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### **Public Significance Statement**

This paper provides several recommendations for mental health clinicians to adapt their therapeutic approach for affirming services with transgender and gender diverse (TGD) adult clients. The adaptations are accompanied by practical guidance for clinicians about how to work with TGD clients in the therapy room. The recommendations are particularly applicable for clinicians working in geographic locations with limited resources for TGD communities.

Bridging the Gap Between Practice Guidelines and the Therapy Room:  
Community-Derived Practice Adaptations for Psychological Services with Transgender and  
Gender Diverse Adults in the Central United States

A client seeking treatment for depression crosses out male/female and writes *genderqueer* on the intake paperwork. The mental health clinician is familiar with non-binary gender identities but is unsure about whether to ask about it in session and wonders if it is relevant for the cognitive therapy that is their typical intervention for depression. In another office, a client who initially presented as a cisgender man seeking help for stress following the dissolution of a romantic relationship has indicated they would like to explore their gender identity and the gender dysphoria they have experienced for many years. The mental health clinician is immediately worried they might ask for a letter for gender affirmation surgery and wonders if they should let the client know right away that is outside of their scope of practice. Unless a clinician specializes in gender therapy or has had many similar cases, it is unlikely they know how to provide culturally-informed care for these clients. Yet, if they are outside of a large urban center, referral options may be limited. This paper is for the many mental health clinicians who have noticed an increase in similar clients in their practices but find many of the materials on how to provide culturally appropriate care either too general to be useful or based on well-resourced urban areas that do not represent their community.

**Transgender and Gender Diverse Clients and the Need for Psychological Services**

National surveys indicate that individuals who identify as transgender or gender diverse (TGD<sup>1</sup>) are more likely than not to seek psychological services at some point in their lives (James et al., 2016). Reasons for seeking services vary by individual and often reflect the same reasons cisgender people seek services, but two factors probably increase the likelihood of seeking services as well. First, structural oppression resulting in marginalization<sup>2</sup> stress experienced by TGD people (Hendricks & Testa, 2012) increases risk for a variety of mental health problems including anxiety (e.g., Bouman et al., 2017), depression (e.g., Nuttbrock et al., 2010), substance abuse (e.g., Gonzalez et al., 2017), and suicidality (e.g., Goldblum et al., 2012). Second, even when there are no mental health concerns, under current Standards of Care set by the World Professional Association for Transgender Health (WPATH; Coleman et al., 2012), access to services for medical gender affirmation, including surgeries and hormones, may require a

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<sup>1</sup> Individuals may use a variety of labels to describe their gender identity including transgender, non-binary, genderqueer, queer, transgender man, transgender woman, gender non-conforming and many others. For the purposes of this paper, the term *transgender and gender diverse* (TGD) will be used as an umbrella term for everyone whose gender identity does not match the gender/sex they were assigned at birth. Individuals whose gender identity matches their gender/sex assigned at birth will be referred to as *cisgender*. We acknowledge that terminology varies across time and across subgroups in communities and any choice excludes the label used by some people, including some of our research participants.

<sup>2</sup> We use the term *marginalization stress* instead of *minority stress* to properly locate the problem with the experience of marginalization itself, not the marginalized person, as requested by our Local Community Board that guides, advises, and engages in research efforts as part of our community-academic partnership.

psychosocial assessment or mental health evaluation. Despite this high need, few mental health clinicians have received training for working with TGD clients and/or the training they received has been based on outdated models that pathologized TGD identities (e.g., Holt et al., 2020). Not surprisingly, when TGD people seek mental health care, they may be refused care or receive inadequate care (Holt et al., 2020; James et al., 2016).

### **Current Resources for Mental Health Clinicians Serving TGD Clients**

In order to help more mental health clinicians be well-prepared to work with TGD clients, various professional organizations have established TGD-specific practice guidelines. Two prominent sets of guidelines come from the American Psychological Association (APA) and the American Counseling Association (ACA). The APA's *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (APA Guidelines; American Psychological Association, 2015) consist of 16 guidelines across five areas, one of which is Assessment, Therapy, and Intervention. The APA Guidelines provide a succinct summary of research and basic information about TGD people followed by examples of how to apply the information. The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC; 2009) developed the ALGBTIC Competencies for Counseling Transgender Clients published by the ACA. Similar to the APA Guidelines, the ACA competencies are grounded in empirical research whenever possible. There are 11 to 17 specific competencies under each of eight domains (e.g. Human Growth and Development; Social and Cultural Foundations). The ACA document does not review the literature in the same way as the APA Guidelines as the format is a list of specific competencies, many of which reflect summaries of the literature (e.g., the role of marginalization stress on TGD health). Another potential resource for behavioral health clinicians who work with TGD clients is the WPATH Standards of Care (Coleman et al.,

