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2-1-2015

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Accepted version. *Professional Psychology: Research and Practice*, Vol. 46, No. 1 (February 2015): 30-36. DOI. © 2019 American Psychological Association. Used with permission.

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# Piloting a Psychotherapy Group for Transgender Clients: Description and Clinical Considerations for Practitioners

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## Acknowledgement

Nicholas C. Heck received his MA in clinical psychology from The University of Montana and is currently a predoctoral intern at the Charleston Consortium Clinical Psychology Internship Program. Following the completion of his doctoral degree at The University of Montana in July 2013, Nicholas will begin a two-year postdoctoral fellowship at the Warren Alpert Medical School of Brown University. His areas of professional and research interests include LGBT mental health and the prevention of health risk behaviors among LGBT youth.

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We thank Drs. Bryan Cochran, Duncan Campbell, and David Schuldberg for their helpful comments on an earlier version of this article.

## Abstract

The likelihood that a psychologist will work with a transgender client is greater today than ever before; however, many psychologists report being unfamiliar with the challenges faced by this population. Training programs provide minimal exposure to transgender issues by way of coursework and practicum experiences, and many barriers prevent transgender persons from accessing quality mental health care. The provision of group psychotherapy services in psychology training clinics may help reduce barriers to treatment, but there is little literature to guide professionals interested in facilitating such a group. In response, this article provides psychologists with a description of an experiential/process psychotherapy group for transgender clients that was offered at a university training clinic. Logistical aspects of forming the group are reviewed. Prominent themes that emerged over the course of three 12-session groups are discussed. Considerations for other professionals and training clinics interested in offering similar groups are also provided.

## Keywords

transgender, psychotherapy, group therapy, competence

## Introduction

The term "transgender" refers to people who express gender variance in relation to society's dichotomous, male-or-female conceptualization of gender; this may include people who identify as cross-dressers, drag queens/kings, female-to-male transsexuals, male-to-female transsexuals, masculine women/feminine men, and people who are born with ambiguous genitalia or physical sex characteristics of both males and females ([Lev, 2004](#)). Transgender persons commonly experience workplace discrimination (Herbst et al., 2007) and interpersonal violence (Herbst et al., 2007; [Kenagy, 2005](#); [Lombardi, Wilchins, Priesing, & Malouf, 2001](#); [Mizock & Lewis, 2008](#)). When compared with men who have sex with men, women who have sex with women, gay men, and heterosexual men and women, transgender persons report elevated rates of suicidality ([Bockting, Huang, Ding, Robinson, & Rosser, 2005](#); [Mathy, 2002](#)). Transgender persons also evidence elevated rates of depression relative to the general population and men who have sex with men ([Bockting et al., 2005](#); [Clements-Nolle, Marx, Guzman, & Katz, 2001](#)). Such elevations are associated with experiencing discrimination ([Pitts, Couch, Mulcare, Croy, & Mitchell, 2009](#)) and violence ([Testa et al., 2012](#)), and although research suggests that family and school supports can reduce these risks, many transgender people lack social support and experience isolation ([Greytak, Kosciw, & Boesen, 2013](#); [Heck, Flentje, & Cochran, 2011](#); Herbst et al., 2007; [Ryan, Russell, Huebner, Diaz, & Sanchez, 2010](#)).

Although transgender people are becoming more visible in today's society, many mental health training programs are unlikely to provide the coursework and experiences necessary for students to develop competence in this area. The American Psychological Association (APA) Task Force on Gender Identity and Gender Variance concluded, "[M]any psychologists and students of psychology currently receive little or no exposure to transgender issues in their education and training" ([APA, 2009a](#), p. 62). In their survey of APA

members and psychology graduate students, the Task Force found that more than one third of respondents had worked with transgender clients, colleagues, or students, but only one quarter believed that they were “sufficiently familiar” with transgender issues. Thus, many practicing psychologists may not feel comfortable or competent to work with transgender clients, suggesting a clear and growing need to train clinicians to provide affirmative mental health services for this population.

