right? Because instead of being a transsexual, and all I could think about was surgery. Like literally that's all my association was, that's not a person, you know. There's no person. So, gradually the poems, the memoirs, the novels, the films, the work of the social worker, Gary Malin, you know those were stories, those were people...I'd call it a crisis of provider because I was up against my own pathologizing view of a group of people.

Having worked through the crisis of provider, Dr. Moore has been able to be more compassionate towards those who are clouded by pathology and how they see TGNB people. She notes this has been helpful in working with parents of TGNB youth.

I don't know if I would call it an identity crisis, it was more like a crisis of provider. Because I was up against my own pathologizing view of a group of people. And then when I saw my way through to the other side, it gave me a lot of compassion, for the people who also have a lot of pathologizing clouding their view of their kid, but also what it's like to be seen through a cloud of pathology every time you walk down the street.

“Holy shit, I'm here to learn”

When describing turning points in her professional development, Dr. Moore shared she attends the Gender Spectrum conference and each year it slowly penetrates her “cisgender brain.” She recounted a story of her attending the National Health Summit of Transgender Excellence. She reflected she had avoided the conference because it was focused on adults and offered nothing related to working with TGNB youth. However, six years ago she decided to attend the conference and she described being blown away.

I'm lucky enough that Gender Spectrum was born in the bay area, so I've been going to their conferences once a year for 11 years or something like that. And the multitude of workshops and conferences, I think just gradually penetrated my cisgender brain and introduced me to a ton of transgender people...I didn't go until about six years ago, because it was all adults, had nothing to do with children. But when I walked into that ballroom, 1000 people 80% of them trans, of those 80% probably 75% people of color, that just blew my socks off. And I was like, “Holy shit! Okay, I'm here to learn. Let me shut up, open up my ears and just learn what I can learn.” And then it was just, I don't know, I think that just got rid of the last of that pathologizing wisps that were my brain. I just thought this is a group of so much power. There was so much pride in the room. I could barely take it all in. It was so much positivity. It was just like, amazing.

Dr. Moore described another conference as a turning point while attending the first US WPATH conference. At this conference, she attended a session presented by transgender women of color. She reflected the presenters were placed in a small room off in the distance. Dr. Moore shared how much she learned in that presentation and how it motivated her to keep the “fight” of her work alive.

Oh, it was the first WPATH USA conference. Oh boy. Oh my god. So, there’s like one session, that’s like being a person of color, you know, in the trans world today. I don’t remember what the title was. And it was like for me, it was like the ghettoization of active. They had this small little room, it felt like you had to go down three stairs, you know, three different hallways to get there. And it was sort of smaller than the other one. I don’t know maybe that wasn’t true, but it felt that way. And they were the only trans women of color at this conference and their stories were so powerful, and they were just so courageous was just like, “Dang, I hope and wish that if I were in their shoes that I would have been as brave.” But I don’t know if I would have, you know, like people who have just been through it been hurt physically, every other which way spiritually, socially, housing discrimination, health discrimination, every kind of discrimination you can imagine...I was just like, “Okay, gloves are off. Fuck it. Like, if they can be like this, then I can be my version and I’m going to keep the fight part of what my work is.”

“Zeroing in on that and highlighting it”

As the first interview was drawing to an end, the conversation drifted to contributions to the field. At this point, I had interviewed enough people to know that contributions only included academic accomplishment and accolades, so I was quick to position that in my question. Dr. Moore reflected she considers her dissertation a contribution and recounted a story of being approached by a doctoral candidate about her work.

Well, I mean, who knows how many, probably very few people have read the dissertation. I had this really fun, crazy experience where I gave a little talk at a conference and this woman came up to me and said, “Are you THE Susanna Moore?” And I was like, “I don’t know. Am I?” And she was like, “I was writing my dissertation and I read your dissertation and I kept it on my desk. And so, I could see it” and dada dada. And I was just like, “Oh my god.” Anyway, one person read it. That’s one of my contributions to the field.

Another contribution to the field has been the role of a clinical supervisor. Dr. Moore shared she often finds joy in helping supervisees learn to honor their strengths and to further develop.

I think one of my themes in my supervision has been to sense the way in which the clinician is devaluing their work or their particular strength as a therapist and really zeroing in on that and highlighting it and explaining, "From my, you know, all these years of experience, I'll tell you, you are good at that." And they tend to believe me. So, I would say that, you know, that's been a contribution to other clinicians for them not to devalue their strengths, but to be aware of their strengths and hopefully grow it more.

"Self-love, self-actualization, and liberation"

The first interview concluded with Dr. Moore discussing what motivates her work. She shared her own struggles with depression and the self-hatred that accompanies it. Because of this experience, it has been her life-long project to help other people and herself become more compassionate towards themselves.

What motivates my work? I know that I have struggled with depression off and on through my life and in the worst moments of depressive episodes, self-hatred has been very much a symptom of the condition. So, I think that my life-long project has been to help other people and myself become more loving with themselves and move towards liberation...I would say self-love, self-actualization, and liberation.

I became curious to know how self-love, self-actualization, and liberation have shifted across Dr. Moore's career. She reflected it has become more refined and if I were to ask her five years ago, she would not have called it self-love. Projecting into the future, Dr. Moore shared she expects some backlash from anti-TGNB groups, but the basics of self-love, self-actualization, and liberation are unlikely to change.

I don't think I would have said self-love. If you'd interviewed me five years ago, I doubt I would have said self-love. I think it's become more refined, the more work I've done... Well, I think we're going to be encountering backlash. You know, there are the ROGD people, the TERF people. I think that those voices in our culture will still be around, I hope they're not as strong, but they might be stronger...I don't think it's gonna really change, you know? The basics of self-love and liberation and you know self-actualization, manifesting one's self-love in the world is kind of how I think of self-actualization. I don't think that's going to change.

“Understand more all of the mountain underneath the iceberg”

The second interview began by asking Dr. Moore if there was anything she would like to add about her professional development. She noted she had not shared how Sand Chang has impacted her understanding. She discussed how being in consultation and attending presentations by Sand provided a history for her that she was not fully aware of. This history was related to the historical treatment of the TGNB community by the mental health community.

But thinking about the kinds of reading that Sand had given us. The way that it helped me develop as a clinician was seeing the arc of how transgender people, whatever the term was at the time, had been treated by the mental health community. And even though my dissertation was on the diagnosis, it was sort of tip of the iceberg, right? [T]o work with Sand, I started to understand more all of the mountain underneath that tip of the iceberg. For instance, the dilemma that trans people ran into where if they were too stable, then they clearly didn't have enough dysphoria to warrant us, the gatekeepers of medical interventions and the grand gender said it all to be you know shifted. But if they were too upset or disturbed then they were too unstable and clearly wouldn't be able to make use and maybe they were crazy and maybe the gender was a feature of their psychosis or their personality disorder, or whatever. And when I contemplated that dilemma, I was like, "Holy shit, this is the crystallization of prejudice against this particular group of people within the mental health field."

“So much is ideological”

After collecting additional narratives related to professional development, the conversation naturally drifted to barriers Dr. Moore encounters in her work. She shared in her clinical work parents can be a barrier. For example, they are part of the culture and can read things that are more hostile towards the TGNB community. She was quick to note it is less common for the families she works with for the parents to hold those hostile assumptions; however, it is a common experience for colleagues.

Well, you know, parents are part of the culture and they look at stuff and they say what about this? I don't have it as much. I don't know if parents don't bring it up to me, or for whatever reason the parents I work with don't tend to read stuff that's hostile towards trans kids. I don't know why because I often hear colleagues like, "Parents keep talking to me about x article or y article..." I do have kind of a self-select group on my caseload

in the sense that they usually either come through the gender center, or the parent has opened themselves up to their kids experience enough.

She further discussed how she notices certain ideologies arise with the kids she has worked with.

Ideologies that are often associated with anti-TGNB rhetoric.

Well, here's what I see in the kids that I work with because there's this, you know, so much is ideological. It's like lesbians have worked hard for women only spaces and therefore, a trans woman is intrusive. Therefore, trans people shouldn't fight for their rights or that ball of wax.

In addition to ideological barriers, Dr. Moore reflected how parents will often jump to action out of their own anxiety related to their child disclosing their gender identity. Because of parents' reactions, she has found she has had to navigate how to assuage parents' anxieties in trying to be a good trans parent and not push families further than they are ready to go.

I guess I'm thinking also of parents who might be jumping ahead out of their anxiety like, "Okay, I have a trans kid, here's what I have to do, I have to do this, I have to do this, I have to do this." You know just let your kid be like, they are three, you know, they don't need to do anything, just keep listening and mirroring and do your own homework. But I've had some parents be narrowing their kid's world from trying to be the good trans supportive parent...I guess what I'm saying is that I hope I don't fall into ideology in either way. In an affirmative model where you don't look like you have to keep in mind tradeoffs, dangers, you know, what a parent is really capable of, you have to weight a lot of things, your therapeutic alliance because they'll leave treatment if you push to far, and is that serving the kid?

Another barrier Dr. Moore identified the switch to private practice has created a barrier in the types of families she is able to serve. For example, she has not been able to work as closely with more socioeconomically diverse youth.

Well, I hate our health insurance. I would love to work with a more socioeconomically diverse group of youth, and I do as much as I can in terms of like when a Spanish speaking working class family contacts me, I try to make room even if I don't have the room...So for me, I would say that's another barrier is that private practice in this day and age doesn't really lend itself to serving poorer people or people with fewer resources.

“I don’t feel isolated”

Shifting the conversation towards sources of supports, Dr. Moore discussed how she does not feel professionally isolated. Being connected to Mind the Gap has helped her stay in conversation and proximity to other professionals.

I don’t feel professionally isolated. I think if I lived in a different partn of the country, I probably would. But I wouldn’t say that’s a barrier here in the Bay. I have lots of colleagues through Mind the Gap.

Another source of support is her cisgender identity. Dr. Moore reflected how her being cisgender grants her more credibility with parents, and is aware if she were transgender, she would not gain that same level of trust.

I think the fact I am cisgender is really interesting, because in some ways, I have more credibility with parents, which is kind of creepy. You know what I mean? Like, it’s kind of like, “Oh you wouldn’t trust me if I were trans because then I’d have an agenda...I don’t like that that exists, but I also want to make use of it in terms of any way that I can gain ground with parents.

I became interested to know how else her cisgender identity shapes her experience, so I opened space for her to reflect on potential criticism for being a cisgender person working with TGNB youth. Dr. Moore discussed how she has not experienced any criticism. As she continued to ponder the question, she shared how Mind the Gap is mostly cisgender White providers and how maybe there is not an opportunity to receive any criticism within that group.

It’s an interesting question...I haven’t really encountered that too much...Because Diane is a leader anybody who does want to have a cis woman as the leader of the group, your part of caring for trans people wouldn’t come back to the group too often, so I think that’s also self-select. In other words, I might not be around the folks who would say, “How are you qualified for this?” Maybe I should find that I probably learn a whole lot more if I were in groups where people were challenging me around my cis privilege.

“I don’t feel comfortable generalizing about the field”

The second interview ended with a conversation about Dr. Moore’s thoughts about the current state of TGNB inclusive therapy. She began with hesitation, not feeling comfortable

generalizing about the field. However, she did discuss how in the US the field feels very medicalized focusing on medical interventions and Big Pharma.

I don't know that I really have a vision of the field. I don't really feel comfortable generalizing about the field. Like I don't know what's happening in other countries. In terms of the US, it feels like there is a medicalization of the field. It's so confusing to me because allowing people to get medical interventions that they want and advocating for insurance companies to consider that a medical necessity are hard won fights. At the same time, there's a lot to be desired in the medical way of looking at things whether you're talking about Big Pharma or on a more philosophical level the split of the mind and body.

Although Dr. Moore expressed discomfort generalizing about the field, I was curious where she would like to see the field go. Her immediate response was to see Sand Chang as the head of WPATH.

Sand Chang would be head of WPATH.

“Who are the gatekeepers”

The final interview started with Dr. Moore reflecting on how she sees the field growing in terms of being more TGNB inclusive. One of the first changes she has witnessed is an emphasis on who are the gatekeepers and why are there gatekeepers. These gatekeepers have historically been cisgender professionals who have written the DSM and run insurance companies.

