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Avoiding unhelpful statements: A proposed theoretical measure of readiness to work with transgender clients

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AVOIDING UNHELPFUL RESPONSES: A PROPOSED THEORETICAL MEASURE OF READINESS TO WORK WITH TRANSGENDER CLIENTS

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ABSTRACT

AVOIDING UNHELPFUL STATEMENTS: A PROPOSED THEORETICAL MEASURE OF READINESS TO WORK WITH TRANSGENDER CLIENTS

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When transgender people most need help, many face hostility and inadequate care from their health providers, including psychologists. This hostility is not surprising given widespread lack of familiarity with transgender issues or perspectives amongst clinicians. Even amongst those who hold the stance of *openness to the other*, most still have considerable difficulty working with transgender clients. Transgender training efforts vary in quality; some even appear to worsen attitudes towards transgender clients. Given these risks, it is crucial that clinical training directors and supervisors evaluate trainees' abilities to facilitate respectful initial conversations with transgender clients. This project proposed an objective instrument for assessing a mental health clinician, or clinical trainee's ability to discriminate between helpful and unhelpful responses commonly made in the initial clinical encounters with transgender clients. Development of the instrument is grounded in a combination of theoretical and empirical literature on the topic and is synthesized with the personal and professional experiences of the primary researcher as a transgender person and emerging clinician. This study utilized systematic expert review to examine the validity of this proposed instrument. This dissertation is available in open access at AURA, http://aura.antioch.edu/ and Ohio Link ETD Center, https://etd.ohiolink.edu/etd

Keywords: transgender, clinical training, multicultural competency, test development

Dedication

This dissertation is dedicated to all who desire to work with transgender clients in a beneficial and non-injurious way, and to the teachers making this possible. This dissertation is also dedicated to those brave enough to speak up on transgender issues—especially when doing so is uncomfortable.

Special thanks to the scholars in my life for teaching me how to undertake this work, and to the rebels in my life for showing me why it is worth it. Thanks also to all who are brave enough to show up for accountability moments with grace.

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Thanks to Dr. Dana Waters for many hours carefully reading this project. The timeliness of your feedback made it possible for me to maintain momentum throughout the course of this project. Without it, I would have been ABD for certain.

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Thanks to my family for supporting me in this process. Special thanks to my love Carissa West for giving me many, many cups of coffee and being very patient on the many weekends and evenings I worked on this project. Thanks to my grandfather for giving me a chemistry lecture instead of being a normal babysitter when I was 8. This was one of many family interactions that helped launch my interest and capacity for science. Thanks also to the found family who listened to me talk my way out of my head and back onto paper.

On the first class of the first year of this program, Dr. Jude Berkgamp addressed the "ghosts in the room"—the people not currently present who have brought us to where we are. Special thanks to the ghosts.

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CHAPTER I: INTRODUCTION

The inspiration for this project came as a result of personal and professional experiences as a transgender person and emerging clinician respectively. My perspective has been shaped by the stories of others in my community, as well as my own experiences as a transgender client. As a clinician in training, I am learning the language of a profession that has done both great good and great harm to people like me. This professional language is gradually becoming my own. As a result of this positioning, it is my duty to use my privilege as a clinician to improve how transgender clients are treated.

My first foray into the field of mental health was working for crisis line that received many calls from transgender individuals. Many of the volunteers were motivated to do the best they could to help. Many had personal experiences of marginalization. All had received at least some transgender-specific training and supervision. Despite this, some had difficulty establishing and maintaining rapport with transgender individuals.

As a trainer at this crisis line, I struggled to find the right material to help volunteers learn how to work with transgender callers. Trainees often struggled with distinctions between terms like *transgender*, *transsexual,* and *transvestite.* I could provide definitions, but trainees and volunteers still struggled to apply this information in conversation. This occurred even when trainees were relatively knowledgeable of transgender issues. On several separate occasions, I have overheard counselors repeating definitions to transgender clients, seemingly in an attempt to appear accepting.

My initial response was to mentally catalog these and other common mistakes to address them preemptively with new volunteers during training. However, this approach seemed to frustrate incoming volunteers. Overwhelmed by a flood of information, they appeared to become

hopeless about their ability to ever get it "right." They often fared little better than those who had received a more cursory introduction to transgender issues.

My focus then shifted to trying to establish some sense of *good enough* trans-specific clinical skills. In my mind, this involved two dimensions: (a) the ability to avoid making a mistake so bad that recovery would be next to impossible and (b) the ability to learn from the mistakes that do happen. Though simple in theory, this too proved challenging to implement. Some volunteers appeared oblivious to critical errors. Some made relatively minor mistakes only to make more critical errors in their attempts to repair trust. It was often difficult to predict which volunteers would acquire the necessary skills and which would not.