## Mental Health Care and Transgender Clients

Even though many transgender individuals are motivated to engage in psychotherapy ([Bockting, Knudson, & Goldberg, 2006](#)), several barriers exist that make it difficult for them to receive adequate mental health care. For example, an estimated 49.9% of transgender persons are without health insurance, and many transgender people report difficulty finding an affirmative therapist or denial of services due to their gender identity (Herbst et al., 2007). In addition, because it is recommended that qualified mental health professionals provide transgender persons with a referral letter for hormone therapies and surgical procedures ([World Professional Association for Transgender Health, 2011](#)), some transgender clients may be reluctant to share feelings of distress with their therapists for fear that they will be denied this letter.

Many excellent resources exist to help mental health professionals work with transgender clients (e.g., [Bieschke, Perez, & DeBord, 2007](#); [Bockting et al., 2006](#); [Brill & Pepper, 2008](#); [Israel & Tarver, 1997](#); [Lev, 2004](#)), yet the process of facilitating psychotherapy groups for this population has been discussed only minimally. Several authors have suggested that group psychotherapy could be a beneficial and cost-effective form of mental health care for transgender people ([de Vries, Cohen-Kettenis, Delemarre-Van de Waal, Holman, & Goldberg, 2006](#); [Sánchez & Vilain, 2009](#)), perhaps resulting from the creation of a safe environment or access to role models ([Hunter, 2007](#); [Walker & Prince, 2010](#)). However, process and outcome research involving group therapy and transgender clients has yet to be conducted ([Dickey & Loewy, 2010](#)), possibly due to a paucity of professionals facilitating, or competent to facilitate, such therapy groups and a dearth of scholarly work in this area.

[Israel and Tarver \(1997\)](#) offered basic pointers for facilitating a transgender support group, which included a brief discussion of recruitment, confidentiality, appropriate behavior, and meeting structure. The Association of Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) specified competencies for group work with transgender clients ([ALGBTIC, 2009](#)). [Singh and Burnes \(2010\)](#) discussed the integration of the competencies into clinical practice from a social justice perspective where counselors act as supporters and advocates of transgender clients, as opposed to “gatekeepers” for medical treatment. Finally, [Dickey and Loewy \(2010\)](#) provided a historical overview of group work with transgender clients and identified specific considerations in relation to group composition, facilitator competencies, group format, and group type (e.g., support, skills training, educational, and process groups). Although these contributions are important, little literature about the process of conducting psychotherapy groups with transgender clients can be found. To fill this void, the following sections provide a description of a transgender-specific, psychotherapy group that was hosted for three semesters at a university training clinic.

## Transgender Therapy Group: Description

A time-limited (12 meetings), closed (i.e., no new members could be added until a 12-meeting session had ended), 90-min, weekly psychotherapy group cofacilitated by two clinical psychology trainees and supervised by the Clinic Director was provided over the course of three semesters. An experiential/process framework ([Yalom & Leszcz, 2005](#)) was selected that used interventions from feminist, cognitive-behavioral, interpersonal, and emotion-focused modalities, depending on the challenges or topics brought to the group by individual members. Each 12-week session followed a general framework whereby the initial sessions emphasized the development of goals and group cohesion, the intermediate sections emphasized “here-and-now” interpersonal process and progress toward group members’ goals, and the final sessions focused on termination, solidifying gains, and planning for the future.

## Recruitment of Group Members

Flyers were posted on campus, in student on- and off-campus housing, and around the local community. Information about the group was provided to the University's lesbian, gay, bisexual, and transgender (LGBT) student group and discussed on student radio during a LGBT-specific program. Announcements for the group were posted on the local LGBT community center's website and advertised on Craigslist.org in the "groups" section. Letters were also mailed to local mental health professionals to encourage referrals. As a result of these efforts, more than 25 individuals contacted the clinic to inquire about the group, and 18 individuals, all of whom identified as Caucasian, met with the two cofacilitators for an initial assessment and consultation meeting.

At the time of the initial meeting, seven individuals were between the ages of 18 and 25, three were between 26 and 35, two were between 36 and 45, and six were older than 45. With respect to education, six individuals were high school graduates, six had completed some college coursework, and six were college graduates. Ten individuals were unemployed, two were employed full-time, five were employed part-time, and one was retired. Ten individuals were single, five were dating or in a relationship, and three were married or in a domestic partnership. The sex assigned at birth for three individuals was female, with the remaining assigned as males. Eight individuals were referred by community therapists, four inquired about the group after seeing fliers or advertisements, three inquired after finding information online, and three learned about the group from a friend. Ten individuals were not involved in concurrent individual therapy at the time of the initial meeting.