Well, I think one big change is, haven't seen this as much in the kid and teen work, but just more emphasis on, “Well, who are these gatekeepers? And why are there gatekeepers? Just addressing the some of the power dynamics, like, you know, is part of the reason why transgender people have been denied what they've been asking for in terms of medical intervention because it's been cisgender professionals who have been gatekeeping and cisgender people who write the DSM and cisgender people who run the insurance companies.

In addition to the field starting to question the gatekeeping role, there have been shifts in the tropes of TGNB lives. Dr. Moore discussed earlier on in her career it was common to hear the

trope of a TGNB person's life being lonely and tragic. It has evolved into a community that engages in activism to create systemic change.

I don't know if I'm just describing my own shift, but I feel like there's something to that. When you go back a few decades, it's sort of like, it feels like more or less the tragic, like the trope of the lonely, tragic trans person who found this amazingly compassionate doctor who actually thought they were a person and did or didn't give them access to medical intervention. That trope has changed. It's not one person, it's a community. There are organizations like Transgender Law Center. There are laws being passed at the federal level.

When asked what has led to the change in tropes, Dr. Moore exclaimed the internet. People have greater access to resources and more visibility of TGNB lives and experiences. She shared a story of a trans woman reading a little article about a transgender person in the Bay Area Reporter, the "gay rag," and her world cracked.

The internet! I remember reading this article about an assigned male at birth person who was like 45 or something and she saw a little article in the Bay Area Reporter, which is the gay rag, that's been around for decades in San Francisco. There was just like a little article mentioning the existence of a transgender person and this trans woman was saying, "My entire world cracked open." This is pre-internet...I think the internet is enormous because you can find community without risking your life.

"Are we talking about 1000 question evaluation?"

As Dr. Moore was reflecting on a high schooler's experience being singled out as the only TGNB person to provide education on what it is like to be TGNB, the conversation turned to current standards of practice and how those may need to be raised. She shared members of Mind the Gap have created an evaluation/assessment committee for that reason. The committee has been running into issues developing a succinct assessment because of all of the nuances.

And you know Mind the Gap we've had this committee, this sort of evaluation/assessment committee trying to come up with a guide or a series of questions that feel like a bare minimum or an affirming approach for your first couple meetings with a family. And that poor group has poured hours and hours and hours and hours into it, and we still aren't done because it's like an octopus that keeps growing arms and is super expansive.... It's like are we talking about an 1000 question evaluation? Which is to say I think even a

group of people who are very well versed, or maybe especially that group are having a hard time kind of melting things down into a basic approach.

“Sand’s curriculum would be a fabulous place to start”

As the conversation had spurred towards education and training, I jumped at the opportunity to ask Dr. Moore what she feels is needed with graduate training program to be more TGNB inclusive. She reflected Sand’s curriculum would be a great start. She stressed the importance of understanding the historical treatment of TGNB people at the hands of mental health providers provides important context into how power has operated in the field.

Sand’s curriculum would be a fabulous place to start, historical I mean. That’s what I was wanting to know. I want to know the big picture. I want to know about the power and history of whatever group we’re talking about and their relationship to mainstream mental health.

She recommended programs incorporate the text, “A Clinician’s Guide to Gender-Affirming Care: Working with Transgender and Gender Nonconforming Clients” and first-person accounts of trying to navigate the mental health field to access services.

Using that book as like a text and then using historical. I would go with a lot of first-person descriptions of what it was like to be a trans person trying to access care. When you talk about that, you can kind of talk about all the misperceptions that were manifested in those experiences and you can talk about, “Okay, so what do we do know? That’s an affirming and enlightened and supportive approach”

“More trans people in politics”

At our time drew to a close, the conversation shifted to what would need to change socially and politically. Dr. Moore reported there needs to be legislation protecting TGNB people, more TGNB people in politics, and socially she was not aware of what would need to shift but jokingly suggested there would need to be a RuPaul on every block.

What would have to change politically is there’d have to be laws on the books protecting trans people from any kind of discrimination whether it’s in health care or housing or worker rights. And there’d have to be more trans people in politics to help advocate and

sort of be vigilant about rollback or pushbacks...And then socially? Oh, Lord, I really don't know socially. A RuPaul in every neighborhood?

She concluded her thoughts by reflecting on liberal people and how they have trouble with using “they” grammatically, and how that’s rooted in a lack of empathy.

There’s something too about liberal people thinking that they’re, that it’s so important that they have trouble with the grammar of working out how to say “they.” There’s something I want to say to those people, and I haven’t figured out what to say because some of them live in my own family. But part of me wants to say like, “Wow, that sounds so hard to work out how to say “they,” I wonder what it’s like to actually be the person for whom that is their right pronoun. What do you think that would be like? Do you think that might be a little harder? Like explain to your doctor or your prospective employer? It’s just this kind of lack of empathy.

Thematic Analysis

Data analysis were conducted within three pre-established categories regarding the experiences of the experts in the field: entry into the field, experiences within the field, and future recommendations. Entry into the field related to participants being immersed in the community because of their own TGNB identity or cisgender participants forming relationships with the TGNB community. In addition, entry was further delineated by timing of entry. For example, those who entered the field much earlier were often recognized by others as leading experts and seen as trailblazers. The category of experiences within the field often related to gender identity. Cisgender participants shared how they often benefited from cisgender privilege whereas TGNB participants recounted narratives of exclusion within the field. All participants, regardless of gender identity, revealed community to be an important protective factor in them being able to continue to push the field forward. The future recommendations category reflected how participants storied change and continued growth in the field and the steps necessary for further transformation. It was evident across narratives the field has advanced and most participants wanted to see an overhaul in the field, which included clinical training programs.

The following results were organized by category and further broken down into themes and subthemes relevant to each category. The categories were constructed from the three interview topics: entry into the field, experiences in the field, and hopes and recommendations for the field. With these categories in mind, I reviewed the constructed narratives and generated codes. From these codes, I developed themes and subthemes (see Table 10). Dr. Wieling reviewed the thematic analysis to ensure the constructed themes and subthemes represented the data.

Table 10
Codes, themes, and subthemes by category

Categories	Codes	Themes	Subthemes
Entry into field	Being in relation with TGNB people ⁺ Giving back to the community ⁺ Tired of horror stories ⁺ How can I help? ⁺	How I got here ⁺ Am I a trailblazer? ⁺⁺	If not me, then who? ⁺ Outta the way cis provider ⁺ First to arrive ⁺⁺ Might be a bit late but I'm here ⁺⁺
Experiences in the field	First in the field to do the work ⁺⁺ Leading expert ⁺⁺ They opened a door ⁺⁺ Effects of transphobia [*] Navigating cisgender privilege [*] Family, community, and work support ^{**} Lack of support/mentoring in the field ^{**} Isolation ^{**} Distrust of cisgender people [*] Changes have occurred ⁺⁺⁺	Cisgenderism rears it's ugly head [*] Community is everything ^{**} Are we there yet? ⁺⁺⁺	Can I have a seat at the table now? [*] Be wary of the liberal cisgender person [*] I wouldn't be here without support ^{**} I wish there were more support ^{**}
Hopes and Recommendations	Disappointed with field ⁺⁺⁺ Gatekeeper role ⁺⁺⁺⁺ Advocate for education ⁺⁺⁺⁺ Restructure curricula/complete overhaul ⁺⁺⁺⁺ It's not happening/infancy/we are kicked into it/it's performative ⁺⁺⁺ Cisgender people need to do their work/unlearning transphobia ⁺⁺⁺ Devoted faculty and administration ⁺⁺⁺⁺ Clear policies ^{***} Lack of legal protections ^{***}	Burn it to the ground ⁺⁺⁺⁺ What do we want? Legal protections ^{***}	Decolonizing the field Moving beyond cis ally performativity

Note. Codes and themes that share superscripts indicate relationships between them.

The themes under the category of entry into the field include “How I got here” and “Am I a trailblazer?” Both of these themes included two subthemes. The category of experiences within the field also contains two themes, “Cisgenderism rears its ugly head” and “Community is everything,” each with two subthemes. The final category of recommendations consists of three themes: “Are we there yet?,” “Burn it to the ground,” and “What do we want? Legal protection.” The aim of this thematic analysis was not to engage in a full inductive process rather it was to show commonalities and divergences. A deductive interpretivist approach was used. To provide an example of how themes were consistent across the constructed narratives, I fully explored the following themes and subthemes: “How I got here,” “Cisgenderism rears its ugly head,” “Are we there yet?,” and “Burn it to the ground.” These themes and subthemes were chosen as they provide an overview of where experts feel the field is currently at with TGNB affirmative therapy practices. In addition, it positions solutions at the systemic level rather than relying on individual actions. For example, I found it more meaningful to examine how cisgenderism appears systemically instead of depicting how it impacts TGNB people’s mental health.

How I Got Here

All participants described how they entered the field and provided rationale for their interest in TGNB mental health. For example, all participants in this sample had a relationship with the TGNB community. The cisgender participants worked closely with the TGNB population as a service provider or at a youth center. Most of the TGNB participants reported wanting to disrupt and help the community heal as the impetus for their entry. One participant in particular reported it was never their intention to become an expert in TGNB mental health. Because of the varied experiences, this theme was separated into two subthemes: “If not me, then who?” and “Outta the way cis providers.”

If not me, then who?

The first subtheme outlines cisgender mental health providers entry into the field of TGNB mental health. An important factor influencing the cisgender people in this sample to be actively involved in TGNB mental health was through the relationships they had cultivated with the population. For example, one participant recounted a story of them working with an LGBT youth group. In this youth group, the participant witnessed the struggles unique to TGNB youth and their families. Through witnessing those struggles, the participant sought out further information to better support this group. Upon recognizing the lack of available information, she made it a point to fill that gap and to advocate for the community to which she was a member.

I loved that work; the kids were so advanced 20 years ago. It's a different kind of context, culturally and I thought the kids were just amazingly brave and spunky and cool. I started working with them individually as needed and a lot of the kids I worked with were trans kids. At the time, I didn't know much about it, there wasn't a lot available. It came apparent to me really quick that these kids and adults need mental health providers to get their medical treatments. So that was something that was a hole in terms of a missing spot. No one was really doing that work in my area. I decided that was something I could try to fill in terms of feeling like I'm being an advocate for my community.

Another cisgender participant reflected how it was her doctoral intern level clinical work with the TGNB population that spurred her into this area. As a master's student she was interested primarily in the LGB population and how to provide affirming services to them. However, upon witnessing the resiliency of the TGNB clients and families she worked with as a clinician, she noticed that she could not go back from that work. In fact, she shared how those experiences transformed her and her direction in an unforeseeable way.

It changed me; it changed my direction and the direction of my career in many ways. Because I felt like I was simultaneously witness to the most profound resilience I had ever seen, just like the most beautiful resilience and adaptiveness. It gives me goosebumps. I

literally feel tears in my eyes thinking about it. The community of folks at the Gender Identity Center where some of the most beautiful people I've ever met. Couples were amazingly adaptive. And I was also witness to just constant transphobia that these folks were facing, not in the organization. The organization was like this beautiful safe have, but even the building owners where we rented the space at the GIC, the community members faced transphobia. I would hear the stories of folks that all they wanted to do was just live their life. And they were facing this discrimination constantly and this oppression constantly. It just shifted my course, it impacted me to such a degree that I thought, "I cannot go back from this, I cannot."

Outta the way cis providers

The TGNB sample of participants shared different motivations for their interests in TGNB mental health. Although there were similarities between cisgender and TGNB participants in wanting to help the TGNB community, their lived experiences as a TGNB person offered them a different vantage point. One participant described their desire to shift the field to reduce the number of horror stories they were hearing of TGNB people seeking and receiving terrible mental health services.

I went back to graduate school in 2005. I was already out as a trans person at that point and was tired of hearing the horror stories that trans people would tell about the care they would get from mental health providers. I said, "Well, you know the only way I know how to change this is to be part of the solution," and that was one of the main reasons I went back to graduate school to become a psychologist.