2012). The mental health section of the Standards and related materials (e.g. Fraser, 2009; Lev, 2009) emphasize clinicians' role in gender affirmation care and guidelines for writing letters for hormones or gender affirmation surgeries, with limited guidance for general mental health care. Any general information in the WPATH Standards of Care on behavioral health care with TGD clients is less specific than either the APA Guidelines or the ACA Competencies.

These are strong professional guidelines for behavioral health care for TGD people but the guidelines are often too general to help a Clinician understand what to do moment by moment in a session. Some excellent resources that may aid clinicians including recent books by Chang et al. (2018), Kauth and Shipherd (2018), and Singh and dickey (2017), as well as a clinical article by Puckett and colleagues (Puckett et al., 2018). Additionally, Austin and Craig (2015) were among the first to address TGD behavioral health from a cognitive-behavioral (CBT) perspective. They have developed an affirmative CBT for anxiety and depression for gender diverse adolescents (Austin et al, 2018), with discussion of extending it to adults (Austin et al., 2017).

The published guidelines, competencies, and new books and research are invaluable for clinicians seeking to provide TGD-affirming care. These resources are particularly strengthened by perspectives from TGD-identified clinicians. The nascent nature of this area necessitates recommendations that are grounded in the needs of diverse TGD communities. Especially given the history of marginalization of TGD people by mental health communities (Ciszek et al., 2021; Riggs et al., 2019), it is essential that the voices of TGD individuals are central in identifying what constitutes TGD-affirmative behavioral health care.

### **Bridging the Gap between Practice Guidelines and Real-World Practice**

*The goal of the Trans Collaborations Practice Adaptations for Psychological Services for TGD Adults described here is to inform psychological services, especially psychotherapy, for adult TGD clients through the lens of TGD communities and clinicians in highly underserved regions of the US. Our primary audience is clinicians with less experience working with TGD communities (a large majority of clinicians in underserved areas), but some Practice Adaptations also will help a more experienced clinician adapt to a rural context. The Practice Adaptations are meant to be a data-driven bridge between professional statements such as APA's Guidelines (APA, 2015) and the daily in-session work of mental health clinicians. Most resources emphasize gender affirming-related care and treatment for gender dysphoria. The Practice Adaptations may be helpful for such care but the emphasis is on adapting a clinician's general approach to make interventions more appropriate for TGD clients seeking care for a variety of problems. Given the evidence in the literature (e.g., Mizock & Lundquist, 2016) and our own work (e.g., Meyer et al., 2020) that marginalization within the therapy context is common, we placed particular emphasis on the many ways stigma can be enacted in the therapeutic context. The Practice Adaptations were informed by the voices of TGD people living in the U.S. Central Great Plains with rural and urban environments that differ in terms of available services and cultural context from the urban coastal areas where most research and professional publications originate. Thus, they are meant to be culturally sensitive to these cultures in the middle of the U.S. in particular. However, overlap with other published recommendations suggest they may be universally good practice for psychological services with TGD adults. The Practice Adaptations also were informed by voices of clinicians working in a variety of outpatient mental health settings who understand the nuances and demands of clinical practice.*

### **Community Participation to Inform the Practice Adaptations**

The primary methodology and results for the study underlying the development of the Practice Adaptations are detailed elsewhere (Holt et al., 2020; Meyer et al., 2020; Mocarski et al., 2019) and available on our website ([go.unl.edu/transcollaborations](http://go.unl.edu/transcollaborations)). The Practice Adaptations were developed via data collection and feedback from our Community Board comprised of six TGD individuals, TGD adults in the community, and behavioral health clinicians (e.g., psychologists, social workers, counselors) they identified as TGD-affirmative. Given the intention to develop materials useful to clinicians in non-coastal, underserved areas, all community members and clinicians resided in the Central Great Plains. Our National Advisory Board of scholars from a variety of disciplines provided input on the various drafts. All procedures for the underlying studies to support development of the Practice Adaptations were approved by the Institutional Review Board at the University of Nebraska-Lincoln.