## Initial Assessment and Consultation Meeting

Initial assessment and consultation meetings can increase group cohesiveness because they allow group facilitators to select group members based on intermember characteristics that result in a "balanced" group (see [Locke, 1961](#)). [Dickey and Loewy \(2010\)](#) recommend balancing the number of male-to-female and female-to-male group members, while acknowledging that this may not be possible in rural areas. Such meetings can also promote motivation to join the group, faith in the process of group therapy, later group cohesiveness, retention of group members, client satisfaction, and group success ([Burlingame, McClendon, & Alonso, 2011](#); [Goldstein, Heller, & Sechrest, 1966](#); [Yalom & Leszcz, 2005](#)).

For the purposes of the transgender therapy groups, the facilitators met with each potential group member for an initial assessment and consultation meeting. Prior to the meeting, each potential group member completed LGBT-affirmative clinic intake forms (see [Heck, Flentje & Cochran, 2013](#)) including a consent form. The facilitators provided basic information about the group and assessed challenges that might preclude or compromise participation in the group (e.g., cognitive impairments, disruptive Axis II pathology, psychosis). When such challenges were present, the facilitators collected additional information, obtained a release of information and consulted with the potential group member's individual therapist (when applicable), received clinical supervision, and scheduled a follow-up appointment. In the absence of such challenges, the initial appointment was used to prepare potential group members for a successful group experience by encouraging each individual to develop goals and examine personal strengths and weaknesses in relation to working in groups.

Although the majority of potential group members would likely have benefited from the group, a minority ( $n = 5$ ) were not good candidates at the time of the initial assessment because of significant cognitive or social skills deficits or high levels of suicidality and emotional dysregulation. Others ( $n = 2$ ) were unable to commit to regular attendance because of geographical (e.g., living in excess of 50 miles from the clinic) and work-related (e.g., having an unpredictable work schedule) constraints. In such instances, the facilitators used the follow-up appointment to discuss the possibility of joining the group in the future and to provide information about resources (e.g., referrals to a transgender support group, referrals to community therapists, and Internet-based resources). Potential members who reported ongoing suicidal ideation (without intent) and/or self-injurious behavior were provisionally accepted into the group, with acceptance contingent on concurrent participation in individual psychotherapy. In such cases, the facilitators connected the individual with a program affiliate who

agreed to provide services on a sliding scale (if necessary). The facilitators obtained releases of information, allowing them to consult with the individual therapists, and on 2–3 occasions over the course of 12 weeks, consultation occurred to ensure that the group member(s) were attending individual sessions. The facilitators also consulted with the individual therapists of members whose participation in the group was not contingent on concurrent individual therapy on an as needed basis.

### Composition of the Groups

The first 12-meeting group commenced in February 2009 with seven (two female-to-male and five male-to-female) members. The group members varied in terms of their gender expression, with some presenting as the gender opposite their birth sex, and others being more androgynous or ambiguous. Two male-to-female members from the first group and three new male-to-female members comprised the second group, which began in September 2009. The remaining members of the first group relocated, prior to the start of the second group. There was no attrition from the first two groups.

In February 2010, the five members of the second group decided to participate in the third group, and one male-to-female member was added at that time. Two members left the third group, one due to physical health concerns and the other due to inconsistent attendance resulting from increasing school/work obligations. Relative to the first group, there was less variability in gender expression among members of the second and third groups, as all members consistently presented as the gender opposite of their sex assigned at birth. The smaller groups may have helped promote a sense of safety within the group and trust among the members. Thus, the smaller size, greater homogeneity, and carry-over from the second to third group may have resulted in greater cohesion among the members of the latter two groups. Finally, the decision to participate in more than one 12-week session was made by each individual group member.