Another participant shared they had always known they had wanted to be a therapist. Within the first year of graduate school, they experienced the discriminatory lens used to talk about the TGNB population in research and clinical work.

I knew I wanted to be a therapist...In our psychopathology class, first year of graduate school is when I learned about Gender Identity Disorder and read about it. I was like, "What? What is? Like this is awful..." I learned about the disparities and the research that was done. A lot of terrible things that were said about us, about just how misgendering was the way of talking about us, about how just because you are trans, you are crazy. This discriminatory language and lens about us was just wrong and not helpful. And there were lots of wonderful people in my life who wanted to learn more and wanted to help, but I didn't have anything to give them to read because what they were reading was terrible.

Because of this experience, this participant took it upon themselves to do the work and contribute to the field to make a difference.

I just was like, “Okay, well, I’m here. So, let’s see, you know, how can I help? I was like, “Well, I can do a big research survey and this and that.” So, I did.

TGNB participants’ pursuits to change the mental health field were often related to dismantling cisgenderism in the field and to disrupt the cis centrism within TGNB mental health.

I think Gabby and Sara’s been a big influence with his work on cisgenderism. Especially that’s been helpful for me to really, it was just that extra step in realizing, “It’s not transphobia.” Yes, transphobia is a huge issue, but it’s bigger than transphobia, right? Cisgenderism is its own thing.

Cisgenderism rears its ugly head

When participants shared their experiences in the field stories of cisgenderism arose. For example, cisgender participants reflected on how they benefited from cisgender privilege. TGNB participants recounted stories of tokenization, discrimination, and exclusion. In addition, they shared the had to often fight for TGNB inclusion within various institutions. As I immersed myself in this theme, it was evident there were important divergences warranting separate in-depth exploration. Two subthemes emerged: “Can I have a seat at the table?” and “Beware the liberal cisgender person.”

Can I have a seat at the table?

In reflecting on their experiences in the field, most of the TGNB participants shared experiences of tokenization, discrimination, and exclusion. These experiences were especially salient when being offered a “seat at the table” by cisgender colleagues. In particular, one participant noted they were included on an NIH grant project as the “token” TGNB person and was removed once the project received funding.

Kind of tokenizing in an exploitative way, sometimes by colleagues. Like wanting you on their research time or their thing because you are trans, but they’re not really giving you

the recognition sometimes, not always. I think I talked last time about being put on an NIH grant and then being taken off it.

Another participant shared how her and other TGNB colleagues who in leadership roles and part of their task is to be token TGNB person. As they have engaged in conversation, they share their disappointment with not being invited into a collaborate process among cisgender colleagues, questioning if it is a project to which they want their names attached.

There has been dialogue amongst a lot of us, trans and non-binary identified, who are working on it as well. We're talking about our experience of it and the degree of disappointment... We've talked like, "Should be keep our names on it or ask to be removed?" Especially, because for some people, the process has not been collaborative at all.

A common trope the TGNB participants shared related to only being offered opportunities because of their gender identity. One participant reflected how cisgender people will make the assumption they were only invited to present because of their TGNB identity and are shocked when people see that their curricula vitae demonstrate knowledge and expertise.

I think the last piece I will say is that sometimes, similarly to the clinical stuff that I was saying earlier, people look at you and they are like, "Oh, you're here because you are trans." So, we need to tick the trans box, right? Then they're surprised that you actually know shit or have an education. The number of times I send my cv to people and people are like, "Oh, wow." And I'm like, "What did you think I was sitting on my ass for the last 25 years?" It's exhausting.

Similar to the above participant's experience, another participant discussed they feel like their cisgender colleagues will find a way to invalidate someone because of their gender identity. Specifically, this participant noted finally starting to feel listened to only after obtaining two doctoral degrees.

I feel like it wasn't until I graduated frickin both doctoral programs, people started listening to me more, so that's been nice. It's also been annoying that it took this long because I've been saying a lot of the same things. But I feel like there's always a reason to invalidate somebody, especially if they're trans.

Beyond tokenization, participants recounted stories of discrimination among other mental health professionals. One participant discussed how she felt uncomfortable after a colleague made comments about her appearance and how he would have never guessed she was transgender.

I get a lot of “Wow, you look good! You look beautiful!” Like when I used to dress up or like a lot of times I go to conferences and stuff like that. And I’m just like, “I’m not doing this for you.” I feel uncomfortable. Why are you commenting on my looks? And then every time he goes, “Oh, I didn’t know you were trans.” Like, that’s not a compliment. All that does is remind me of all the people who come into my office who will never be perceived as cis. Like that is so fucked up.

Another participant shared a story of attending a conference earlier on in their career and being approached by a “leading expert” in the field. This person began to ask them inappropriate questions demonstrating their lack of knowledge about experience of the TGNB community.

This is like weird. You’re supposed to be an internationally renowned expert and you’re asking me something like you don’t understand. Because you don’t understand. You don’t understand...I think that was an experience you know, just kind of realizing that folks who were touted as international experts had no idea about our experiences and were very wrong.

Even within organizations focused on LGBT issues, participants noted they often had to push for the “T” to be recognized. One participant mentioned how he attempted to advocate for transgender to be listed first to no avail.

There was no mention of transgender in any divisions, any offices within APA. Eventually the committee of LGB issues became the committee of LGBT issues. Division 44 became the Society for Psychological Study of Lesbian, Gay, Bisexual, and Transgender Issues. Both of those organizations have switched their names to the Psychological Studies of Sexual Orientation and Gender Diversity. I kept pushing back saying, “Why does sexual orientation need to come first?” At some point, people said, “Let’s put women first and the men second.” Well, why don’t we put the trans people first? Why does it have to be sexual orientation and gender identity?

Furthermore, another participant reflected this even occurs in organizations focused solely on the “T.” He shared leadership in these organizations is primarily made up of cisgender people who

refuse to step aside and allow for TGNB people to take on more of the role in advancing the field.

I think that really depends on when cis people who build trans health care are willing to step aside and allow trans people to take the field and lead, like truly lead the field. We've seen some shifts in that over time, but it's a slow struggle and cis people really love to tell trans people about themselves and how things were.

Be wary of the liberal cisgender person

The cisgender experts were quick to situate how their cisgender privilege afforded them certain opportunities in TGNB mental health. One participant reflected how her privilege enabled her to create change within the MFT field and recognized how she speaks for the TGNB population.

I have a ton of privilege in the way that I am queer, and a lot of folks don't. So, I feel like I am using my privilege to create changes, that's what I want to do. I'm out here speaking for this population that I'm not a part of.

Another participant shared how she is aware of how cisgender privilege influences her clinical work. She discussed how parents of TGNB youth often position her as an expert and are more willing to be open to her. She continued by remarking that experience would be different if she were a member of the TGNB community.

I think the fact I am cisgender is really interesting, because in some ways, I have more credibility with parents, which is kind of creepy. You know what I mean? Like, it's kind of like, "Oh, you wouldn't trust me if I were trans because then I'd have an agenda...I don't like that that exists, but I also want to make use of it in terms of any way that I can gain ground with parents.

Similar to the aforementioned benefit of cisgender privilege, one participant reflected on how she receives warranted criticism being a cisgender scholar conducting research on the TGNB community.

Yeah, most certainly. And it's warranted I mean that's the thing, that's the tricky part of it is warranted. I get folks saying, "Hey, we shouldn't be studying trans folks, we should

be studying why cis folks are so screwed up.” Then I’m like, “Gosh, you know you’re not wrong. You’re not wrong.

Related to the ways in which cisgender folks may be so “screwed up” is the cautioning of liberal cisgender people and how they reinforce cisgenderism. In particular, a participant spoke on how parents are often unaware of their problematic attitudes.

The good liberal parents who are super supportive of their kid, and also don’t understand how transphobic they really are. Those are a tough nut to crack usually, and that’s another very common scenario. And actually, they’re making an effort. They want their kid to see a trans therapist and they want to provide them with the best care. And they’re really not looking at their own kind of internalized transphobia versus cisgenderism and all of that.

Such an experience occurs among cisgender mental health providers. The same participant reflected on how they started to question which colleagues are actually allies based on how they protect and make excuses when cisgender scholars perpetuate cisgenderism.

I would talk about that with some of my cis colleagues and it would always be like, “He’s not that bad. He’s a nice guy...” And that’s exhausting too because you get to see all the people who you thought and even know...and some folks I’m not surprised, but other folks I’m like, “I thought you actually were a decent human being and a friend, and you are supporting this person who’s actually like really made their career on hating queer and trans folks.

Another participant corroborated the above participants’ sentiments. They have experienced those who are cisgender presidents of international organizations be unaware of the potential harm anti-TGNB rhetoric is for the field.

Oh, and also people assume that certain people know more, right. For example, someone, who at some point was the president of WPATH...came up to me and he’s like, “Why do you think...I heard that you know, somebody was talking about there’s this one research paper on rapid onset gender dysphoria and why are people up in arms about this? Like it’s one research paper and it’s not even good.” And I’m like you are so removed and you’re the president of WPATH. We can’t afford that, that’s dangerous. That level of disconnection from community, especially at this time, is dangerous.

Lastly, one participant reflected they recognize that cisgender mental health providers say they are all about being TGNB inclusive but does not trust them to engage in the work necessary to be about “this life.”

And cis people say they're about this life. There are people that I believe are allies, advocates, accomplices, we don't have a lot of co-conspirators in the room...It will take a lot of learning for them to get there and accountability. I have faith in the trans therapists that are doing trans inclusive work, I know that cis therapists, if the books are written, they'll read it. I don't trust the integration into action. I don't trust doing the work to unlearn the binary and the programming of cissexism for them to understand the nuances of when to refer, when somethings not what you think it is.

This participant continued to discuss how cisgender providers risk losing things like relationships when confronting cisgenderism and they fear few cisgender providers will step up to the plate and make that sacrifice.

To trust a cis therapist? I imagine being a dominant identity is comfortable. There's so much that you have to risk to lose. It's not just a nine to five. It's a whole are you going to stand up to your family member in your home when they're transphobic? Or are you going to let it go? I don't trust the entire life shifts and mind shifts that have to happen...And I don't trust cis therapists to check their egos at the door and be like, "This is just my sacrifice to for a community I claim to work with..." I don't trust cis people will live in the rocky both/and with us.

This is an important piece as a cisgender participant shared how they really do not receive any criticisms for engaging in the work. She is a member of a consultation group focused on providing TGNB affirmative therapy and noted she rarely receives any challenges to how privilege operates in her practice.

It's an interesting question...I haven't really encountered that too much...Because Diane is a leader, anybody who does want to have a cis woman as the leader of the group, your part of caring for trans people wouldn't come back to the group too often, so I think that's also self-select. In other words, I might not be around the folks who would say, "How are you qualified for this?" Maybe I should find that. I'd probably learn a whole lot more if I were in groups where people were challenging me around my cis privilege.

The effects of cisgenderism are evident within the mental health field and it has a profound impact on how far the field has come in terms of being TGNB inclusive.

Are we there yet?

There is no doubt some advancements have been made in the field. An example of change has been a shift in attitudes toward TGNB inclusive practices. One participant reflected on how earlier in her career she was met with more resistance and defensiveness, which often made her feel anxious when engaging in advocacy. Now, she feels like people are more supportive and open.

Well, it's a welcome shift. Towards the beginning of my work, I had to do a lot of advocacy in schools. People were defensive about – "what do you expect us to do?" Now it feels like a lot more people want to support but don't know how...I remember how it used to feel different. I remember feeling a lot of anxiety going into those settings. Advocacy was more important. So, it's not like it made me back down. It certainly has made my job easier when people are more receptive.

Another participant discussed how they feel more people in the field are wanting to be more inclusive and how that is a nice experience.

I think that everybody wants to be transgender affirming now, and that's nice.

Although these two participants shared shifts in attitudes within the field, other participants felt the field has not made much traction in being transgender inclusive. In fact, one participant shared it is not happening.

I don't think it's happening. Yeah, I don't think it's happening. The only reason it happened at all in my life is because I just kept demanding it. I remember taking a gender class and we were supposed to read a book off of one of two lists. And I said, "We're missing a list." The course instructor said, "You know, create a list and I'll gladly send it out to students." I was part of a task group in Division 17 and one of the things we did as a group was create a toolkit for people who are training counseling psychologists that included articles for any class that would have been taught. I don't know that that's been widely disseminated yet.