As a transgender person, it was uncomfortable to hear volunteers make mistakes. I have seen volunteers use dehumanizing language to describe transgender clients, both directly and in case notes. I have also observed volunteers wrap up conversations by *misgendering* the client (for example, with statements like, "You seem like a nice guy," when the client was a transgender woman). To hear these mistakes as a transgender person meant I could often vividly imagine how the client might have felt. However, I was also struck by the knowledge that these struggling volunteers were likely receiving more transgender education than would the vast majority of clinical professionals.

Though it was often difficult to hear their mistakes, I felt for the volunteers. Many were motivated to help others because of their own experiences of shame, stigma, and oppression. Learning often involved a painful period where awareness grew faster than other skills. I stand in awe of the grace these volunteers showed during the learning process. This project is offered in the spirit of service to all who are willing to learn, all who are willing to teach, and to their future transgender clients.

Overview

In the Review of Literature, the current state of transgender mental and physical healthcare is reviewed from a national public health perspective. In addition, the historical context of transgender healthcare has been included. This chapter also reviews several approaches to the assessment of multicultural competency in counseling as it applies to transgender care. Transgender narratives and training applications have been woven throughout, with the goal of providing a vivid picture of how specific mistakes in the provision of transgender care negatively impact transgender clients.

The methods chapter describes the overarching methodology for the instrument's development and provides details on the first two stages of test development, now completed. The test development process began with a pilot study to create the test construct, format, and first iteration. This was followed by a two-step process of review and revision to establish feasibility of the proposed test and begin content validation. Ultimately several iterative evaluations will be necessary to confirm whether instrument content, administration materials, and scoring standards are congruent with intended interpretation. Future work has been planned to further refine and validate the test and supplemental materials for use in clinical training.

Terminology

Much of the terminology used in this project may be unfamiliar or confusing. Even the widely-used acronym "LGBT" (lesbian, gay, bisexual, transgender) has had several different versions and interpretations. This is partially because many terms commonly used in transgender communities have only come into use recently (Serano, 2014). Though transgender identities are widely believed to have existed since ancient times by a myriad of names, many of these names have fallen out of use as a result of the passage of time and the impact of colonialization

(Najmabadi, 2005; Nanda, 1999; Roscoe, 2016; Singh et al., 2014). Colonizers have suppressed much of the gender diversity of our world or have used it as part of broader efforts to dominate, civilize, and exploit other peoples (Roscoe, 2016). Present-day gender assumptions in the United States are inherently bound with this history of imperialism (Driskill, 2010; Lugones, 2007; Najmabadi, 2005; Nanda, 1999; Shanks & Jackson, 2017).

Transgender terminology has also changed as a result of discursive oppression (Kukla, 2014), meaning that as oppressive groups gain access to transgender terms, their use of these terms can gradually lead to negative connotation and distortion from the original meaning. As a result, the search for "preferred" terms has no true end. It is vital to both adopt language in response to this process and to remember that improved language does not in itself solve the problem of oppression (Serano, 2014).

This section reviews several of the contemporarily preferred terms critical to this project. The definitions and terms presented in this work are not exclusive and may be amenable to many different interpretations. This is not to suggest that any term not included in this document is inappropriate or unimportant. Rather, these terms have been omitted to create a document that is both accessible to clinicians and respectful of prevailing transgender concepts, values, and identities.

Gender Binary

The term *gender binary* is a concept popularized by transgender activists in the 1990s to explain gender-based oppression (Serano, 2016b). The concept states that all people in our culture are socially coerced into presenting themselves as either a man or a woman, based on the sex assigned at birth. In contemporary United States culture, parents often presume a great deal about their child's future personality and interests based on the outward appearance of their

genitals (Lindgren, 2010; Paoletti, 2012; Stern & Karraker, 1989). People who do not fit neatly into one of these binary categories, or who fail to adhere to such gender norms, are typically marginalized in modern American society (Serano, 2016b). This marginalization is pervasive and often invisible (Fine, 2010; Stern & Karraker, 1989). As a result, many incorrectly assume the gender binary is natural.

Nonbinary

Many transgender people do not identify exclusively as a man or a woman. They may identify as genderqueer, gender-fluid, or two-spirit; moreover, they may have some other identity, multiple identities, or may have no gender identity at all. The term *nonbinary*, like the term transgender, is an umbrella term, comprising a wide variety of gender identities. In this case, nonbinary refers to all gender identities that fall outside of the gender binary. Many nonbinary individuals use they, them, and theirs as singular pronouns, though many other pronouns are also used. Some nonbinary individuals may also use conventional binary pronouns, such as he, him, and his or she, her, and hers (Darr & Kibby, 2016; Galupo, Pulice-Farrow, & Ramirez, 2017).