### Characteristics of the Group Facilitators

A biological male and a biological female, both of whom were Caucasian and neither of whom identified as transgender, cofacilitated the therapy groups. The [ALGBTIC \(2009\)](#) *Competencies for Counseling with Transgender Clients* indicate that facilitators should “be aware of how their own gender identities, beliefs about gender, and lack of knowledge about transgender issues may affect group processes” (p. 12). Such awareness was facilitated in supervision, where the facilitators’ beliefs about gender could be examined and challenged by their supervisor. Facilitator awareness was also increased by asking the group members to consider how the gender of the facilitators impacted member–facilitator relationships. The topic of male privilege was broached in relation to feelings of connection with the facilitators and also as a way to acknowledge members’ losses or gains of male privilege. Some group members reported feeling more connected to the female facilitator as a result of her gender and more nurturing therapeutic style. The same group members noted that their feelings of connection with the male facilitator increased over time as they came to recognize that he could empathize with and validate their experiences.

The nontransgender statuses of the facilitators were also mentioned by some group members as a factor that made talking about sexual behavior (e.g., masturbation; anal, oral and vaginal sex) more difficult. For some, talking about sex in the presence of the facilitators was akin to talking about sex with one’s parents; for others the concern was again related to the idea that because the facilitators were not transgender, they could not understand a member’s unique experiences. In these instances, the facilitators reframed the concern back to the group; members were asked to share their thoughts about whether nontransgender people in general and the facilitators in particular could empathize with and understand their experiences.

## Initial Sessions of the Group

Group cohesion is vital to the success of a group and a key predictor of client outcome ([Yalom & Leszcz, 2005](#)). During the initial sessions, the facilitators worked to foster cohesion by providing structure, encouraging self-disclosure, and promoting safety within the group.

### Identifying Treatment Goals

Discussion of members' goals in the initial sessions appeared helpful for several reasons. First, it ensured that all group members had identified goals toward which they were working. Second, it helped some group members to see that others shared similar goals. Third, knowing each other's goals helped group members to encourage and hold each other accountable for working toward those goals, which appeared to promote cohesiveness within the group.

Although some group members' therapy goals were similar (e.g., to reduce social isolation), other individual therapy goals seemed to reflect an interaction between participants' gender identity development and their current life circumstances. For example, group members who had only recently acknowledged their transgender identities set goals of hearing about the experiences of others, working through a history of denying feelings related to being transgender, and developing a more solid sense of gender identity. In addition, many wanted to discuss strategies for navigating the coming out process with friends and family members. As noted by [Lev \(2004\)](#), the process of coming out is lifelong, and compared with a lesbian, gay, or bisexual person who comes out in relation to assumptions of heterosexuality, transgender people come out in relation to assumptions of concordance between the sex one is assigned at birth and one's gender identity.

Group members in the process of transitioning or those who were physically and psychologically in the process of moving from one gender identity to the other ([Lev, 2004](#)) had diverse goals. These included but were not limited to "passing," selecting a new name, making changes to legal documents, building self-confidence, and managing and expressing emotions in a healthy manner—especially emotional reactions due to changes in hormones or decisions to come out to family, friends, and employers. Some group members who were transitioning later in life (i.e., after having married and having had children) wanted to grieve significant losses related to family relationships and status, while concurrently embracing their true selves.

Group members who had previously transitioned sometimes had goals of learning to trust and love other people, improving sexual health, and continuing to develop an authentic sense of self. Some posttransition group members entered the group to provide mentorship and support for other transgender people. Given the idiographic nature of the transgender identity development process, the curative factors central to an experiential/process framework (e.g., altruism, catharsis, direct advice, interpersonal learning, universality) assisted group members as they worked to achieve their goals, regardless of what those goals were.

### Emphasizing Confidentiality

In the initial group session, the group members reviewed and signed a group confidentiality statement. Although confidentiality is essential to any therapeutic endeavor, emphasizing confidentiality was particularly important in this case because some of the group members were not out (i.e., they were early in the process of developing their identities, they lived in unsafe or unaccepting environments, or they had not told other people in their lives about being transgender). Some group members who had previously transitioned were also concerned about confidentiality because they could now "pass" and did not want others to know their transgender histories.

## Acknowledging Subgrouping

Reducing or eliminating subgrouping in group therapy is especially important when conflicting goals of reducing social isolation and maintaining confidentiality naturally coexist (Yalom & Leszcz, 2005). This is complicated by the fact that transgender individuals often experience social isolation (Bockting et al., 2005; Herbst et al., 2007), and intentional or unintentional socialization could reduce such isolation. The facilitators acknowledged the problematic group dynamics that can result from subgrouping and emphasized the time-limited nature of the group and the importance of discussing outside-of-group encounters within the group. Group members discussed incidental encounters that occurred outside the group, and requests to protect confidentiality and minimize subgrouping appeared to be honored.