A second example of change is seeing an increase involvement by the TGNB community. One participant shared how she is witnessing a surge of TGNB people engaging in the field and some are even returning to school as later in life to play a role in shaping the field.

Well, I see a lot more trans and non-binary folks getting involved. Even like folks who've beyond like college years, are returning to school, who want to play a role, you know, have a hand in shaping things. I feel like a lot of it does come from what people wish they had or wanted.

Another participant echoed seeing more TGNB people enter the field and become clinical scholars provides them with increased hope that things may change.

How do I see the field growing? Well, um literally you exist. I can only see it growing because I see clinical scholar activists budding. That gives me a bit of hope.

A final example was larger organizations' attempts at inclusion. One participant witnessed a couple keynotes focused on rebranding the field from MFT to systemic psychotherapy. In addition, some programs have begun to restructure their curricula so TGNB folks are embedded throughout courses.

I've seen one or two keynotes talk about that over the years which is great and exciting. I believe there's a conversation about changing the MFT name to a systemic psychotherapy direction...But there is resistance and reluctance from many members...I know the program at Stout tries to have kind of like LGBTQ folks embedded in the curriculum...And interracial relationships embedded in the curriculum, right? So, I think some things are happening, they're just happening slowly in a very discreet level.

Although change has been observed by participants, some reflected on how the mental health field is still in the early stages of developing TGNB inclusive practices. One participant stated, "Infancy?" Another participant echoed that sentiment and discussed how the field is really at the beginning. People have heard of the word transgender and how people think they know more than they do, which is a dangerous spot for the field.

We are at the beginning. People have heard of the word transgender. AH! People are beginning to start to talk about it. But what I find is that knowing a little is dangerous. So, we're in this place where a lot of people think they know a lot more than they actually do and are teaching and passing along old practices. There's just going to be a lot of catch-up work.

Lastly, a participant reflected on how she feels the MFT field is two steps behind the other professions. However, even those fields that are more “advanced” in this area are missing the mark. She recalls calling on the field to make changes before it becomes antiquated.

And they asked them what was your experience going to see a psychologist and the cluster fuck of things these people encountered. It was awful. And I was thinking, this is psychology, APA has put out standards! What would this look like if it was MFT?...And nobody's done that research. Nobody's looked at how trans folks experience MFT. And I think a lot of it is because they don't go to MFTs, because they want to stay safe. And just the top like the name, Marriage and Family Therapist already, I think folks are like, "Whatever, not going over there..." I remember writing, "This field is going to be antiquated unless we get our stuff together, we figure out how to work with all people." And that was still at the time when we had a subsection of our membership that was at least outwardly anti-gay marriage. I've worried that our field is always two steps behind.

With the resounding echoes of some small fought battles won, what is needed for the mental health field to not become stuck in a rut?

Burn it to the ground

In line with much of the existent TGNB inclusive therapy literature, all participants discussed the need for students and faculty to have an increased training and for programs to create an infrastructure to support their TGNB students and colleagues. While these are indeed vital, something emerged from four participants that might just shake up the system quite a bit if strongly considered and applied. Since the aim of this dissertation is in many ways a political call to action, excluding these recommendations from the conversation would be inappropriate and negligent. In essence, these four participants spoke deeply of dismantling capitalism and decolonizing the field to envision a brighter reality. To accomplish such a feat the field as we know it would need to disappear. Simply put, burning it to the ground and reconstructing the field outside of how we have come to know it.

Decolonizing the field

It became apparent a decolonizing framework needs to be applied to the field for continued transformation. One participant in particular discussed gender cannot be separated from the colonial project that it is.

We can't talk about gender without talking about colonialism, without talking about how dehumanizing indigenous and Black and Brown bodies was allowed for the ongoing colonial project to thrive. And part of that is creating this binary system of gender, which is also linked to capitalism and the idea of property of land or people, right?

They continued to share how there needs to be a complete overhaul of the graduate training programs.

A complete overhaul of our training programs to start with...So, sure people need to know what to do when they're dropped in a room with a client, and also people really need to have an understanding of the historical roots of the field. Very few courses really do kind of a historical theoretical development in the field of family therapy. For example, a lot of folks don't even know or might passingly know what I mean by second order cybernetics or things like that...I think our curricula do not serve our students.

In addition to overhauling programs, this participant stressed systems thinking is inherently political and clinicians need to be trained in how to intervene in that system because of the impact it has on people's lives.

Systems thinking is inherently political, if we want to think about it in that way. Because if politics is a system, that's what we do. We work for systems and so inherently we're gonna be political for our intervention...but if there isn't systemic change, just adding diversity to the same formula is not going to do it. And we know that this whole diversity/inclusion model still supports the system as it is.

Extending a systemic approach to changing the field requires an examination of who is shaping the field. Another participant discussed how clinicians need to question who is shaping the field and who is funding the field. We cannot understand the field without knowing the values of those who are in influential positions.

I think my first answer is the field needs to re-examine who funds it. What are their values?...So thinking about the economic influences of the fields. I'm thinking about

capital lately, so capital being beyond economic but also social and cultural. Who is shaping it? Who do we actually listen to? Who has the social capital? Who has the economic capital? Who is shaping the culture of the field? I see a lot of White people. I see a lot of cis people.

In addition to asking those questions, there needs to be unlearning. One participant shared a need to unlearn cisnormative ideology and heal from the internalized gender toxicity.

Trauma informed care is an approach, it's not like trauma focused CBT, it's really to recognize that the experience of not being witnessed, not being seen, and in my case, think of trans people who are not being accurately witnessed constitutes a lot of built-up gender toxicity... What that work entails is meeting with my clients, first finding out where they are in their process, helping them uncover the past, then inviting them to revisit the past.

Part of unlearning is engaging in decolonizing practices. Another participant noted how decolonizing can be a powerful process that would leave the field unrecognizable.

I want to say the second part to the unlearning part is definitely a decolonizing part. But when I think about that, then the organization doesn't exist anymore, when I think through all of that. But just kind of like basic decolonizing practices is re-examining how we use the DSM as a tool for gender dysphoria. Do people even understand what that is like? There's just certain things that I think are so rooted in White supremacist, cisnormative, heteronormative ideas that we haven't untangled and healed yet.

Moving beyond cis ally performativity

While we wait for decolonialization to happen, these four experts recommend cisgender people to work through their own gender stuff and to move away from cis ally performativity.

One participant shared they do not think cisgender people are not qualified to sit in the therapy room with a TGNB person until they have done their own gender work.

Reid Vanderburgh is the first trans therapist book that I read. He says that you're not qualified to sit across from a trans person until you've done your own gender work... That's part of what I do, and in my course, is make people sit down with who first told you, you were a girl or a boy? Because usually had to be told, and what as that context?

This participant further discussed how cisgender providers have come to center themselves in TGNB mental health because of their own anxieties.

A lot of what we do, at least half like we talked about, is treating cis anxiety. And really with information and answering questions, and also helping people be okay with the unknown and the unknowing and relearning that comes along with this population... You can name more, but I think that once we get better at naming that, we can then be like, "Okay, why don't we focus on trans care."

An additional example of how cisgender people center themselves in TGNB mental health is by joining TGNB specific consultation groups and attempting to miss use that space. One participant shared how cisgender providers will email the consultation group asking for assistance about non-gender related issues or asking on behalf of colleagues.

I see people like join the consultation groups and we have these listservs to post stuff. And people are like, "Oh this is a non-gender case." No, no, no, this space is specifically for this, you don't get to use this as an opportunity that you joined and have access to all these people to then post things like that... That feels like exploitation... Also a lot of people go, "I'm asking for a colleague." No. That colleague needs to join this consultation group and ask for themselves. Don't interpret their stuff. And what you're going to get an answer from us and pass it on to your colleague? That client is fucked... They just do the bare minimum... People don't actually follow through it's performative, so performative.

Another example of cis ally performativity is the gaslighting TGNB colleagues when they attempt to disrupt trans oppression. One participant shared a story on how a cisgender scholar presented at a conference and proudly proclaimed her ignorance.

Conference presentations where people are self-declaring how incompetent they are. International Academy of Sex Research Prague. I can't remember what year it was; it was sometime in late 2000s... Lisa Diamond is giving a keynote on trans folks goes, "I don't really know anything about trans people." Like she's straight up saying this to the crème de la crème... and this should be fucking public. This kind of shit. So, she goes, "I don't really know about trans people. I know there's a whole field out there." She's literally this dismissive and then proceeds to give this terrible talk.

What is important about this story is how when cisgender scholars present on TGNB topics they are uplifted and TGNB scholars receive a different response as this participant shared.

If it's a cis clinician that does something, they're going to be uplifted and elevated. "You should write a book or make a presentation." It's like, "Yay, cis people doing trans things, you're awesome." And then if the trans person it's like, "Is that really good? How good is this? And isn't this a little biased? Okay, that's what you did? That's nice."

The final example of cis ally performativity is faculty failing to engage in their own cultural humility work and modeling that for their students to help construct an inclusive classroom rather than feigning inclusion.

I hope that faculty can do their own cultural humility work, I am doubtful. So that when they are thinking and structuring their syllabi and thinking about how they're going to frame the world and relationships and people, they're aware of all the systems and they're aware of all the people and they're aware of all the margins...So, they're modeling what their students should be doing as well and how they should be thinking. I love a good inclusive classroom as much as they can be.

CHAPTER 6

DISCUSSION

I begin this chapter by returning to the self-of-the-researcher. I experience a mixture of emotions. I am excited to finish this marathon of a sprint that has been this doctoral journey. I started this journey bright-eyed, bushy-tailed, and full of energy. I end this journey in a very different place, a terrifying place that I do not enjoy. I am exhausted emotionally, physically, and spiritually. The following quote from Wanda Maximoff eloquently depicts this feeling, “I’m so tired. It’s...It’s just like this wave washing over me, again and again. It knocks me down, and when I try to stand up, it just comes for me again. And I...It’s just going to drown me” (Shakman & Feige, 2021). More often than not, I look at myself and wonder, “Who have I become?” Hearing the experience of TGNB experts while encountering cisgenderism in this program brings with it a heaviness. A heaviness that becomes too difficult to carry alone yet feeling there are few people who are willing to help carry it. The truth is I have not been the same since confronting cisgenderism in a MFT program meeting in Spring 2020, and I am unsure if I can reclaim that person. I know self-doubt and imposter syndrome are common experiences among doctoral candidates finishing their dissertation. However, as I reflected, the real struggle I was encountering was, “Do I have enough fight left in me to confront and challenge cisnormativity within the academy?” Sadly, I cannot provide an answer to that question, and I feel I am stuck between a rock and a hard place. I recall one participant sharing it is fairly common for TGNB people to enter the mental health field only to leave because of the effects of cisgenderism. When sitting in that revelation, I think, “Is it time I call it quits and exit

the field?” In a blink of an eye, my mind wanders to another participant who quoted “Heathen” by Bob Marley, stressing the importance of staying in the fight. In those instances, I feel like I cannot give up and cannot stop fighting. I have to learn when and when not to pursue the fight. This dissertation is definitely a fight and an exhausting one at that. Earlier I addressed cisgender and TGNB readers separately and I take space to do so now.

To the cisgender readers, your willingness to support and fight is noted and please recognize what your role is in those fights. It is not to protect and save TGNB people. Trust me, the TGNB experts and I have depicted throughout this dissertation our resiliency and tenacity. Do not confuse our struggles with the effects of cisgenderism (i.e., mental health) as a sign of weakness. We are not damsels in distress waiting for you to gallivant in on your white horse. We can handle a fight. TGNB people, particularly Black transgender women, have long been the first to lay down their lives for queer liberation. Your roles are to shut up, open your ears, learn, dismantle your own gender toxicity, and use your cisgender privilege to disrupt cisnormativity. I guarantee you do not know as much as you think you do and you acting as if you do is dangerous. For too long you have let your worries and cisgender fragility shape TGNB mental health. It is time you do the uncomfortable work to become the co-conspirators we need in the room, and that includes the cisgender faculty. This work is not only for the cisgender post-graduate clinician or cisgender student. Cisgender faculty have to do their own work to effectively train cisgender students in this important process.