To be as broadly applicable as possible, the Practice Adaptations focus on aspects of psychological services that are common across therapeutic approaches. These so-called *common factors* include the therapeutic alliance, a credible rationale and intervention, and a confidential setting that reinforces the credibility of the clinician and process (e.g. Frank & Frank, 2004; Kazantzis et al., 2017; Wampold, 2015). Although the role of common factors on clinical outcomes has been debated (e.g. Hofmann & Barlow, 2014), there is substantial evidence that these common factors are important in reducing symptoms (Lambert, 2005). Common factors are a necessary, if not always a sufficient part, of successful outcomes (Hofmann & Barlow, 2014; Laska et al., 2014). Given the Practice Adaptations are focused more on commonalities across therapeutic approaches, recommendations to employ a clinician's usual approach is noted at several places where a more specific intervention is indicated. This broad application also

ensures that many clinicians can utilize these Practice Adaptations as opposed to those specializing in a particular approach (e.g., CBT).

### **Trans Collaborations Practice Adaptations for Psychological Services for TGD Adults**

The following 12 Practice Adaptations were drawn directly from the community and clinician interviews and advisory board feedback. A list of the Practice Adaptations are presented in Table 1. Reviews of the relevant literature were considered where available and appropriate, with greater emphasis placed on empirical studies than case reports. Ordering of the Practice Adaptations does not reflect order of importance and the Practice Adaptations are of varying complexity. In certain places the gender identity of clinicians is mentioned explicitly but it should be noted that cisgender and TGD clinicians will use these Practice Adaptations according to how their own identities show up in the therapy room. The Practice Adaptations assume that clinicians have basic knowledge of gender identity and terminology relevant to the experiences of TGD people. Many clinicians do not have this basic knowledge and should seek continuing education training on working with TGD clients and consult relevant scientific literature (Whitman & Han, 2017). This information is available from many sources, including recent books (Kauth & Shipherd, 2018; Singh & dickey, 2017;), and APA guidelines and ACA competencies, so it is not provided here.

#### **Practice Adaptation 1: Setting. *Provide a TGD affirmative public face to services, including the website, office features, paperwork, referral process, and office staff.***

The therapeutic setting (e.g. Frank & Frank, 2004) predominantly refers to the physical space where therapy occurs. However, contact with clients begins before they walk into the therapy office, such as through online materials, calling to set an appointment, and completing

intake materials. The client's progression into the actual therapy office can communicate messages of inclusion or marginalization.

In our interviews and focus groups, the first step in seeking a clinician for many TGD individuals was to seek recommendations from their online or in-person community, if they have one. From there, many potential clients seek online information and described scouring websites for signals a clinician may be competent and affirmative for TGD clients. Elsewhere we have described ways clinicians can signal they are affirmative (Holt et al., 2020). The messages can be subtle if needed. In some rural communities, clinicians we interviewed reported there can be hesitancy to be too explicit in public materials for fear of backlash that impairs their ability to make a living.

Once a TGD individual has selected a clinician for an initial consultation, they encounter the physical space of the therapeutic setting. Cochran and colleagues (2018) and Puckett et al. (2018) provided excellent recommendations for making one's office space and procedures TGD-affirming, many of which are similar to what our participants reported. Community participants in our interviews identified that markers of stigma and lack of support in the waiting room, paperwork, and initial encounters with a clinician or support staff often act as barriers to care or cause stress and anxiety. For example, a binary option for gender on intake paperwork conveys a stigmatizing message, whereas a blank space for specifying gender and the name you wish to be called allows maximum flexibility for a wide variety of gender identities and individual situations (Holt et al., 2019; Puckett et al., 2020). (Another option is to defer discussion of these identity markers until in the privacy of the therapy room.) Stigma can be enacted via interactions with all staff members, necessitating training staff on use of correct names and pronouns and avoiding comments on changes in clients' appearances.

In certain settings, clinicians have less control over the messages conveyed by their setting such as an affiliation with a conservative religious health organization, group practice settings where the clinician is not the owner, or a geographic location where privacy may be limited. For example, one participant described being distressed by visual reminders that their clinician worked within a Catholic health organization and that they would likely terminate care prematurely, despite having positive experiences with that individual clinician. Such situations are compounded in rural spaces where TGD individuals may be bound to clinicians associated with unwelcoming institutions or influenced by non-affirming state and local policies because there are no other options. The onus is on clinicians to help TGD clients negotiate stigmatizing spaces and understand what limitations, if any, the clinician may have in helping them. The clinician should also be taking steps to decrease the sources of stigma within their workplace so that clients can be more affirmed in seeking care.