## Establishing Trust

Throughout the early sessions, the facilitators emphasized the notion of trust. As the group members became more comfortable in the group, they began to take more risks and to reveal increasingly private information about themselves, their perceptions of each other, and their perceptions of the facilitators. Questions were posed to group members about how much trust they had in the group and in the facilitators, how their level of trust could be increased, and which aspects of the group made it difficult for them to trust each other (and perhaps other people in their lives). When dialogue drifted toward intellectually stimulating but less personal topics (e.g., intellectualized discussions of gender representations in society), the facilitators would often reframe the discussion to emphasize trust and safety. In turn, this promoted cohesion by helping the members share their challenges and experiences.

## Disarming the Pressure to Conform

Within the early sessions, it appeared that prior transition experiences, preconceived notions about transitioning, and conceptualizations of gender often influenced how members related to one another. Even within the transgender community, pressures to conform to viewing gender as a dichotomous construct can exist, and pressures within the group related to transitioning and the use of hormones became evident. Some of the group members viewed gender in a traditional dichotomous manner and saw transitioning and “passing” as a member of the opposite sex as an important end-goal for all transgender people. Other group members (typically those in the 18–25-year-old age bracket) viewed gender more on a continuum and felt comfortable ending their transitions with hormones or alterations that would allow for multiple or ambiguous gender presentations. Manageable conflict between members with opposing views on this topic was sometimes evident in the group. In those moments, the facilitators asked the group members to examine the origins of their beliefs and explored why opposing views could feel threatening in the “here-and-now.” This exploration appeared to promote cohesiveness by helping group members consider and respect alternative viewpoints and by reducing pressure to view gender or transitioning in a uniform manner.

## Intermediate Sessions of the Group

As the groups progressed, there tended to be greater cohesion and an increase in the level of trust. Not surprisingly, these signs of group maturity typically corresponded with deeper disclosures by group members about their experiences and about their relationships with friends, family, each other, and the facilitators. Although many themes arose during the course of the groups (e.g., gender norms in society, sexuality and sexual health, sexual orientation, personal safety, “dressing” and “passing,” discrimination, hate crimes, internalized transphobia, gender identity-related insecurities, and thoughts and feelings toward the group facilitators), two themes appeared to dominate the group members’ self-disclosures: coming out and transitioning.



## Coming Out

In discussions related to coming out, group members often expressed fears of rejection and abandonment (both emotional and financial), desires to express their true selves, and a felt need to suppress emotions in order to protect important relationships. In particular, group members frequently talked about experiences with family members who were unsupportive or conflicted and their sense that they needed to justify their transgender identities or suppress negative emotions in order to maintain these relationships. In response to such disclosures, the facilitators focused on members' emotional experiences during those poignant, sometimes invalidating or even frightening interactions. The safety of the group often gave members permission to experience and express feelings of grief, anger, and disappointment more fully.

Sometimes role-plays were used to help group members practice coming out. Group members were able to observe how subtle changes in verbal and body language might reduce conflict, disarm defensiveness, and/or deepen a connection. Role-plays also appeared helpful for group members who were struggling to balance their needs to justify their transgender identity and their reactions to being criticized or invalidated by an important person or persons in their lives.

## Transitioning

Transitioning (e.g., experimenting with gender expression, using hormones, seeking surgery) was by far the most frequently discussed topic in the groups. Pretransition group members expressed discomfort with their bodies or acknowledged feeling that something was biologically "incorrect," but they varied in terms of how much they had thought about or acted on their desires for change. Consequently, members frequently explored important and sometimes anxiety-provoking, transition-related questions in the group (e.g., "Should I transition?" "When should I start the transition process?" "To what extent should I transition?" "If I do decide to transition, should I relocate first or remain here?"). Not infrequently, one or more group members made comments similar to "a person just 'knows' whether transitioning is right for them," or "transitioning in another place helps you to 'leave the past behind.'" In these instances, the facilitators discussed what "knowing" might feel like, suggested that not all transgender individuals experience transition in the same way and challenged them to think not only about taking the initial steps toward transitioning, but also about where they wanted their transition to lead further into the future. Broaching these topics was intimidating for the facilitators, because they did not want to appear antitransition. At the same time, the facilitators wanted to help group members consider whether transitioning (at all, at this time, in this place, and/or at what speed) was best for them.