To the TGNB readers, I know you are tired, and you need soul cleansing rest. It is exhausting educating your peers and faculty at every turn. Every moment you have to remind your colleagues of your existence and correct them when misgendering occurs chips away at you. I am not going to tell you to keep fighting. In fact, I am going to tell you to rest. Being in

constant fight mode is not an effective strategy and at the end of the day the cisgender folks who truly care will make the necessary behavioral changes. You need to care for yourself because cisgenderism is omnipresent. You need to create a community of support, which can include other TGNB folks or cisgender co-conspirators, to lean on in moments where you feel like giving up. Cisgenderism wants us to quit because our very existence is a threat. You are stronger than you will ever realize.

The remainder of this chapter is focused on discussing the results of both phases of the study and implications. For simplicity, the discussion of Phase 1 and Phase 2 results occur separately. In those sections, strengths and limitations are also discussed. Following these discussions, I utilize a grand discussion approach to invite the findings from both phases to converse to provide implications for clinical training programs and suggestions for future research.

Phase 1

The purpose of Phase 1 of this study was to examine student and faculty self-reports of clinical competency working with TGNB clients and their perceived assessment of affirmative training in their clinical graduate program through a cross-sectional survey design. The research questions were: 1) What are students' assessments of the level of TGNB affirmative training they receive in their program? And does this differ across APA, CACREP, COAMFTE, and CSWE programs? 2) What is the level of students' self-reported competency working with TGNB clients? And does this differ across APA, CACREP, COAMFTE, and CSWE programs? 3) To what degree is students' assessment of the overall level of their TGNB affirmative training associated with their self-reported competency working with TGNB clients? 4) What are faculty's assessments of the level of TGNB affirmative training provided in their program? And

does this differ across APA, CACREP, COAMFTE, and CSWE programs? 5) What is the level of faculty's self-reported competency working with TGNB clients? And does this differ across APA, CACREP, COAMFTE, and CSWE programs? 6) To what degree is faculty's self-reported competency working with TGNB clients associated with their assessments of the level of TGNB affirming training in their program?

Students' Level of TGNB Affirmative Training

The results of Research Question 1 indicated that students somewhat agreed they received TGNB affirmative training in their clinical graduate programs. These results are interesting as 70.2% of students reported receiving at least one hour of TGNB affirmative training and 51.1% reported attending one or more workshops focusing on TGNB affirmative training. A possible explanation is students are attending workshops and receiving additional training outside of what is offered in their clinical graduate programs. In fact, there were significant mean differences across accredited programs on the Class subscale, which indicated students reported experiencing varying levels of TGNB content in their coursework based on national accreditation type. These findings appear to support other scholars who argue that mental health providers do not receive adequate training (Benson, 2013; Carroll et al., 2002; Whitman & Han, 2017). Considering accreditation standards of each discipline require content related to gender identity within the standard curriculum, it would appear some clinical graduate training programs fail to meet this requirement. These findings are disconcerting as student trainees, in general, are likely ill-prepared to provide competent care to a population of clients who routinely experience discrimination from the mental health field unless they seek out continuing education during and after their clinical training. For example, clinicians report a lack of familiarity with referral procedures to assist TGNB clients in accessing medical transition care

(e.g., hormones and surgeries) and social transition care (e.g., legal name change and changing gender markers on legal documents; Whitman & Han, 2017).

Students' Level of Perceived Clinical Competency

The results of Research Question 2 indicated students perceived themselves as somewhat competent in working with TGNB clients. Similar to Rock and colleagues' (2010) study focusing on LGB affirmative training and clinical competency, the Awareness subscale had the highest mean ($M = 6.74$), indicating low levels of self-reported transphobia. Students' mean score on the Knowledge subscale was 5.50 suggesting a moderate level of understanding how cisnormativity and discrimination impact clinical practice. The mean score on the Skills subscale for students was 3.32 indicating lower skill in working with TGNB people. This finding is interesting as 70.2% of students reported receiving some education related to TGNB affirmative therapy. Overall, this finding is promising given students reported low levels of transphobia. Participating in educational programs focused on reducing transphobia can be an important first step for students to challenge their internalized assumptions (Mizock et al., 2017). In addition, clinicians who strive to be more competent and maintain an awareness of their own biases are less likely explicitly or implicitly to perpetuate discrimination and stigma towards TGNB clients (Whitman & Han, 2017). These clinicians may also strive to be more proactive in seeking adequate resources and supervision to support the TGNB community and advocate for better training in their programs.

Certain social identities and experiences appeared to be associated with overall means on the GICCS-R and its subscales. Specifically, cisgender students reported lower means on the Awareness subscale, those who worked with a TGNB client reported greater means on the Knowledge subscale, Skill subscale, and overall mean on the GICCS-R, and those who attended

workshops specific to TGNB reported greater skill and overall competency. These findings further substantiate previous literature that suggests identifying as cisgender is associated with negative assumptions of TGNB people (Brown et al., 2018) and engaging in further education and working with TGNB clients are associated with greater competency (Gonzalez, 2020; Mizock et al., 2017).

Students' Affirmative Training and Perceived Clinical Competency

The results indicated that students' mean scores on the ATI-S were associated Skill subscale. In essence, students who rated their training as more TGNB affirmative also reported greater skill working with TGNB clients. This finding is important as it supports the arguments in the literature that graduate training programs need to move beyond understanding TGNB lived experiences to examining how cisnormativity influences clinical practice and education (Boe et al., 2020; Blumer et al., 2013; Edwards et al., 2019; McDowell et al., 2014; McGeorge et al., 2021).

While students' scores on the ATI-S were associated with their overall scores on the Skills subscale, it was not associated with Awareness subscale or Knowledge subscale. Therefore, their self-reported level of TGNB affirmative training was not associated with their level of transphobia towards TGNB clients or their knowledge of how cisnormativity and discrimination experienced by TGNB individuals in clinical settings. These findings are similar to Rock and colleagues' (2010) study on LGB affirmative training. They surmised the teaching methods and content faculty used did not significantly impact students' internalized homophobia nor their personal beliefs about the discrimination LGB people experience. A similar process could be at play with regards to the training experiences related to TGNB affirmative therapy.

Faculty's Level of TGNB Affirmative Training

The results of Research Question 4 indicated that faculty somewhat agreed TGNB affirmative training occurred in their program, and there were no significant mean score differences among the national accreditation types. These results are interesting as a 73.1% of faculty reported attending at least one hour of TGNB affirmative training and 91% reported attending one or more workshops focused on the topic. These findings suggest faculty may have received limited training themselves in TGNB affirmative therapy and may not be integrating it into their coursework or at the programmatic/departmental level because of their limited training. A similar process appears to occur with LGB affirmative therapy whereby faculty receive limited training (Corturillo et al., 2016; Godfrey et al., 2006; Long & Serovich, 2003; McGeorge & Carlson, 2016), which impacts the inclusion of LGB topics in curricula (McGeorge et al., 2018). Similar to students' level of affirmative training, based on faculty's self-reports, it appears some clinical graduate training programs fail to meet accreditation requirements of providing education related to gender identity. One glimmer of hope rests in the students who report receiving greater training and who are becoming faculty across mental health disciplines and integrate TGNB affirmative training into their curricula (McGeorge et al., 2018). In fact, faculty who reported more client contact hours, hours of education, and workshops attended were more likely to include TGNB affirmative training in their teaching and their experiences as faculty.

Faculty's Level of Perceived Clinical Competency

Similar to students, faculty perceived themselves as somewhat competent in working with TGNB clients. Moreover, the means on the subscale followed a similar trend to students. Faculty rated themselves as having greater Awareness ($M = 6.79$), followed by Knowledge ($M = 5.79$), and Skill ($M = 4.27$). Similar to the results above, there were no significant mean score

differences on faculty's perceived clinical competency across accreditation type. These results suggest the faculty in this sample report low levels of self-reported transphobia, a moderate understanding of how cisnormativity and discrimination impact clinical practice, and lower skill levels working with TGNB clients. Similar to students, faculty who reported having more client contact hours, more hours of education, and having attended workshops specific to TGNB affirmative therapy tended to have greater awareness, knowledge, skill, and overall clinical competency compared to faculty who did not (Gonzalez, 2020; Mizock et al., 2017).

Faculty's Perceived Clinical Competency and Affirmative Training

The results indicated that faculty's mean scores on the GICCS-R were associated with their overall mean on the ATI-F, Teaching subscale, and Experience subscale. In essence, faculty who self-reported greater clinical competency also reported higher means on the Teaching subscale, Experience subscale, and their overall mean score on the ATI-F. These findings are not surprising as previous literature indicates faculty members who reported greater clinical competency working with LGB clients was associated with including LGB affirmative practices in their teaching (McGeorge et al., 2018). It is important to note this is the first study connecting an association with TGNB clinical competency to faculty's curricula. Similar to the students' results, faculty tend to teach what they know and as students with greater self-reported clinical competency become faculty it would not be surprising for them to integrate this knowledge into their courses (McGeorge et al., 2018).

While faculty's scores on the GICCS-R were associated with their scores on the Teaching subscale and Experience subscale but was not associated with the Program subscale. Therefore, their self-reported level clinical competency was not associated with the extent of affirmative training at the programmatic level. In some ways these findings are not surprising as

accreditation standards do not require faculty to seek out continuing education related to affirmative therapy. COAMFTE requires faculty to support students in developing competencies in “LGBT Affirmative Practices” (COAMFTE, 2017, p. 49). This same requirement does not exist for faculty. APA requires graduate programs must support students in developing competencies in “Individual and cultural diversity,” which includes gender identity (APA, 2015, p. 9). In addition, faculty in APA accredited programs must “demonstrate substantial competence” (p. 12), and programs must recruit and retain “diverse faculty” (p. 13). CACREP requires students to develop competencies in “multicultural counseling” (CACREP, 2016, p. 10) and defines multicultural as, “term denoting diversity of racial, ethnic, and cultural heritage; socioeconomic status; age; gender; sexual orientation; and religious and spiritual beliefs, as well as physical, emotional, and mental abilities” (p. 42). However, like COAMFTE, those same requirements are nonexistent for faculty. CSWE requires gender identity be included in their “implicit curriculum” related to programs’ commitment to diversity and students must demonstrate the essential qualities in this implicit curriculum (CSWE, 2015, p. 14). In addition, “programs demonstrate that faculty is qualified to teach the courses to which they are assigned” (p. 15). If accrediting bodies require students to develop these competencies, it would be beneficial to assess faculty members’ level of clinical competency. By evaluating faculty, those who report less clinical competency, which may be a result of their own lack of training, can engage in continuing education to address this lack of knowledge (McGeorge et al., 2018).

Strengths of the Study

There are several strengths to the survey study conducted in this first phase. First, this is the first study in the mental health field that addresses clinical competency related to working with TGNC clients and establishes a baseline for future research in this area for both student and

faculty samples. Second, this study is the first study to explore the level of TGNB affirmative therapy training students receive in nationally accredited clinical graduate programs. Third, this is the first study to examine clinical competency and level of TGNB affirmative training across APA, CACREP, COAMFTE, and CSWE, which allows for an exploration of possible differences among these accredited programs. Lastly, this is the first study to examine associations between TGNB clinical competency and perceptions of affirmative training, which provides evidence for increased education in TGNB affirmative training and greater clinical competency for both students and faculty. Such findings have important training implications that are discussed in greater detail.