Transgender

The term *transgender* can be broadly taken to describe anyone whose gender identity is different from what many conventionally expect based on their assigned sex at birth (GLAAD, 2017; Serano, 2016a, 2016b; Trans Student Educational Resource, 2017). For instance, those who identify as *transgender women* are usually women who were assigned male or intersex at birth, and *transgender men* are usually men who were assigned female or intersex at birth. For this dissertation, the term transgender should be assumed to include nonbinary individuals.

It is important to note the term transgender applies whether or not someone seeks, or has sought, medical transition. Those who do seek medical transition occasionally prefer the term *transsexual*, though others now consider this term inappropriate and offensive (GLAAD, 2017; Trans Student Educational Resource, 2017). At times, some within the transgender spectrum might opt for other terms, or may even consider themselves post-transition (American Psychological Association, 2015).

Cisgender

Cisgender merely means someone who is not transgender, and who, presumably, identifies with the gender assigned at birth. To illustrate, women who were assigned female at birth are usually cisgender, and men who were assigned male at birth are also usually cisgender. By contrast, a person identifying as a woman, who was assigned male at birth, would not be considered cisgender.

The prefix *cis-* is not a slur against those who are not transgender, though this is a common misconception (GLAAD, 2017; Serano, 2016a, 2016b; Trans Student Educational Resource, 2017). The term is widely considered to have been coined by transgender author Julia Serano and is the preferred way to describe non-transgender people (GLAAD, 2017; Trans Student Educational Resource, 2017; Serano, 2016a, 2016b). Cis is a term framed by the use of the Latin prefix cis-, the opposite of the prefix trans- (Traupman, 2007, p. 98). Terms like *normal*, *biological*, or *real* are not recommended, as the use of these terms implies that transgender identities are abnormal, unnatural, or imaginary (GLAAD, 2017; Serano, 2016a, 2016b).

Cissexism

Cissexism refers to the assumption that cisgender identities are more normal, valid, or healthy than transgender ones. As with sexism, these assumptions are pervasive in United States

culture and often hidden. Cissexism is also associated with systematic oppression (Serano, 2016a; Testa et al., 2017). Many consider cissexism and transphobia to be synonymous, though cissexism is currently more broadly used because anti-transgender oppression involves more than just the concept of fear indicated by the root –phobia (Serano, 2009). A similar term, *transmisogyny*, refers to cissexism against transgender women. Most examples of cissexism are better captured by this term, as attitudes against transgender women are more pervasive than negative attitudes against transgender men (Serano, 2009).

Gender Dysphoria

Gender dysphoria refers to both the psychiatric disorder (previously known as Gender Identity Disorder) and the feeling of incongruence between an individual's gender identity and their body, gender presentation, or the way their gender is perceived by others (American Psychiatric Association, 2013; Serano, 2016b). Gender dysphoria is described in a variety of ways (Karlan, 2016; Micah, 2012), though many descriptions focus on a felt sense of intense emotional and physical discomfort with one's body. It should be noted that gender dysphoria is distinct from negative body image, though the two can occasionally co-occur (Coleman et al., 2012; Dentata, 2012; Edwards-Leeper & Spack, 2012; Finch, 2017). Some individuals under the transgender umbrella do not experience or are not bothered by gender dysphoria (Bockting, Knudson, & Goldberg, 2006; Lanepatriquin, 2014).

Medical Transition

Medical transition includes a wide variety of gender-affirming interventions for alleviating dysphoria (Coleman et al., 2012). Not all transgender people need or desire medical transition, but it is an essential aspect of transgender healthcare for many. As a medical practice, it also affects how clinicians often first come to understand transgender individuals. Hormone therapy and gender-affirming surgeries are often of chief focus for clinicians. In most cases,

transgender people seeking gender-confirming hormone therapy or gender-confirming surgeries are required to go through a process of assessment with a mental health professional (Coleman et al., 2012). In other cases, transgender people may access medical transition via an informed consent model. By this model, transgender people are permitted access to hormones and occasionally surgery if they can demonstrate they (a) understand the risks and benefits of the procedures they seek and (b) have autonomy and agency sufficient to consent (Informed Consent Access to Transgender Health, 2017; see also Cruz, 2014). Both models have merit and are periodically updated in response to emerging research or cultural changes.