Insert Table 1 About here

**Practice Adaptation 2: Perceptions of Cultural Messages.** *Explore the meaning of cultural events and messages individually with each client because cisgender people and TGD people may interpret such messages differently.*

Consuming TGD-related media from a variety of sources is helpful for staying up-to-date on terminology and current issues that are important to the community. However, even if cisgender clinicians and their TGD clients hear the same cultural messages about TGD issues and see the same TGD public role models, the perception of those messages and role models may vary. For example, our interviews indicated cisgender clinicians might view TGD celebrities as providing useful role models or having a pro-TGD educational message for society. The messages may be more complex or even negative for a TGD client. Public TGD figures

often have a great deal of privilege to finance their gender affirmation that is not available to (or even desired by) other TGD people. Also, some TGD communities, such as transgender men of color, are rarely represented in the media (Capuzza & Spencer, 2017; Rood et al., 2017).

Furthermore, many TGD media portrayals show TGD people as a form of trans normativity, where the TGD character is upper-middle class, white, post-gender affirmation procedures, heterosexual, and, paradoxically, without sexuality—all while being played by a cisgender actor (Mocarski et al., 2019).

**Practice Adaptation 3: Clinician’s Experience of Gender. *Be aware of the experience of your own gender and how you may automatically enact gender roles that may convey either a marginalizing or an affirmative message to TGD clients.***

At the heart of the therapeutic alliance is a relationship between two human beings, albeit a relationship with different roles and constraints than typical day-to-day interactions (Newhill et al., 2003). However, both the clinician and client bring in perspectives, skills, habits and expectations from their other relationships that have gendered overtones. For cisgender clinicians in particular, heightened awareness of how they automatically enact gender roles based on their perception of the other person’s gender is important. For example, a clinician who is a cisgender man holding the door for a TGD client to precede them into the therapy space is enacting dominant cultural messages about men holding doors. A transgender woman who enacts traditional gender norms may perceive this act as neutral or perhaps affirming. A transgender man may have the opposite reaction. A transgender man may step aside to allow a cisgender woman to enter first, as an act of claiming an expression of their gender identity. The purpose here is not to give guidance on who should enter a room first but to heighten awareness of how we often convey gendered messages automatically. TGD clinicians similarly must be aware of

their experiences of gender given that we are all subject to the internalization of gendered messages and expectations (Butler, 2011).

**Practice Adaptation 4: Comfort with Various Gender Identities/Expressions. *Recognize and be comfortable with variability and fluidity of gender identity and expression that may vary in unpredictable ways over time for a given client. Your role is to support and affirm each individual gender journey, not diagnose their gender identity or impose a particular journey on the client.***

One theme that emerged in our interviews was the importance of clinicians being affirming of, and often even encourage, a client's experience of ambiguity and/or fluidity of their gender identity as well as recognize that no two gender journeys are identical. Through our interviews, it became clear that more experienced clinicians understand that for some clients this self-discovery and exploration of identity terms can be a circuitous process. The gate-keeping role for access to medical gender affirmation services can create a sense the client must "prove" their gender identity to the clinician. Clinicians can address this directly with clients by telling them whatever they say about their gender identity is acceptable and it is not for the clinician to decide what is "right" nor impose standards based on the clinician's own gender identity journey. Sometimes gender identity fluidity may itself be the resolution (e.g. Fiani & Han, 2019). Therapeutic approaches (e.g. many cognitive behavioral therapies) that include setting and monitoring explicit treatment goals can overtly or covertly convey messages that there is a correct choice or a specific timeline, and once a choice is made, it must not be changed. Witnessing and supporting the process without demanding a resolution is experienced as helpful for TGD clients. Thus an intervention for anxiety or depression, for example, can proceed in the context of gender identity fluidity rather than requiring that it be resolved before addressing

presenting problems or expecting the anxiety or depression to remit only when a person experiences no shifts in their gender experience.

Although treatment of gender dysphoria and gender affirmation care are not the primary focus of these Practice Adaptations, clients may seek treatment for a behavioral health or substance abuse problem at the same time they are taking steps on their gender journey. Clinicians who do not specialize in gender affirmation services may have a prototypical view of the process. An important theme across the interviews was that each journey of gender affirmation is unique. Although some clients went to a clinician to see if they qualified for a diagnosis of gender dysphoria, most clinicians described themselves more as a witness and sounding board rather than a diagnostician. The role of clinicians seems to be supporting the self-discovery process rather than directing it. Clinicians can encourage this process by facilitating exploration of emotions and cognitions such as celebrating achievement of desired outcomes around gender affirmation. Clinicians can also help with problem solving and planning (e.g., developing contingencies for handling negative outcomes when coming out to family members). This should be incorporated as needed into an overall treatment plan.