Limitations

There are several limitations to this phase. First, the GICCS-R, ATI-S, and ATI-F are self-report instruments. As such, findings for this phase are limited to discussing perceived competency and affirmative training and not their actual level of competency and affirmative training. Second, social desirability may influence student and faculty self-reporting of their competencies and affirmative training. For example, the means for both students and faculty of the Awareness subscale were heavily skewed indicating more favorable attitudes toward TGNB people. It is possible students and faculty over-compensated on the awareness subscale to avoid appearing transphobic. Another limitation to survey research is participation bias. The primary recruitment method used in this study involved relying on program directors and clinical training directors to disseminate the invitation to participate to students and faculty. It is possible program directors and clinical training directors with more affirming beliefs were more likely to forward the invitation to students and faculty than those with less affirming beliefs. Fourth, missing data for students and faculty related to the ATI-S/ATI-F Program and Department

subscales. It is possible that students are unaware of policies related to affirmative training or faculty and department administrators are not explicit in these policies. In addition, faculty may be unaware of policies or the policies related to affirmative training do not explicitly exist within the program or larger department. Lastly, the student and faculty sample size were relatively small indicating a lack of statistical power, which can lead to Type II errors. In fact, to effectively run these analyses, power analyses indicated that a student and a faculty sample of 400-500 (100-150 per group) was needed to detect a minimal effect of .294.

Phase 2

The purpose of Phase 2 of this study was two-fold: 1) Garner in-depth accounts of experts in TGNB mental health and their experiences engaging in the field to advance training initiatives, and 2) Understand and document specific strategies to increase TGNB affirmative training in mental health as recommended by the eight experts. Using the transcribed interviews, individual narratives were constructed for each of the participants. These constructed narratives were then used to employ a deductive thematic analysis to communicate congruent and divergent themes that emerged across participants within the pre-established categories: entry into the field, experiences within the field, and future recommendations. Within these broader categories, seven themes and 10 subthemes emerged. Because of the breadth and scope of data gathered, the following themes and corresponding subthemes were fully explored for the dissertation: How I got here, Cisgenderism rears its ugly head, Are we there yet?, and Burn it to the ground.

How I got here

The overarching story arc participants described for their entry into the field was to reduce mental health disparities faced by the TGNB community. In particular, the cisgender participants recounted stories working with TGNB people and recognizing a dearth of TGNB

literature on how to work effectively with this community. These participants' entry into the field resembles that of ally development. In particular, their early stages of professional development were ripe with naivety and developing awareness of different treatment as a result of cisnormativity and cisgender privilege. These early experiences reflect the developmental stage of allies for self-interest. Allies at this stage are primarily motivated to protect those they care about from being hurt, seeking to be an ally to an individual with whom they are personally connected (Edwards, 2006). The individuals for these participants were typically TGNB people to whom they provided clinical and social support.

Conversely, the TGNB participants entered the field to protect their community. They often shared they were exhausted from hearing the horror stories of how TGNB people were treated by the mental health field. Their accounts reflect the existent literature that examines experiences of TGNB clients in seeking mental health treatment. TGNB people are often wary to seek mental health services (Weeks et al., 2016) because of the historical/continual marginalization by mental health systems and providers (Benson, 2013, Lev, 2004). TGNB clients often share experiences where the mental health provider attempts to change their gender identity (Weeks et al., 2016), displays explicit expression of disapproval or discomfort with TGNB people (Johnson, 2014), and misgender their TGNB clients (Blumer et al., 2013). In addition, many TGNB clients experience their providers as insensitive (Sperber et al., 2005) and lacking adequate education (Whitman & Han, 2017).

Cisgenderism Rears Its Ugly Head

All participants in the study openly discussed how cisgender privilege and cisgenderism was present in their experiences. In particular, the cisgender participants reflected on how their cisgender privilege allowed them to have a different experience with clients that is not often

afforded to TGNB therapists. For example, both cisgender and TGNB participants reflected how families with TGNB youth often sought a second opinion from a cisgender provider because they assumed the TGNB provider was biased and had an agenda. In addition, the TGNB participants reflected how they often experienced cisgenderism from so-called allies, those touted as leading experts in the field.

Ansara and Hegarty (2012) situate cisgenderism as neither increasing nor decreasing overall, rather mental health professionals are more cisgenderist than other authors. They suggest those who are closely tied through publication with the most prolific author (e.g., read as “ally”) in the field are likely to adopt pathologizing and misgendering language. These authors are then most likely to have work cited that perpetuates cisgenderism. In an effort to reduce cisgenderism within the literature it is vital that scholars reflect on how citational practices reify or resist cisgenderist knowledge production (Mott & Cockayne, 2017). To curb cisgenderist practices, mental health providers have to move away from the idea that having knowledge about cisgenderism is the sole key (Blumer et al., 2013). Such ideology is similar to the idea that having awareness of racism or heterosexism automatically reduces these ideologies (Kim et al., 2003). Mental health providers need to become aware of their own cisgenderist assumptions (Blumer et al., 2013; McGeorge et al., 2021). One participant reflected how providers need to dismantle what they called gender toxicity. Gender toxicity can be conceptualized as the internalized cisgenderist assumptions. To begin the process of dismantling gender toxicity, providers have to do their own gender work. This work requires them to examine their own cisgenderist assumptions of gender (e.g., woman/man, trans/cis; Ansara & Hegarty, 2012; McGeorge et al., 2021). Such topics to explore include narratives of how gender was taught in

families and how internalized cisgenderism is present in the therapy process (Boe et al., 2019; McGeorge et al., 2021).

Are We There Yet?

Participants reflected there have been advancements within the field in that there is a noticeable shift in attitudes toward TGNB affirmative therapy. For example, one participant noted she is met with less resistance and defensiveness when presenting. Her recount is not surprising as overall attitudes toward TGNB people are becoming increasingly positive among mental health providers (Brown et al., 2018). In addition, the findings from Phase 1 of the study indicated both students and faculty perceive themselves as less transphobic. Students and faculty may feel they are, but one participant reflected that people tend to think they know more than they actually do. Another participant shared they do not feel cisgender people will do the work to be co-conspirators against cisgenderism. Although attitudes are shifting, most of the participants shared they do not feel like the field has made substantial changes.

One participant noted they do not think TGNB affirmative training is happening, and others feel like the field is in its infancy. Findings from Phase 1 of this study support participants' narratives. Both students and faculty reflected TGNB affirmative training was somewhat happening in their programs, and they reflected they lack the skills necessary to work effectively with TGNB clients. Previous literature on lack of adequate education and training reinforces the narrative of the field being in the beginning phases (Benson, 2013; Carroll et al., 2002; Whitman & Han, 2017).

Burn It to the Ground

In line with previous literature, the participants in Phase 2 of the study clearly articulated the need for increased training and for programs to provide institutional support for their TGNB

students and colleagues. TGNB students and faculty frequently experience marginalization and discrimination within university settings (Goldberg et al., 2020; Seelman, 2014). It is common for TGNB students and faculty to engage in activism in the university setting. However, they often experience burnout, compassion fatigue, depression, and hopelessness when participating in activism with limited social support (Vaccaro & Mena, 2011). To address institutional barriers four participants discussed the need to decolonize the mental health field in order to effectively overhaul the educational system.

There are three primary conceptual therapeutic frameworks when working with TGNB people: medical, developmental, and deconstructive (Malpas, 2006). Tracking the process among these frameworks there is a shift from pathology to normalizing TGNB identities to deconstructing gender. From the findings of this phase of the study, the field might be on the precipice of another framework: decolonizing. Two participants in particular expressed that the field needs to gravitate towards a decolonizing framework to address the ongoing colonial project within the field.

Colonialism is present in psychotherapy (Vecchio & Lockard, 2004). First, traditional approaches reduce and disempower clients by labeling them with psychopathology without examining pathology in larger systems. Second, even when applying a systemic perspective, it is often done so passively (Vecchio & Lockard, 2004). For example, the approaches that do attempt to help clients recognize systemic influences often do not link clients to social action initiatives. Third, when attending to gendered power dynamics few scholars examine how gender is a colonial project, often situating their analysis within a cisnormative frame (Boe et al., 2019). A project that forced new rigid performances of gender and sexuality and built a power relation within a binary model of sex, gender, and sexuality (Lugones, 2007). Decolonization requires

connecting academic research and transformative action (Cannella & Manuelito, 2008; McDowell & Hernández, 2010). Through a decolonizing framework, mental health science-practitioners draw their attention to disrupting prevailing powerful societal discourses in interpersonal and institutional practices that maintain colonial ideology and its effect in shaping people's lives (Cruz & Sonn, 2011; Harding, 1998).

One participant shared the field needs to re-examine who is shaping the mental health field. Another participant reflected how in TGNB mental health it is often cisgender providers who have the most influence in the field. Such an examination is vital from a decolonizing framework. Modifying Smith's (2000) questions for decolonizing research, similar questions can be applied to the TGNB mental health field. What type of research on gender do we want to do? Who are the SOCs for? Who benefits most from the SOCs? Who is this research for? What difference will it make? What will be reified in the process? Who will conduct the study? Who will own the research, and who will benefit from it?

Strengths of the Study

There were several strengths to this phase of the study. First, narrative inquiry allows researchers to understand experience. Often researchers focus on outcomes, disregarding the impact of experience itself (Bell, 2002). In my case, the narrative approach heightened the professional journey, nuanced experiences among experts, and critical reflection on TGNB affirmative therapy in the broader mental health field. Second, the use of narrative data allows researchers to examine deeply hidden assumptions. My efforts to develop an in-depth understanding from these eight experts opened space for me to discover assumptions of how cisgenderism and cisnormativity shape TGNB mental health and how cisgender lives are centered within this domain. Third, this phase of the study is the first to examine TGNB

affirmative therapy using this qualitative methodology. The insights provided from the eight experts can be used to continue to advance TGNB affirmative therapy in various ways. A final strength relates to trustworthiness of the study design. Throughout the process of constructing individual narratives for each of the eight participants, they had an opportunity to review and edit the constructed narratives and the three interview transcripts. This level of member checking allowed the participants to co-construct my interpretations of the interviews and their stories.

Limitations

This phase is not without limitations. Bell (2002) situates methodological limitations related to narrative inquiry. First, the time required to conduct a rigorous narrative study is unsuitable for larger samples. Second, the ethical issues inherent to narrative inquiry necessitates close collaboration with participants as researchers take their stories and place them in a larger narrative. This collaboration allows participants to reflect and respond to the researcher's interpretation. Third, the narratives generated were limited to experts in the field, which constrained eligibility for participation. It is possible with broader eligibility criteria those in the mental health field (e.g., student trainees) who hold different levels of power, privilege, and oppression may have added depth to the findings. For this phase, I believe it was important to restrict participation to experts in TGNB mental health to provide a critical perspective of the current state of the field. Lastly, in person interviews were not possible due to the COVID-19 pandemic and a video conferencing platform was used to facilitate virtual face-to-face interviews. Although in person interviews may provide richer data compared to telephone interviews (Sturges & Hanrahan, 2004), some experts may not prefer to be interviewed in person (Harvey, 2011).

Implications for Clinical Training

This dissertation was theoretically guided by queer theory and phenomenological variate of ecological systems theory (PVEST). At the individual level, mental health providers should consider how their various sociocultural identities operate as unique sources of resiliency or as compounding stressors (Edwards et al., 2019). From a queer theoretical perspective, our sociocultural identities position us towards certain ways of being and knowing. Mental health providers need to be aware of how their sociocultural identities impact their clinical practice, how their clients may interact with or perceive them, and how normative discourses based on sociocultural identities position other identities as deviant or unnatural. Scholars often lean on intersectionality (Crenshaw, 1989; Moradi, 2017) to assist in such analysis. Addison and Coolhart (2015) provide an example of how mental health providers can examine how sociocultural identities intersect among various relationships and how these intersections influence relational dynamics. PVEST was further extended by examining the ways in which trans oppression and clinical implications are nested within and across macro-, meso-, micro-systems (Edwards et al., 2019). To best discuss implications for clinical training, I address each of these systems individually. These implications are a co-construction of the data and my own experiences as a scholar.

Microsystem

The microsystem involves the relational systems with which the individuals interact (Edwards et al., 2019). These relational systems include family, peers, workplace, place of worship, school, among many others. In graduate training programs, students and faculty need to engage in critical reflection of how cisgenderism influences their assumptions. A powerful intervention is to engage in your own gender work. This work entails you exploring and

deconstructing what you learned about gender and how that impacts your clinical work. Specifically, it's an examination of your own assumptions of gender and how those beliefs connect with binary normative assumptions (Boe et al., 2019; McGeorge et al., 2021). McGeorge and colleagues extend gender work in their three-step model to deconstructing cisgenderism. They suggest mental health providers need to explore the societal messages they were taught about gender identity, but they also need to critically reflect on the assumptions they hold of how TGNB people are *supposed* to look, act, and exist (McGeorge et al., 2021).