Surgeries

Many transgender people seek a variety of gender affirming surgeries to alleviate gender dysphoria. Historically, these procedures have been referred to as *sexual reassignment surgery* (SRS) and *sex change*. Alternative terms, such as *gender-confirming surgery* or *gender-affirming surgery* have gradually increased in use, and are currently more broadly accepted (GLAAD, 2017; Serano, 2016b). Other commonly used terms, including *bottom surgery* or *lower surgery* (describing a variety of genital surgeries) and *top surgery* (describing a variety of chest surgeries), are often used and broadly accepted (Serano, 2016b). A transgender person might have multiple surgeries or might have none. This diversity of surgical options is one of the reasons why common questions such as, “Have you had *the* surgery?” or “Have you completed the sex change?” are often received poorly by transgender clients (GLAAD, 2017; D. Johnson, 2014). Such questions often imply an assumption that a person’s gender is incomplete unless their body has been surgically changed. These questions also suggest such a change can be completed all at once. Such assumptions may be interpreted as unfamiliarity with transgender issues, as opposed to overt hostility (Bauer et al., 2009; D. Johnson, 2014).

Gatekeeping

Gatekeeping is how many in transgender communities describe the powerful position clinicians hold with regard to access to medical transition (Serano, 2016b). Transgender people often refer to clinicians in this position as gatekeepers (Serano, 2016b; Singh & Burnes, 2010). Clinical training centers use the term gatekeeping in another way, often describing the process of preventing unfit clinical trainees from becoming licensed clinicians (Erickson & Shultz, 1982).

Passing and Passability

Passing refers to the degree to which others consistently perceive a transgender person as the gender with which they identify (Serano, 2016a, 2016b). In other words, a person passes when their gender is read correctly by most people they meet. A person passes when their identity aligns with how they are automatically perceived by others. Transgender communities adopted the term from the concept of *passing as white* used in ethnic studies (Serano, 2016b). Transgender people with high *passability* often do not have to remind others to use their preferred pronouns because those around them do so automatically based on prior expectations and the gestalt of their appearance. A transgender person who is passing may conditionally access the privileges associated with being cisgender while also experiencing invisible marginalization based on transgender identity (Serano, 2016b).

The necessary qualities of passing vary depending on the person and their immediate context; the same person might pass in some situations and not in others. For example, height may be less noticeable in contexts where wider ranges of height are common. Awareness that transgender people might be present can prompt others to scan more vigilantly for signs of difference. This can lead groups of transgender people to be more conspicuous. These contextual

cues may lead some cisgender people to be incorrectly read as transgender (Bond, 2016). A transgender person may also pass inconsistently for unknown reasons.

Transgender people who pass may choose not to disclose that they are transgender for safety reasons, or just as a matter of preference. However, passing is not always a goal of transgender people (Bolin, 1994; Waist, 2017). If very few people in their life are aware they are transgender, such a person may use the word *stealth* to describe themselves, though this term has picked up some negative connotations over time (Serano, 2016b).

Purpose of the Study

This project concerns the development an objective instrument for assessing a mental health clinician or clinical trainee's ability to discriminate between helpful and unhelpful responses in clinical conversations with transgender clients. This is necessary because many transgender people face hostility and inadequate care from their health providers. Very little is currently done to evaluate the efficacy of transgender training efforts, or preparedness before trainees work with transgender clients. This adds avoidable distress for both the trainees and the transgender clients who work with them. Early identification and intervention with these trainees would make it possible to protect transgender clients from harm, and could help supervisors intervene more effectively with trainees. These points are covered in more depth in Chapter II.

CHAPTER II: REVIEW OF LITERATURE

Respectful clinical work with transgender clients involves finesse and skill. As with many other aspects of clinical training, these skills emerge through a combination of didactic training and supervised experience over time. Though an individual clinician's first few encounters may be imperfect, they can often grow from early mistakes provided they make use of supervision. The difficulty is that at some levels of skill, clinicians and clinical trainees are at risk of harming transgender clients, even with the support of a supervisor (D. Johnson, 2014; Mikalson, Pardo, & Green, 2012; Xavier et al., 2013). Some common mistakes are so disruptive the client may avoid necessary treatment far into the future (James et al., 2016).

These problems are concerning given that transgender people represent an already vulnerable population. Like many marginalized special populations, transgender people experience health disparities, including higher rates of depression, suicidality, disability, and general poorer physical health compared to those who are not transgender (Fredriksen-Goldsen et al., 2014; Haas, Rodgers, & Herman, 2014; Xavier et al., 2013). These disparities are thought to have multiple interrelated causes, such as lack of access to safe housing, education, and employment. All of these factors have an interrelated impact on the health of a community and its denizens (Nelson & Prilleltensky, 2010). Experiences of minority stress also negatively impact transgender health (Bauer et al., 2009). As a group, transgender individuals experience external stressors such as discrimination, rejection, and even violence targeting their identity (Testa, Habarth, Peta, Balsam, & Bockting, 2015; Testa et al., 2017). Subsequent internalization and anticipation of these stressors accelerates the experience of stress, negatively impacting health (Testa et al., 2015; Testa et al., 2017). Although these aspects of transgender health are important, the behavior of clinicians is the focus here.