To facilitate these discussions, the facilitators sometimes talked about caring for the group members, wanting what was best for them, and fearing rejection if they were perceived to be invalidating. Such self-disclosure appeared to solidify connections and sometimes prompted other group members to share previously unexpressed concerns. For some group members, these difficult discussions appeared to help them think through their plans to transition at a deeper level—to slow down, build a greater support system, and/or otherwise develop more fully a plan of action that would lead to a more solidified sense of gender identity. For other group members, similar discussions prompted action that led them to take the next step(s) in their transitions.

## Termination

As termination approached, the facilitators emphasized larger patterns and changes that had taken place over the previous weeks. Group members reflected on their initial goals, the progress that they had made, and on future goals. During the final weeks of the group, two observed tendencies warrant specific attention: (1) the tendency of some group members to make accelerated progress toward their goals, and (2) the tendency of some group members to avoid discussion or expression of emotions related to termination.

## Progress Toward Therapy Goals

Some group members began to make serious efforts to change aspects of their lives or to make significant decisions, perhaps in the growing awareness that the group would be ending. For example, several group members began to attend group sessions dressed in the clothing of the gender with which they identified. Others postponed decisions related to transitioning and/or coming out until additional social and financial resources could be secured. Notably, some group members seemed to exert more pressure on other members to self-disclose and to make more concrete decisions (e.g., about coming out or transitioning). In these instances, the facilitators worked to keep the group timeline distinct from individual members' timelines for achieving their goals, by reminding group members that major life decisions are often not made in 12 weeks and pointing out that it might be irresponsible (though well-intentioned) to encourage premature decision making by other members of the group.

## Avoiding termination

Group members often wished to avoid the reality of termination, either by avoiding discussion of the topic or by assuming that saying "goodbye" was unnecessary because the group would run again. The facilitators felt it was particularly important for group members to share their experiences of and feelings toward each other and the group, given that many of them had never before had a safe space to explore and express feelings about being transgender. Both group members and the facilitators acknowledged wishes for the group not to end. Group members were also encouraged to reflect on the importance of the group and the contributions that they and others had made and to provide each other and the facilitators with feedback, to reduce the risk of unfinished business. Such feedback seemed to strengthen connections between group members and between the group members and the facilitators.

## Training Clinics and Description of Training Model

The transgender therapy group just described took place in a university training clinic for doctoral-level clinical and school psychology students. Such venues are particularly well suited for group work with transgender clients. First, most training clinics offer low-fee services, making them more affordable for persons with limited resources. Second, training clinics often are situated on university campuses, which may make it easier to recruit group participants, especially those who are younger and perhaps more willing to seek mental health services. Third, training clinics are attentive to issues of competence and diversity, and they can provide in-service and training workshops around transgender issues, exposing students to information that they might not encounter elsewhere in their coursework. Fourth, such clinics usually have audio or video recording capacity and one-way mirrors that can enhance supervision, supervisors' skills, therapists' skills, and a range of therapy techniques. Fifth, these training tools can also be utilized by junior clinicians, with the permission of clients, to observe group process and notice their own affective reactions to material without the pressure to respond therapeutically. Finally, training clinics provide therapists with regular supervision, helping both therapists and supervisors to examine closely their practice, biases, privileges, and blind spots.

For other psychology clinics or mental health professionals interested in offering a transgender therapy group, the following sections describe the steps that were taken to promote competence in the facilitators and emotional safety within the clinic.

## Supervision

The [ALGBTIC \(2009\) \*Competencies for Counseling with Transgender Clients\*](#) explicitly state that those who run groups for transgender clients should seek "consultation and supervision with mental health professionals who are competent and have more experience working with transgender issues" (p. 12). If attempts to locate local supervision or consultation fail, a next step might involve searching the websites of professional mental health organizations, which allow visitors to search for a provider based on areas of expertise. For example, the APA website (<http://locator.apa.org>) allows visitors to search for psychologists who work with clients with gender

identity-related concerns. Next, divisions or associations within professional mental health organizations may provide members with access to useful resources. For example, mental health professionals seeking consultation or supervision services can access listservs, such as the one hosted by APA's Division 44 (Society for Lesbian, Gay, Bisexual, and Transgender Issues), to locate services. Finally, college and university faculty members may be able to provide information regarding community supervision or consultation resources. The *2009 Graduate Faculty in Psychology Interested in Lesbian, Gay, Bisexual and Transgender Issues Survey* ([APA, 2009b](#)) results provide information about college and university faculty members who are involved in LGBT issues, either through teaching, research, or training.