**Practice Adaptation 5: Managing Marginalization. *Recognize the pervasive stigma and marginalization that many TGD people face in large and small ways in their daily lives. Trust the client's perceptions of their experiences as you help the client find appropriate coping responses, drawing on the client's strengths, resilience, and support system.***

Experiences of bias and discrimination are, unfortunately, an inevitable part of a TGD individual's life experience. In both large and small ways from family, friends, strangers, institutions, and cultural messages of cisgender hegemony, TGD people encounter oppression and marginalization (Puckett et al., 2021). This includes experiencing job loss, misgendering,

rejection, public outing, systemic barriers, and verbal and physical aggression (James et al., 2016; Klein & Golub, 2016; Testa et al., 2012), which can be exacerbated for rural TGD communities compared to urban counterparts. Many of the participants in our interviews displayed resiliency when facing these challenges and, for some, learning to manage stress from these adversities was part of their gender journey. Regardless of their own gender identity, clinicians may not immediately see bias when it occurs and must listen carefully to the client's experiences. Then they must balance helping their TGD clients cope with this adversity while checking their own outrage at what occurred. The ability to be angry at unfair treatment can be a privilege not shared by the TGD client who is often trying to cope with the reality in which they live. On the other hand, the client may feel validated and seen knowing that their clinician shares their views on this marginalization. As such, this is nuanced and there is no one-size fits all approach that will work for all clients.

Two aspects of experiences with marginalization tend to be addressed in therapy. First, TGD clients may benefit from interventions to improve coping with the stress of marginalization itself. This could include specific stress management interventions such as relaxation, making life changes to live in a more TGD-affirmative space, and/or seeking online or in-person social support. Second, and perhaps the greater challenge, is disentangling the various aspects of the marginalization experience including the circumstances, other people's motivations and behaviors, and the client's reactions. A common strategy for coping with negative experiences with a cisgender client experiencing anxiety or depression includes exploration of whether their perceptions of the situation may be distorted (e.g. overestimation of the likelihood or cost of negative outcomes; Beck, 2011). As noted by Chapman et al. (2013), such an approach is problematic for experiences of marginalization, especially if the clinician has a majority identity.

Challenging a client's experience of biased treatment or discrimination extends the marginalization into the therapy session by suggesting they do not know what happened to them. For example, a client who is going to a family reunion for the first time after a social transition may be anxious about the reactions of family members and potential disruption of the occasion. The clinician can help the client decide whether it is important to them to attend, whether they can safely attend, and how they will manage any unsupportive or hostile reactions. Another aspect that can be explored is that the TGD client is not responsible for how others react to them. Identifying the true source of the problem (other people or social institutions) is key to empowerment rather than continued marginalization in therapy.

**Practice Adaptation 6: Non-Defensive Stance.** *Take responsibility for minimizing marginalization experiences within the therapy room and be open and non-defensive when you make errors or misunderstand a client.*

Despite best intentions, clinicians are likely to make occasional stigmatizing errors in session such as using the wrong pronoun or wrong name. Interviewees reported that repeated instances of microaggressions (e.g. Nadal et al., 2012) were highly problematic in therapy. An occasional error can be handled within the ongoing work, based on the clinician's own style and case conceptualization of the client. In our interviews, it was clear that the reactions of others are particularly important to clients who are in the midst of an active gender affirmation process and positive reactions can increase self-efficacy and mood. This suggests that how a clinician handles a rupture in the therapeutic alliance (e.g., Safran & Muran, 2000) when they stigmatize a client should include careful consideration of the meaning of the event to the client, as this will be highly variable across time and across clients. When clinicians make mistakes, it is important to acknowledge that these have occurred and make a repair while not monopolizing the space or

launching into extended discussion of the clinician's knowledge, discomfort, or other feelings as this shifts the focus away from the client's care and onto the clinician, which can recapitulate marginalization.