The second step in the model is to explore cisgender privilege and “binary advantage” (McGeorge et al., 2021, p. 6). Cisgender students and faculty need to work to become aware of their cisgender privilege and how it impacts their work. Specifically, cisgender mental health providers need to recognize the benefits they receive for living in a cisnormative society (Salpietro et al., 2019) and how they reify cisgenderism (Ansara & Hegarty, 2012). While cisgender providers earn binary advantage, binary transgender people also receive binary advantage based on how well others perceive them as cisgender (McGeorge et al., 2021). This perception is often related to greater economic resources that allow for binary transgender people to undergo the medical and social transitions they deem appropriate for their gender journey (Vipond, 2015). To refute the existence of binary privilege as tool of cisgenderism continues to negate how certain TGNB bodies are read as “valid” (Vipond, 2015). Shipman and Martin (2019) note that people who are perceived as identifying within a binary understanding of gender receive more societal acknowledgment and potentially greater access to resources. I am not suggesting binary transgender people and non-binary people are in a struggle to *prove* who has it worse rather how does cisnormativity and transnormativity lead to internalized assumptions of transness among TGNB providers. In fact, internalized cisgenderism can have a profound impact

on how affirming TGNB providers are to their TGNB clients. A TGNB provider who has not done their own gender work related to internalized cisgenderism is at risk for upholding dominant and damaging narratives of gender much like their cisgender counterparts (Shipman & Martin, 2019).

The third step in the McGeorge and colleagues' model is unique to cisgender providers as it focuses on exploring cisgender identity development. Similar to anti-racist work, in which White individuals need to admit they have a racial identity (ayo, 2005), cisgender people need to admit they have a gender identity (McGeorge et al., 2021) and how that identity developed. Cisgender people can reflect on various questions related to their gender development. Example questions include: "When did you first learn you were a girl or boy? Who told you? How would you explain how you developed your gender identity? and How was your gender identity reinforced by others?" (McGeorge et al., 2021).

Specific to TGNB students and colleagues, cisgender faculty and supervisors need to be aware of how TGNB people are often in the position to educating them about the unique challenges and considerations of being a TGNB clinician (Chang et al., 2018; Shipman & Martin, 2019). TGNB providers often have to navigate self-disclosure and therapeutic relational dynamics (e.g., transference and countertransference; Chang et al., 2018; Shipman & Martin, 2019). As more students with diverse gender identities enter clinical graduate programs, faculty, particularly cisgender faculty, need to engage in their own edification and gender work to best support these students (Shipman & Martin, 2019).

Mesosystem

The mesosystem relates to how systems in which individuals operate intermingle. For example, faculty of clinical graduate training programs often interact with accrediting bodies and

the larger university system. Based on the findings from this study, specific concepts and practices related to TGNB affirmative therapy need to be integrated into the curriculum of graduate training programs. Results from Phase 1 indicated clinical competency was associated with TGNB affirmative training students receive and faculty provide. Training programs have an ethical responsibility to include content and practices in their courses and supervision (Rock, et al., 2010). However, it is evident based on how students and faculty both reported being somewhat competent and somewhat receiving/providing TGNB affirmative training that graduate programs may not be meeting accreditation standards. This phenomenon may be in part due to a lack of clarity in accreditation standards on what education looks like beyond a one three-credit hour diversity class. With the goal of embracing multiculturalism, accreditation bodies may need to develop standards around what is considered novice, intermediate, and advanced clinical knowledge and competency in TGNB affirmative therapy. By offering clearer guidelines, clinical graduate programs are better able to conform to standards. Moreover, accrediting bodies need to take a direct stance on what is necessary for clinical graduate programs to maintain their accreditation status. It became apparent in Phase 2 of the study that advancing TGNB affirmative therapy practices requires more than mere education about TGNB people. Participants reflected that TGNB people need to be developing and teaching courses related to TGNB affirmative therapy. To meet this recommendation programs, need to hire a TGNB faculty member who specializes in TGNB affirmative therapy. It is tricky to advise programs to hire adjunct faculty, until they can offer a tenure track position, as they are often underpaid and overworked compared to tenured faculty members, often living close to the poverty line if not working another job (Nica, 2018).

Beyond overhauling curricula, faculty and students need to be active at the university system and advocating for TGNB inclusive policies. Jordan and Seponski (2018a, 2018b) suggest mental health providers need to be engaged in political action as the political system greatly impacts not only their clients' lives, but their family, colleagues, and their own lives. However, many mental health providers report time and lack of knowledge as barriers to political involvement (Jordan & Seponski, 2018a). Mental health providers need to receive training in how to intervene at the political level because of anti-TGNB legislation (Boe et al., 2020). Faculty can provide students with opportunities for advocacy by integrating it into their curricula (Goldberg et al., 2020). Such methods model for students how to engage in socially just practices. For example, in courses focused on diversity, privilege, and oppression, faculty can instruct students to conduct research on policies at the university level or the larger political level related to TGNB lives. In addition, faculty and administrators in higher education need to engage in advocacy with and on behalf of TGNB students and colleagues to create TGNB-inclusive policies (Goldberg et al., 2020). Through creating and publicizing TGNB-inclusive practices, institutions demonstrate an awareness and acceptance of TGNB lives, but these practices must be focused on long-term systemic change (Goldberg et al., 2020).

Macrosystem

The implications discussed at the micro- and meso-system have clear ties to transformation at the macrosystem. The aim at the macrosystem is to transform the cultural context. Foucault (1980) suggested power is discursively produced from bottom-up rather than top-down authoritative discourses. From a Foucauldian perspective power cannot be acquired, seized, or shared. In addition, Combs and Freedman (2012) assert that once people become aware of systemic injustice, they are able to question and align with differing discourses to disrupt power relations. For example, people unknowingly reify cisgenderism in their interactions with themselves and others. It is not until people become more aware of the cultural context of cisnormativity and transnormativity that they are able to resist and challenge it. However, power does become institutionalized (McDowell et al., 2018). Institutional power is evident through anti-TGNB policies and legislation. Consider laws like HB2 in North Carolina, which bans TGNB people from using restrooms that align with their gender identity. This law emboldens any businesses to deny access to restrooms with greater force and determination (Edwards et al., 2019). Another example of anti-TGNB legislation is HB 276 in Georgia that seeks to ban transgender girls from competing in single-gender sporting events if it doesn't align with their gender assigned at birth. These types of legislation demonstrate how institutions allow for individuals to perpetuate cisgenderism. As such, power is the reciprocal relationship between bottom-up and top-down, representing a mobius coil. To effectively intervene at the macrosystem individual action (e.g., dismantling cisgenderism in the self) and advocacy in the systems one interacts in is needed.

Suggestions for Future Research

Phase 1 of the study was designed to measure perceived level of clinical competency and affirmative training; observational methods can be used to determine students' and faculty's actual competency and affirmative training. Another area for future research could be to explore effective teaching methods in helping students and faculty heighten their skills in working with TGNB clients. Because Phase 2 of this study explored experts' recommendations, it could be interesting to collect narratives from cisgender therapists and their cis-ally development to determine which factors are most beneficial in reducing transphobia and strengthening their resolve to become co-conspirators against cisgenderism. Such findings would have implications for effective training practices. Another area for research could be a qualitative examination of what mental health educators and providers believe are basic, moderate, and advanced knowledge and skills of TGNB affirmative therapy and clinical competency. Those findings could have implications for accreditation standards and evaluating graduate training programs in terms of curricula development. Scholars could then conduct fidelity and efficacy studies on the developed curricula to test overall effectiveness of educating clinical graduate students on TGNB affirmative therapy.

Conclusion

This dissertation is the culmination of years of researching, theorizing, and writing on TGNB affirmative therapy and clinical competency. It encapsulates a two-phase multi-method study design examining the current state of TGNB affirmative therapy in clinical graduate programs. In Phase 1, I found students and faculty self-report programs providing somewhat of an education related to TGNB affirmative therapy and somewhat having clinical competency to work effectively with the TGNB community. In Phase 2, I found experts in the field have noticed

shifts within the field, but further work is needed. Participants in Phase 2 shared cisgenderism remains present in mental health and education alone will not reduce its impact on clinical practice.

TGNB people encounter numerous barriers when trying to access TGNB affirmative therapy. Providers are often ignorant (Sperber et al., 2005; Shipherd et al., 2010) and perpetuate microaggression against their TGNB clients (Blumer et al., 2013). Although results from Phase 1 of the study indicated students and faculty reported low levels of transphobia, mental health providers are still likely to reify cisgenderist ideology (Ansara & Hegarty, 2012). An in-depth examination of and resistance to cisgenderism individually and institutionally are necessary steps to addressing the historical/continual oppression the TGNB community faces at the hands of mental health providers (Ansara & Hegarty, 2012; Blumer et al., 2013). However, individuals, graduate training programs, the broader mental health field, and the larger society must be willing to contend with the effects of colonialism and cisgenderism to create transformative change. One participant from Phase 2 shared:

Cis people say they're about this life. There are people that I believe are allies, advocates, accomplices, we don't have co-conspirators in the room...It will take a lot of learning for them to get there and accountability. I have faith in the trans therapists that are doing trans inclusive work. I know that cis therapists, if the books are written, they'll read it. I don't trust the integration into action. I don't trust the work to unlearn the binary and the programming of cissexism for them to understand the nuances of when to refer when something's not what you think it is.

If you, the reader, are about this life, then consider this dissertation an invitation to start/continue the work.

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APPENDIX A

IRB APPROVAL LETTER FOR PHASE 1



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Human Research Protection Program

EXEMPT DETERMINATION

August 28, 2020

Dear [Elizabeth Wieling](#):

On 8/28/2020, the Human Subjects Office reviewed the following submission:

Title of Study:	How are Mental Health Providers Equipped to Provide Transgender and Non-Binary Affirmative Therapy? Exploring Faculty and Student Preparedness
Investigator:	Elizabeth Wieling
Co-Investigator:	Joshua Boe
IRB ID:	PROJECT00002285
Review Category:	Exempt 2(iii)

We have determined that the proposed research is Exempt. The research activities may begin 8/28/2020.

Since this study was determined to be exempt, please be aware that not all future modifications will require review by the IRB. For more information please see Appendix C of the Exempt Research Policy (<https://research.uga.edu/docs/policies/compliance/hso/IRB-Exempt-Review.pdf>). As noted in Section C.2., you can simply notify us of modifications that will not require review via the "Add Public Comment" activity.

This project has received Limited IRB Review. It has been determined that there are adequate provisions to protect the privacy of participants and to maintain the confidentiality of data. Changes to study procedures that affect privacy and confidentiality must be made by submitting a modification.

A progress report will be requested prior to 8/28/2025. Before or within 30 days of the progress report due date, please submit a progress report or study closure request. Submit a progress report by navigating to the active study and selecting Progress Report. The study

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE: SURVEY

1. What is your age?
2. What is your sex? Female, Male, or Intersex
3. What is your gender identity? Trans woman, trans man, non-binary, agender, cisgender man, cisgender woman, prefer to self-identity
4. What is your race/ethnicity? African American/Black, Asian, American Indian/Alaskan Native, Native Hawaiian/Other Pacific Islander, Latino/a/e/x, White European American, prefer to self-identify
5. Which type of national accreditation does your program have? APA, CACREP, COAMFTE, CSWE, Dual/Multiple
6. What is the degree type you are teaching/enrolled in? Masters/PhD
7. Is your program either religious informed or at a religious institution? Yes/No
8. Which region of the US is your program located? Northeast, Midwest, South, West
9. Which best describes your level of training? 1st year student, 2nd year student, 3rd year student, Doctoral candidate
10. Approximately how many TGNB clients have you worked with clinically?
11. Approximately how many hours of therapy have you provided to TGNB clients?
12. Approximately how many hours of education have you received on TGNB affirmative therapy?
13. Approximately how many workshops have you attended on working with TGNB
- 14.

APPENDIX C

GICCS-R

Statements are rated on a Likert scale from strongly disagree (1) to strongly agree (7).