## Facilitator and Practice Environment Preparation

A number of books, articles, and films are available to help mental health professionals who wish to learn more about the experiences and concerns of transgender populations. [Whether preparing for outreach activities or group facilitation, mental health professionals may want to consult with transgender individuals in their communities to discuss those individuals' experiences and to identify challenges that transgender people face at the local level. In addition, facilitators should consult with mental health professionals and organizations that work with transgender clients in their communities to take advantage of their expertise and experience. Facilitators should consider developing a list of resources and services available for transgender individuals within their communities \(e.g., for trans-positive medical providers, voice coaching, electrolysis, beauticians/stylists, local support groups, and transgender advocacy organizations\), so that informed referrals and recommendations can be made. Resource lists might also contain information related to the processes for changing identification cards and birth certificates \(Dickey & Loewy, 2010\) or local businesses \(e.g., grocery stores, property management companies, restaurants\) that are transgender-affirming.](#)

Facilitators should also make efforts to ensure that their clinic environment is safe for transgender clients. Posting transgender-friendly materials within the practice environment can demonstrate that transgender clients are welcome and respected. When possible, facilitators may want to convert male/female bathrooms into unisex bathrooms, to provide clients with comfortable and safe places to dress before and after group meetings. Assessment, intake, and practice paperwork should be reviewed to ensure that these documents are affirming of LGBT people ([Heck et al., 2013](#)). Importantly, none of these factors will make transgender clients feel safe unless they are also treated with respect. Facilitators should consider hosting an in-service training on transgender issues for the staff (including administrative assistants, psychotherapists, trainees, and other staff members) to increase understanding, awareness, and acceptance at an institutional level ([Singh & Burnes, 2010](#)). Finally, facilitators should solicit feedback from group members regarding their feelings of safety and comfort within the practice environment.

## Summary

Early writings devoted to the topic of group psychotherapy relied heavily on anecdotal reports and case histories ([Goldstein et al., 1966](#)). This led researchers to conduct empirical investigations that would eventually demonstrate the general effectiveness of the group modality ([Stockton, 2010](#)). Currently, few, if any, detailed descriptions of transgender-specific psychotherapy groups exist in the clinical literature. We hope that this overview prompts psychotherapy researchers to investigate how to best meet the mental health needs of transgender clients. To carry out such investigations, research is needed to adapt and validate existing psychotherapy process and outcome measures for use with transgender clients. New measures that assess outcomes unique to transgender clients (i.e., a measure to assess identity development and integration, see [Lev, 2004](#)) should also be developed.

We also encourage practicing psychologists to consider whether the mental health needs of transgender persons are being met in their communities. Some psychologists, especially those practicing in rural areas, may think that recruiting enough transgender clients to run a viable psychotherapy group would be too difficult. Our

recommendations for skeptical clinicians would be to consult with transgender individuals or groups in the community and with other local mental health professionals to determine whether a need for such services or variations on such services (e.g., a group for parents of transgender children), might exist.

In closing, we acknowledge the absence of ethnic/racial diversity among the group members, facilitators, and supervisor. This clearly limits the degree to which our impressions and observations will ring true for psychologists working with clients who identify as both transgender and racial/ethnic minorities. In addition, formal evaluation of the transgender therapy group described herein was not conducted, and thus we make no claims regarding the effectiveness of the intervention. Clearly, research and scholarly discourse regarding the adaptation and implementation of mental health services for transgender individuals are necessary if, as a profession, we hope to demonstrate empirically that group psychotherapy is an effective method for reducing psychological distress and promoting transgender emergence.

## Footnotes

<sup>1</sup> Entries in the reference list that are marked with an asterisk indicate training materials that were used to prepare the facilitators to work with transgender clients.

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