**Practice Adaptation 7: Clinicians Educate Themselves. *Take responsibility for educating yourself about the local cultural context, social and legal climate, and local available services for TGD communities. Be knowledgeable about clinical guidelines, mental health literature, and needs of TGD clients. Clients are not responsible for educating clinicians and deserve the highest quality, culturally responsive services.***

One of the most frequent themes in the interviews with TGD community members was their frustration at having to educate clinicians about what it means to be TGD and the care they need. Participants recount bringing stacks of books or papers to clinicians that may not have ever been read or returned. Clinicians can glean pertinent information on their own from sources such as the ACA Competencies (ALGBTIC, 2009). However, the clinician must also delve into the context in which clients live including TGD resources, affirmative and discriminatory employers, clinicians, and religious communities, availability of appropriate healthcare referrals, relevant local, state, and national legal protections or lack thereof, and the cultures found in the local TGD communities. Both clinicians and community members emphasized that it is preferable for clinicians to be involved in the community by attending public events such as pride celebrations or taking on advocacy roles. On the other hand, joining TGD-related organizations or using events as a marketing opportunity was seen as exploitive by our interviewees. Increased likelihood of encountering clients outside of the office (whether by the clinician being visible in the local TGD community or simply by living in a small town) necessitates an early discussion of the likelihood that could happen and how both parties will

handle it. Furthermore, community involvement by the clinician means that discussion of such activities could become part of the therapy hour. The clinician has the responsibility to maintain a therapeutic focus.

**Practice Adaptation 8: Share Power. *Take responsibility for sharing power with TGD clients as much as possible, especially given the history of marginalization in the healthcare system. Recognize the impact of the gatekeeper role (clinicians providing letters for medical gender affirmation) on exacerbating the power differences that are always part of therapy.***

TGD clients come to mental health services in the context of a system that has historically marginalized TGD people and many clients have had personal negative experiences (e.g. Mizock & Lundquist, 2016). Mental health clinicians' gatekeeper role for access to medical gender affirmation services can exaggerate the power difference inherent in the therapeutic relationship (shuster, 2016). This difference can be heightened in underserved locales with few options for care and increased opportunities for multiple relationships. Even for clients who were not actively seeking a letter, the specter of the gatekeeper role made power differentials between clients and clinicians more salient.

Our data revealed a wide variety of responses about the clinicians serving as evaluators for medical gender affirmation. Some TGD clients experienced the letter requirement as demeaning while other participants were more comfortable with the requirement. TGD clients seeking a letter may resist disclosing doubts about affirming their gender, mental health problems, or other important information because they fear it will prevent them from getting a desired letter. Clinicians in this dual role of evaluator and clinician may or may not be aware of what a client is holding back and this can interfere with care. Awareness of the power differential can help clinicians thoughtfully negotiate it within their own theoretical orientation and style,

just as they would negotiate other dual role relationships (Zur, 2016). For example, in our interviews, many clinicians chose to state up front what their policies were regarding provision of letters which can provide transparency to this process.

**Practice Adaptation 9: Incorporate Gender into Case Conceptualization.** *Include the entire identity and experience of TGD clients in case conceptualization including past, current, and future gender identities and expression, experiences of marginalization, the affirmative or stigmatizing context of their lives (family, work, legal system), gender roles, sexual orientation, gain/loss of gender-related privilege, and intersectionality with other identities (e.g., race/ethnicity, religion, socioeconomic status, age, ability).*

Case conceptualization has been described as the “heart of evidence-based practice” (Bieling & Kuyken, 2003) and a road map to guide treatment (Aston, 2009), integrating relevant scientific findings and theory and the client’s presenting problem, specific characteristics and context through the clinician’s expertise and judgement (APA, 2006). Incorporating gender into the case conceptualization for TGD clients means consideration of their gender, associated gender roles, *and* their status as an oppressed group. Additionally, all of this can change over time if the client is actively engaged in medical or social affirmation of their gender during the course of therapy. Of course, intersectionality means gender is occurring in the context of other sociocultural identities which must be considered within case conceptualization.

The experiences and gender presentations of TGD communities are far too varied to have a generic “transgender, gender diverse” case conceptualization. As a clinician comes to understand a client’s gender at a given point in time, the clinician must also understand the meaning of the gender the client holds, how gender will be enacted (e.g., gender roles), how others are likely to perceive and react to the client’s gender and gendered behaviors, and the

client's experience of those reactions. This is not the entire case conceptualization for most clients but is a crucial context for understanding any presenting problems such as anxiety, depression, or substance abuse, or decisions about gender affirmation. We would argue that while this aspect of case conceptualization may appear more complex for TGD clients due to our default assumptions and experience with a traditional gender binary, a similar process could be used to incorporate a deep understanding of gender in all case conceptualizations.