1. I have received adequate clinical training and supervision to counsel transgender clients.
2. The lifestyle of a transgender client is unnatural or immoral.
3. I check up on my transgender counseling skills by monitoring my function/competency via consultation, supervision, and continuing education.
4. I have experience counseling female-to-male transgender clients.
5. Transgender clients receive “less preferred” forms of counseling treatment than non-transgender clients.
6. At this point in my professional development, I feel competent, skilled, and qualified to counsel transgender client.
7. I have experience counseling transgender couples.
8. I have experience counseling male-to-female transgender clients.
9. I am aware some research indicates that transgender clients are more likely to be diagnosed with mental illnesses than are non-transgender clients.
10. It’s obvious that a relationship involving a transgender person is not as strong or as committed as one involving a non-transgender person.
11. I believe that being highly discreet about their gender identity is a trait that transgender clients should work towards.
12. I have been to in-services, conference sessions, or workshops which focused on transgender issues in counseling.
13. Prejudicial concept and transphobia have permeated the mental health professions.
14. I feel competent to assess the mental health needs of a person who is transgender in a therapeutic setting.

APPENDIX C CONTINUED

Statements are rated on a Likert scale from strongly disagree (1) to strongly agree (7).

15. I believe that transgender couples don't need special rights (domestic partner benefits, or the right to marry) because that would undermine the normal and traditional family values?
16. There are different psychological/social issues impacting transgender men versus transgender women.
17. It would be best if my clients viewed a non-transgender lifestyle as ideal.
18. I have experience counseling non-binary clients.
19. I am aware of institutional barriers that inhibit transgender people from using mental health services.
20. I am aware that counselors frequently impose their values concerning gender identity or expression upon transgender clients.
21. I think my clients should accept some degree of conformity to traditional gender identities.
22. Currently, I do not have the skills to do a presentation or consultation if my clients were transgender.
23. I believe that transgender clients will benefit most from counseling with a non-transgender counselor who endorses conventional values and norms.
24. I have done a counseling role-play as either the client or counselor involving a transgender issue.
25. Personally, I think being transgender is a mental disorder or a sin and can be treated through counseling and spiritual help.
26. I believe that all transgender clients must be discreet about their gender identity or expression around children.
27. When it comes to being transgender, I agree with the statement: "You should love the sinner but hate or condemn the sin."

APPENDIX D

REVISED ATI-S

Statements are rated on a Likert scale from strongly disagree (1) to strongly agree (6).

Coursework Subscale

1. Content related to transgender and non-binary is specifically addressed in each of my clinical courses.
2. I learned about the presence of cisgender bias (i.e., the act of conceptualizing human experiences in cisgender terms, thereby discounting transgender and non-binary experiences) in my clinical training program.
3. I learned about the concept of cisnormativity (i.e., the seemingly natural assumption of cisgender identities that structures institutions and interactions resulting in the erasure of transgender and non-binary experiences and realities).
4. I learned about the concept of cisgender privilege (i.e., the unearned advantages given to cisgender men and women based solely on their gender identity) in my clinical training program.
5. The faculty in my clinical training program encourage students to explore their own cisgender bias (i.e., the act of conceptualizing human experiences in cisgender terms, thereby discounting transgender and non-binary experiences).
6. My program provides students with information on transgender and non-binary affirmative therapy (i.e., an approach to therapy that embraces a positive view of transgender and non-binary individuals and address the negative influences that transphobia and cisnormativity have on the lives of transgender and non-binary clients) through readings, lectures, supervision, etc.

APPENDIX D CONTINUED

Statements are rated on a Likert scale from strongly disagree (1) to strongly agree (6).

Program Subscale

1. The faculty in my clinical program would be supportive of students pursuing research on topics related to transgender and non-binary individuals, couples, and/or families.
2. My program provides students with the opportunity to work with transgender and non-binary clients.
3. My program takes an affirmative (i.e., a positive view on transgender and non-binary identities) stance toward transgender and non-binary individuals.
4. My program would be a safe place for students to disclose their transgender or non-binary gender identities and/or to transition.

Department Subscale

1. The faculty in my department (outside of the clinical faculty) would be supportive of students pursuing research on topics related to transgender and non-binary individuals, couples, and/or families.
2. My department takes an affirmative (i.e., a positive view on transgender and non-binary identities) stance toward transgender and non-binary individuals.
3. My department would be a safe place for students to disclose their transgender or non-binary gender identities and/or to transition.

Open-ended Questions

1. What do you believe are necessary components for training on transgender and non-binary affirmative therapy?
2. What do you believe are barriers for providing training on transgender and non-binary affirmative therapy?
3. What do you believe would be helpful for advancing training on transgender and non-binary affirmative therapy in your program?

APPENDIX E

REVISED ATI-F

Statements are rated on a Likert scale from strongly disagree (1) to strongly agree (6).

Teaching Subscale

1. In my clinical courses, I specifically include content related to the experiences of transgender and non-binary individuals.
2. In my clinical courses, I teach my students about the influence of cisgender biases (i.e., the act of conceptualizing human experiences in cisgender terms, thereby discounting transgender and non-binary experiences) on the therapy process.
3. In my clinical courses, I teach my students about the concept of cisnormativity (i.e., the seemingly natural assumption of cisgender identities that structures institutions and interactions resulting in the erasure of transgender and non-binary experiences and realities).
4. In my clinical courses, I teach my students how to explore the negative influence of cisnormative (i.e., the seemingly natural assumption of cisgender identities that structures institutions and interactions resulting in the erasure of transgender and non-binary experiences and realities) may have on the lives of transgender and non-binary clients.
5. In my clinical courses, I teach my students about the concept of cisgender privilege (i.e., the unearned advantages given to cisgender men and women based solely on their gender identity).
6. I encourage my cisgender students to explore their own cisgender privilege (i.e., the unearned advantages given to cisgender men and women based solely on their gender identity) as part of their self-of-the-clinician work.
7. In my clinical courses, I teach my students about models of transgender and non-binary identity development.
8. In my clinical courses, I teach my students the necessary skills to support transgender and non-binary clients in the disclosure and/or transition process.

APPENDIX E CONTINUED

Statements are rated on a Likert scale from strongly disagree (1) to strongly agree (6).

Teaching Subscale Continued

9. In my clinical courses, I teach my students to work with transgender and non-binary individuals, couples, and families in an affirming manner.
10. In my clinical courses, I teach my students about transgender and non-binary affirmative therapy (i.e., an approach to therapy that embraces a positive view of transgender and non-binary individuals and address the negative influences that transphobia and cisnormativity have on the lives of transgender and non-binary clients) through readings, lectures, supervision, etc.

Program Subscale

1. My training program intentionally recruits transgender and non-binary students.
2. Our program would be a safe place for a transgender or non-binary student to disclose and/or transition.
3. The other faculty in my clinical program take an affirmative (i.e., an approach to therapy that embraces a positive view of transgender and non-binary individuals and address the negative influences that transphobia and cisnormativity have on the lives of transgender and non-binary clients) stance toward transgender and non-binary individuals.
4. My clinical program takes an affirmative (i.e., an approach to therapy that embraces a positive view of transgender and non-binary individuals and address the negative influences that transphobia and cisnormativity have on the lives of transgender and non-binary clients) stance toward transgender and non-binary individuals.
5. My program has specific policies designed to create a transgender and non-binary affirmative environment.

APPENDIX E CONTINUED

Statements are rated on a Likert scale from strongly disagree (1) to strongly agree (6).

Program Subscale Continued

6. Overall, the clinical program in which I teach provides students with information on transgender and non-binary affirmative therapy (i.e., an approach to therapy that embraces a positive view of transgender and non-binary individuals and address the negative influences that transphobia and cisnormativity have on the lives of transgender and non-binary clients) through readings, lectures, supervision, etc.

Faculty Experience Subscale

1. I have supervised student research (e.g., thesis, dissertation) on topics specifically related to transgender and non-binary individuals, couples, and/or families.
2. I have sought out continuing education opportunities to further my own knowledge of transgender and non-binary affirmative therapy and training.
3. I have experience supervising students working with transgender or non-binary clients.
4. I feel competent in my abilities to train students to be affirmative in their clinical work with transgender and non-binary clients.

Department Subscale

1. The faculty in my department (outside of the clinical faculty) would be supportive of students pursuing research on topics related to transgender and non-binary individuals, couples, and/or families.
2. The faculty in my department (outside of the clinical faculty) include content related to the experiences of transgender and non-binary individuals.
3. My department intentionally recruits transgender and non-binary students.
4. My department takes an affirmative (i.e., an approach to therapy that embraces a positive view of transgender and non-binary individuals and address the negative influences that transphobia and cisnormativity have on the lives of transgender and non-binary clients) stance toward transgender and non-binary individuals.

APPENDIX E CONTINUED

Statements are rated on a Likert scale from strongly disagree (1) to strongly agree (6).

Department Subscale Continued

5. My department would be a safe place for students to disclose their transgender or non-binary gender identities and/or to transition.

Open-Ended Question

1. What do you believe are necessary components for training on transgender and non-binary affirmative therapy?
2. What do you believe are barriers for providing training on transgender and non-binary affirmative therapy?
3. What do you believe would be helpful for advancing training on transgender and non-binary affirmative therapy in your program?

APPENDIX F

INTERVIEW PROTOCOL

Interview 1: Professional Development

Review informed consent and introduce myself and my work

Setting the Context – How long have you been in the field? And what have your roles been?

Question: Can you tell me how you became interested in the area of transgender mental health?

Question: What experiences contributed to your growth as a research/scholar/clinician in this area?

Question: Who would you say are your biggest influences in your professional journey? How did they influence you?

Question: What professional turning points did you experience in your career? How have those impacted your work?

Question: How would you describe what motivates your work? How have these changed throughout your career?

Question: How would you describe your contribution(s) to the field?

Question: Please describe the type of legacy you want your work to be.

Interview 2: Experiences in the field

Question: What has been your experience in the field as it relates to your clinical/research work?

Question: What have been sources of support that have enabled you to do your work?

Question: What types of barriers do you encounter within your work?

Question: What professional and personal experiences have you had because your particular experiences?

Question: What do you think about the current state of transgender inclusive therapy practices within the field?

Question: What would you want to stay the same and what would you want to be different?

APPENDIX F CONTNUED

Interview 3: Hopes and recommendations for the future

Question: How do you see the field growing in terms of transgender inclusive practices?

Question: What do you see as already happening the field that invites that future? Could you say more about how that contributes to it?

Question: What do you think is needed to help make this future a possibility? Could you say more about how you think that can be implemented?

Question: What do you see as needed within graduate programs for TGNB students? For cisgender students? For faculty and administrators? For professional organizations? For social and political arenas?

Question Across Interviews

Question: Is there anything you did not have a chance to talk about today that you feel is important for me to be aware of?

APPENDIX G

IRB APPROVAL LETTER FOR PHASE 2



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Human Research Protection Program

EXEMPT DETERMINATION

May 22, 2020

Dear [Elizabeth Wieling](#):

On 5/22/2020, the Human Subjects Office reviewed the following submission:

Title of Study:	Beyond Self-Education: Recommendations from Experts in the Transgender and Non-Binary Affirmative Practice
Investigator:	Elizabeth Wieling
Co-Investigator:	Joshua Boe
IRB ID:	PROJECT00002321
Review Category:	Exempt 2ii

We have determined that the proposed research is Exempt. The research activities may begin 5/22/2020.

Since this study was determined to be exempt, please be aware that not all future modifications will require review by the IRB. For more information please see Appendix C of the Exempt Research Policy (<https://research.uga.edu/docs/policies/compliance/hso/IRB-Exempt-Review.pdf>). As noted in Section C.2., you can simply notify us of modifications that will not require review via the "Add Public Comment" activity.

A progress report will be requested prior to 5/22/2025. Before or within 30 days of the progress report due date, please submit a progress report or study closure request. Submit a progress report by navigating to the active study and selecting Progress Report. The study may be closed by selecting Create Version and choosing Close Study as the submission purpose.

In conducting this study, you are required to follow the requirements listed in the Investigator Manual (HRP-103).