This chapter presents an introduction to the literature concerned with defining and identifying the minimum skills necessary to conducting respectful clinical conversations with transgender clients. The importance of transgender-specific skills will be covered first, beginning with an exploration of how transgender patients are impacted by insensitive or inexperienced clinicians. This section is followed by a discussion of the social and historical context of transgender healthcare in the United States, and the mutual distrust between transgender communities and healthcare professionals, as described by gender identity historians. This critical analysis is essential to understanding how present-day tensions and legal conditions have influenced the provision of transgender healthcare in the United States.

The most common problematic comments and behaviors in the provision of transgender care are also reviewed. These unhelpful responses include exotification, denial of bodily privacy, denial of transphobia, and more. This section uses qualitative accounts of both transgender clients and clinicians to illustrate how these statements commonly manifest.

Training efforts are also discussed, with an emphasis on the importance of having both clear training goals and evaluation methods that complement these goals. This focus on evaluation is important because previous literature on this topic has often made vague recommendations for increased education or awareness and few to no recommendations for evaluation (Lev, 2006; Moll et al., 2014). As a result of these vague recommendations, training efforts vary greatly in quality. First, this section reviews the common ways in which training efforts can backfire, rendering clinicians either more defensive or misinformed than they were prior to training. This section also reviews important aspects of emotional reactance to evaluation and remediation efforts. An additional section explores how physicians and psychologists currently define transgender care.

Current approaches to skill measurement are discussed next, beginning with an overview of broad multicultural competency measures and ending with current transgender-related measures. This section will explain why current evaluation methods are insufficient. The final section summarizes the points covered thus far and introduces test development methodologies as they apply to the current study.

Importance of Transgender-Specific Skills

Transgender Population Sees Clinicians as Inexperienced and Hostile

Many in transgender people describe clinicians as unhelpful, inexperienced, and even hostile. Such is the case for access to both routine and transition-related care. Two large surveys of transgender experiences in the United States demonstrate the scope of this problem: the *National Transgender Discrimination Survey* (Haas et al., 2014) and the *National Center for Transgender Equality 2015 US Transgender Survey* (James et al., 2016). Although the first of these studies involved 6,456 self-identified transgender people in the United States, the second was much more extensive, involving over 27,000 transgender participants. Both studies found widespread reports of hostility from medical professionals. In the larger of the two studies (James et al., 2016), 33% of transgender respondents reported recently having a negative experience with a doctor or medical provider. Transgender participants reported that their clinicians asked invasive and unnecessary questions about being transgender (15%) and some denied transition-related healthcare outright (8%).

These widespread problems are not surprising since most healthcare providers appear to lack a basic understanding of transgender terminology or identities, let alone transgender-specific health concerns (Rondahl, 2009). This lack of awareness means transgender patients can expect most of their providers will be unfamiliar with transgender issues. Also, providers are likely to misunderstand the terms transgender patients use. Clear communication is especially important

in the provision of psychotherapy. Unfortunately, very few psychologists report familiarity with transgender issues (American Psychological Association Task Force on Gender Identity and Gender Variance, 2009).

These findings echo those of smaller regional studies, such as the *Virginia Transgender Health Initiative Study*, a multi-year project to elucidate the social service needs of transgender Virginians (Bradford, Reisner, Honnold, & Xavier, 2013; Xavier et al., 2013). This study examined the prevalence of perceived transgender-related discrimination in healthcare, employment, and housing. The study also investigated the barriers transgender Virginians commonly experienced when accessing healthcare. Approximately 20% of participants reported having to educate their primary care provider about their health needs. More than 25% reported not being able to access transgender-specific care (including counseling) in the past year. Those who described themselves as *out* to their providers (meaning they were open about being transgender) reported higher rates of discrimination and refusal of care. Researchers concluded discrimination was not only widespread, but also often the result of a combination of individual and systemic problems.

The pervasiveness of this problem is concerning as it suggests transgender individuals are currently receiving inadequate care on a vast scale. Even when transgender individuals have some positive healthcare encounters, the overall picture that emerges is relatively poor. As a result, transgender individuals often come to expect their healthcare providers will be unfamiliar with transgender health issues and may even be hostile towards patient-led attempts at education.