### *Specifics of TGD Case Conceptualization*

Several aspects of TGD peoples' experiences of gender are especially crucial to consider when formulating a case. First, although a case conceptualization for a cisgender individual may include the experience of marginalization or privilege for women and men (in the context of other identities such as race/ethnicity), marginalization stress for a TGD person warrants special attention as the experience of being a transgender woman, even if one is rarely misgendered, differs from being a cisgender woman for example. Even our research participants who reported rarely being misgendered, described times when their TGD identity became salient or was disclosed. Second, the case conceptualization should incorporate the TGD client's experience of change in their gender, if applicable to them. This could include both positive and negative aspects of their own sense of self and self-identity, positive and negative reactions from others, and the experience of gaining or losing cultural privilege related to perceived gender. Third, written documentation of the case conceptualization should utilize identity terms and descriptors that the client uses themselves to help situate the client's experience and ensure respectful and affirming communication. Fourth, regardless of whether a clinician tends to include the environmental context in their case conceptualizations, inclusion is essential for TGD clients. Consistent with research (e.g., Tebbe & Moradi, 2016), many of our clinicians highlighted the

importance of a good support network and emphasized it in their clinical work with TGD clients. The environment can offer support that helps buffer stressors, or it may create proximal stressors through lack of acceptance, overt threats, or biased treatment. The larger environmental context also affects TGD clients, such as anti-TGD legislation (e.g., Hatzenbuehler & McLaughlin, 2014). An understanding of the client's experience in their environment and extent to which they engage with media messages beyond their direct experience can help inform the case conceptualization. This will allow the clinician to have a better understanding of whether particular cognitive or emotional reactions should best be understood as originating from within the client or as a reaction to environmental context, or a combination of the two.

**Practice Adaptation 10: Identify Focus of Services.** *Recognize that a TGD identity may not be the primary organizing identity for an individual and TGD-related concerns may not be the primary focus of therapy.*

The TGD individuals who participated in our study identified as part of the community to the extent they were willing to participate. However, many also did not see their TGD identity as an organizing part of their daily lives. In the interviews, participants reported feeling stigmatized when clinicians assumed that any psychological or medical problems were associated with being TGD, and sometimes they were unable to access the same care a cisgender individual would receive for similar presenting complaints.

*It is not always about being TGD.* When working with TGD clients, clinicians may assume that the goals of therapy will be related to gender affirmation or gender dysphoria. However, TGD clients seek therapy for anxiety, depression, substance abuse, or a host of other problems for which any person seek services. Identifying as TGD should always be part of the context, but medical or social affirmation and gender dysphoria may not be the focus of

intervention. In fact, gender dysphoria is not always be an appropriate diagnosis for clients living in their affirmed gender without related distress. Case conceptualization can guide treatment selection for the presenting problem and help clinicians identify any needed adaptations for a TGD client. For example, incorporating an understanding of current and past gender identity will add important nuance to a treatment plan that includes a general intervention such as increasing assertiveness skills to improve social relationships as part of a treatment plan for depression.

**Practice Adaptation 11: TGD-Affirmative Referrals.** *Consider the implications of referrals to needed services that may not be TGD-affirming and may exacerbate the problem such as a referral for hospitalization in a non-affirming facility. Problem-solve to get the best possible option, even if it is not a traditional solution.*

Given many TGD clients have a personal or vicarious experience of marginalization in healthcare settings, they may need support to follow through on a referral, even if the new clinician is likely to be affirming. Making referrals for additional services, such as drug and alcohol detoxification or hospitalization for suicidality is a routine part of most clinical practice. Especially in rural settings with few options, these referrals can present additional challenges if there are no TGD-affirming options. Hospitalization for a transgender woman with acute suicidal risk who will be placed in a hospital known to be non-affirming with a male roommate and called by the wrong name can exacerbate the crisis. Clinicians in our interviews described the importance of thinking through the implications of a referral with a client and creatively problem solving to get the best possible option.