Impact on Transgender Clients

Avoidance of necessary care. The combination of inexperience mixed with the risk of hostility means many transgender people expect their clinician may cause them harm, even when

seeking care for reasons unrelated to being transgender. This negative expectation leads many transgender people to avoid necessary medical care. James et al. (2016) found approximately 23% of respondents reported recently avoiding seeing a doctor because of anticipated mistreatment. At times, transgender people avoid even emergency care (Bauer Scheim, Deutsch, & Massarella, 2014).

This chronic avoidance of care is unsurprising given that researchers have also observed medical mistrust with other marginalized groups (Bonvicini & Perlin, 2002; Hammond, Matthews, Mohottige, Agyemang, & Corbie-Smith, 2010; López-Cevallos, Harvey, & Warren, 2014; Thorburn, Kue, Keon, & Lo, 2012). This pattern of avoidance can have cascading consequences for marginalized populations. With avoidance often comes lower rates of preventative screenings, lower rates of treatment for routine illnesses, and higher rates of serious medical problems across the lifespan.

Lack of access, despite effort. Some clients cope with the expectation of mistreatment by seeking providers who have experience with transgender clients. However, this is often a difficult task. Hagen and Galupo (2014) found transgender people spend a great deal of time searching for affirming and competent providers. Despite this effort, it appears only 6% of transgender people successfully find a primary care provider they consider "very knowledgeable" (James et al., 2016). Barriers to care can also be identified in the hidden nature of transgender-specific services. As a result of stigma against this population, many aspects of transition-related care operate *behind the counter*—meaning there exists no centralized resource advertising what treatment options are available, or where to find them (B. Morgan, personal communication, July 2017). This means that transition-related care is often inaccessible unless transgender patients are lucky enough to ask for it in a specific place, and in a specific way.

These preferred ways of asking are often provider-specific; what works well with one provider may not for the next. While some provider-specific health information is shared via transgender social networks, these resources are typically both local and ephemeral. It is not uncommon for an experienced provider to retire soon after becoming well-known within transgender communities. This process makes it difficult for individual transgender clients to find the supportive providers who do exist.

Fear during clinical encounters. Even positive encounters with healthcare professionals appear to be marked by the anticipation of mistreatment. This was the finding in a phenomenological study of transgender healthcare by Applegarth and Nuttall (2016). Initial sessions were described as a "fearful time," during which it was critical for the client that the clinician affirmed their identity (Applegarth & Nuttall, 2016, p. 69). Unfortunately, clients also reported feeling as if they had to convince clinicians that their identity was genuine (as opposed to a fantasy or deliberate deception). If they failed to convince providers that their identity was genuine, participants reported being treated by providers with suspicion. Unsurprisingly, transgender clients are expected to be highly vigilant of rejection during visits with a new provider.

Experiences of rejection have medical consequences beyond emotional discomfort. For example, some researchers have directly linked experiences of rejection with increases in unhealthy practices such as the injection of street hormones or silicone (Grossman & D'Augelli, 2006; Hughto, Reisner, & Pachankis, 2015; Sevelius, 2013). By contrast, when clients are made to feel welcome and affirmed, we see improved medical compliance and utilization of preventative care (Hagen & Galupo, 2014; Sevelius, Deutsch, & Grant, 2016).

There are two crucial points to take from these studies. First, it is important to note how pervasive fear could negatively impact clinical conversations. While mistakes may seem minor to cisgender audiences, to a fearful transgender client, they are warning signs of impending rejection. This is because, from the patient's perspective, the mistakes portend additional significant mistakes to follow. Second, it is important to address the extent of emotional labor transgender clients endure to access care (Morris & Feldman, 1996). Transgender patients enter clinical conversations experiencing great fear and yet must put aside this fear to educate their providers. This is no easy task. As explored previously, these efforts to provide education can occasionally precipitate overt hostility towards transgender patients (Bradford et al., 2013; Xavier et al., 2013).

Bias negatively impacts the quality of clinical care. Bias is more than just unpleasant for those it targets; it also negatively impacts the quality and effectiveness of clinical work. In addition to the emotional impact on transgender clients, the presence of bias against transgender patients can also negatively impact how clinicians work with this population.