**Practice Adaptation 12: Advocacy.** *Be prepared to advocate for TGD clients and plan ahead about how such advocacy fits within the overall approach and case conceptualization for a*

*given client. A clinician and client may decide together that the clinician's privilege that comes from being well educated and/or cisgender can be used to a client's benefit.*

Many of the interviews included descriptions of clinicians as advocates for their TGD clients, in line with previous literature (Hope et al., 2020; Singh & Burnes, 2010). This included making telephone calls, writing letters, identifying support groups, and similar activities. A clinician who calls a physician's office to gauge whether they are TGD-affirming may get greater detail and buffer the client from ignorant or inappropriate responses. Although many clinicians are more accustomed to helping clients learn to advocate for themselves and that may be a long-term therapeutic goal, in our interviews the clinician using privilege they may have (e.g., education, cisgender) to help mitigate the client's marginalization was an important component of advocacy.

### **Discussion and Implications**

There is a growing array of high-quality sources for mental health clinicians who serve TGD communities, including professional guidelines, lists of competencies and rich clinical writing from clinicians with extensive experience. Although some of those sources offer more general guidance (Austin & Craig, 2015; Puckett et al., 2018; Richmond, et al., 2017), much of it is focused on treating gender dysphoria and social, medical, and legal gender affirmation. In contrast, the Practice Adaptations are meant to be appropriate for TGD people seeking care for a variety of presenting problems. Using the lens of TGD communities and clinicians in rural and underserved locales, the purpose of these Practice Adaptations is to fill a gap between current resources and what happens with specific clients in the therapy room in a concise document. The Practice Adaptations focus mostly on common factors or more general aspects of psychological interventions to be most broadly applicable. A key strength of these Practice Adaptations is that

they evolved from an iterative research process (Holt et al., 2020; Meyer et al., 2020) involving TGD community voices, community mental health clinicians, and academic scholars from a variety of disciplines.

Although culturally adapted approaches improve outcomes in other minority groups (e.g., Griner & Smith, 2006), there is little information about the efficacy of psychosocial interventions, culturally adapted or not, for TGD clients. Other than interventions focused on HIV risk (e.g., Garofalo et al., 2016), there is a paucity of affirming research on clinical interventions with TGD adults (Budge & Moradi, 2018; Budge et al., 2020). Evidence-based information on how to adapt the most effective psychological interventions to meet the needs of TGD communities can spur clinical trials to identify best practices and help reduce mental health disparities. We envision these Practice Adaptations would allow a clinical scientist to reformulate a particular treatment protocol for a disorder or group of disorders to make it TGD-affirmative and then test the efficacy of the resulting protocol with TGD participants. We are currently undertaking such an effort.

### **Limitations**

Several limitations to the Practice Adaptations should be noted. First, the Practice Adaptations are limited by the sources of data from which they are drawn. We purposefully collected data from TGD communities in the Central Great Plains as the experiences of these TGD communities are underrepresented in the research and clinical literature. It is possible additional Practice Adaptations might have emerged if the data were collected in a different part of the U.S. or in a different health system. However, overlap with clinical recommendations such as those found in Kauth and Shipherd (2018), Puckett et al. (2018), and Singh and dickey (2017) suggest the Practice Adaptations are more broadly applicable. Second, all of our community

participants were adults and interviews with clinicians focused on care for adults. It is unknown whether the adaptations are appropriate for behavioral health care for children and youth. There are other excellent resources on evidence-based interventions for adolescents (e.g., Austin & Craig, 2015). Finally, the Practice Adaptations do not stand on their own. We assumed that clinicians would have background on TGD communities including resiliency, marginalization stress, HIV risk and other health disparities, aspects of social, legal, and medical gender affirmation, and the local context. This knowledge is crucial for TGD affirmative services and represents basic competency. This knowledge also will continue to evolve, necessitating clinicians engage in continuing education and life-long learning about issues impacting TGD communities. The focus of the Practice Adaptations is to bridge the gap between that background and psychological services from the perspective of TGD clients in underserved areas, especially for interventions for general mental health concerns.

### **Conclusion**

Professional understanding of what constitutes high quality health care for individuals who identify as TGD has evolved substantially since the first Harry Benjamin Standards of Care in 1979. Similarly, the TGD communities have changed as more people have access to the knowledge and language to recognize themselves as having a gender that differs from the sex they were assigned at birth and there is increased visibility of TGD experiences. However, structural oppression and resulting mental health disparities remain pervasive. Reducing barriers to behavioral health care means that serving TGD clients must move from a highly specialized service available only in resource-rich areas to the scope of practice for the average clinician. Eventually, this work must be supported by clinical research that identifies how to provide the

most effective care, which, by definition, also must be affirming. These Practice Adaptations will help achieve those dual goals.

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