The problem of bias in clinical work is not new. Numerous studies have demonstrated the negative impact of bias on the provision of medical and mental healthcare. For example, Van Ryan (2002) and Van Ryan and Burke (2000) found evidence of racial bias amongst physicians and several other types of medical professionals. Analysis of audiotapes of medical visits revealed physicians were less patient-centered and more generally aggressive with African American patients (R.L. Johnson, Roter, Powe, & Cooper, 2004). Additionally, several studies have found evidence that bias against overweight patients negatively impacted both diagnosis and the overall provision of care (FitzGerald & Hurst, 2017; Schulman et al., 1999; Swift, Hanlon, El-Redy, Puhl, & Glazebrook, 2013; Tobin et al., 1987). Bias leads clinicians to listen

less carefully, verbally dominate conversations, jump to conclusions, and generally rush through sensitive clinical encounters (Cooper et al., 2003; Cooper et al., 2012; Phelan et al., 2015; Tobin et al., 1987). In many instances, clinicians do not appear aware of these patterns of differential treatment (Hanssmann, Morrison, & Russian, 2008; Whitman & Han, 2017).

Bias can also impact the provision of transgender care indirectly, such as via *informational erasure*—the omission of population-specific information due to the presumption that such information is unimportant (Bauer et al., 2009). Just as it is often inappropriate to assume research about and by men would apply to women, it is often inappropriate to assume research about and by cisgender individuals would apply to transgender individuals. Since healthcare research often presumes all research participants are cisgender, transgender experiences and issues become invisible to clinical training programs. This means that even well-meaning clinicians enter the field both under-equipped to provide appropriate care to this population and often unaware of the information they are missing. A Boston study found many providers treating unrelated health issues had difficulty doing so with transgender patients because of a lack of basic knowledge about transgender identity (Sperber, Landers, & Lawrence, 2005).

Anti-LGBT bias persists amongst clinicians. Many mistakenly assume the problem of anti-transgender bias in healthcare will improve on its own if transgender communities are patient. However, analysis of a related problem, homophobia in healthcare, suggests this is not the case. Though progress has been made, homophobia persists in the healthcare industry (Batza, 2016). For example, in 2004, approximately half of Austrian medical students surveyed by Arnold, Voracek, Musalec, and Springer-Kremser (2004) did not know whether homosexuality was “officially classified as a disease” or not (Rondahl, 2009, p. 2). Similar studies have also

found evidence of homophobia amongst physicians in the United States (Kelly, 1992; Klamen, Grossman, & Kopacz, 1999; Lee, Kelz, Dubé, & Morris, 2014). These clinicians appear uncomfortable with gay, lesbian, and bisexual patients, and give substandard care as a result (Bonvicini & Perlin, 2002).

What is even more troubling is, despite this evidence of bias, many clinicians also reportedly assert that they are prepared to work with lesbian, gay, and bisexual patients (Rondahl, 2009). Clinicians may perceive that the problems of homophobia and transphobia have been resolved when, in fact, there is much to be done (Bartlett, King, & Phillips, 2001). Though it may be comforting to believe such problems will be resolved as a result of natural progress over time, this is a dangerous assumption (Foucault, 1978; Shelton, Richeson, Salvatore, & Trawalter, 2005). As will be explored in the subsequent discussion of the Social and Historical Context of Transgender Healthcare, progress is a complicated business and rarely follows a linear path.

Experience of bias causes psychological harm. Since the societal rejection of transgender people is pervasive (Grant et al., 2011; Mikalson et al., 2012; Xavier et al., 2013) it should come as no surprise that bias also negatively impacts the provision of transgender healthcare. As previously described, transgender patients describe experiencing intense fear before medical appointments, often delaying necessary care as a result (Applegarth & Nuttall, 2016; Grant et al., 2011; Haas et al., 2014; James et al., 2016). However, in addition to subsequent avoidance of medical care, rejection from clinicians also directly causes psychological harm. As has been demonstrated in several large studies (Haas et al., 2014; Testa et al., 2017), the suicide risk is higher for transgender people who have been rejected from public service settings.

It is unclear why rejection from public service settings carries such high risk. However, the answer may lie in the nature of healthcare as a public service. Unlike many other professions, healthcare is an essential service, provided for the betterment of the public as a whole (BEA Virtual Working Group on Restrictions Affecting Diversity Training in Graduate Education, 2015). When transgender people are rejected from such services, it communicates to them that they cannot fully participate in the public sphere. Because of this, rejection from healthcare providers carries considerable social weight. When clinicians reject transgender patients, it sends the message that transgender people do not belong in public in the same way as others. Since thwarted belongingness has been established as a significant risk factor for suicide (Van Orden et al., 2010), this may explain why rejection from healthcare professionals is so hazardous.

Benefits of Affirmative Care

Affirmative care is protective. While rejecting care carries significant risk, respectful and affirming care can have a profoundly positive effect on transgender health (Korell & Lorah, 2007). When health practitioners demonstrate knowledgeableness of transgender issues and acceptance of transgender identity, transgender patients report feeling immense relief (Benson, 2013). More broadly, transgender social acceptance has been demonstrated to predict greater self-esteem, social support, and general health (Ryan, Russell, Huebner, Diaz, & Sanchez, 2010; Witten & Eyler, 2012). Affirming support also appears to be a protective factor against depression, substance abuse, and suicide (Ryan et al., 2010). Transgender patients who experience affirmative care are likely to utilize preventative services and follow their provider's recommendations, thus providing an additional protective element (Hughto et al., 2015). Such non-adversarial care is also anticipated to help improve the quality of communication in clinical

encounters. As the next section will explain, this is critical to addressing the specific health needs of transgender patients.

Specific Health Concerns of Transgender Individuals

Transgender people have several specific health concerns including, but not limited to, medical transition. This is one reason why clinician inexperience is problematic. Not only does this inexperience lead to unhelpful and even disrespectful communication, but it also leaves clinicians unprepared to address the specific health needs unique to the transgender community. A few examples will be provided to illustrate, but should not be considered comprehensive.

Medical transition. Though not all transgender people desire or seek medical transition, it is one of the most sensitive and important aspects of transgender care. For those who seek medical transition, timely access to these services is critical (Ainsworth & Spiegel, 2010; De Cuypere et al., 2006; Murad et al., 2010). Medical transition appears to be the most effective treatment for gender dysphoria, often increasing both personal comfort and social functioning (Ainsworth & Spiegel, 2010; De Cuypere et al., 2006; Murad et al., 2010). After accessing medical transition, many transgender people have daily functioning and quality of life similar to the general population (Ainsworth & Spiegel, 2010; James et al., 2016). This is a powerful result given that 39% of transgender people report being in serious psychological distress, and that rates of rejection increase in the ten years following the start of medical transition (James et al., 2016).

Part of what complicates access to medical transition is its interdisciplinary and multifarious nature. There are many different ways to medically transition. Even the most common forms of transition involve medical specialists from multiple medical disciplines, all of which have different approaches to transgender care. One particular aspect of medical transition,

hormone therapy, is of critical importance to review. For a more detailed description of medical transition, see Coleman et al. (2012) and the University of California San Francisco Center for Excellence in Transgender Health (2017).

Hormone therapy. Although not all transgender people utilize hormone therapy, it is one of the most transformative forms of medical transition. It is also generally one of the first aspects of medical transition sought. For most, hormone therapy is well-tolerated with few deleterious emotional or physical side effects, but some complications can occur (Coleman et al., 2012). Inexperienced clinicians are somewhat prone to stopping or reducing hormone therapy when these problems arise. Even though this approach makes sense for many other pharmacological interventions, transgender people can perceive such recommendations as an effort to restrict, halt, or reverse transition. Luckily, most of these problems can be treated with additional medical or behavioral interventions. The problem is many clinicians and transgender individuals are unaware that this is an option. As a result, many either halt hormone therapy when doing so is unnecessary or needlessly endure side effects. Rupture, treatment noncompliance, and subsequent avoidance of medical care are common outcomes (Bauer et al., 2009; James et al., 2016). Even when stopping hormone therapy is appropriate, there are additional psychological risks to address. Clinicians who can communicate these risks in an identity-affirming and non-defensive manner are expected to achieve better treatment compliance in clients than those who do not.

Preventative screenings. At times, transgender patients avoid preventative screenings for many of the same reasons cisgender patients do; people often do not want to endure uncomfortable procedures when they are not experiencing symptoms. However, for transgender people, there are additional components to consider. For example, psychological discomfort

during screenings can often be more than a minor annoyance for transgender patients. Many essential screenings are provided in highly gendered contexts (for instance, with labels such as *women's reproductive health*) that may be incongruent with the patient's identity. These examinations also often involve close examination of intimate areas of the body that many associate with dysphoria (Light, Obedin-Maliver, Sevelius, & Kerns, 2014). Even when transgender people seek preventative screenings, many are turned away or ridiculed by clinicians because their appearance did not match expectations for the screenings sought (McPhail, Rountree-James, & Whetter, 2016). For example, transgender men have been known to be turned away from OB/GYN care (Dutton, Koenig, & Fennie, 2008; Hagen & Galupo, 2014). This compounds the problem of anticipated rejection in medical encounters (Applegarth & Nuttall, 2016).

Providers may also be unaware of what screenings are necessary for transgender clients. For example, they may not prompt transgender women with reminders about prostate exams, and they may not prompt transgender men with reminders about cervical exams (Coleman et al., 2012). As a result, many transgender people are believed to be at a higher lifetime risk of serious health complications (Xavier et al., 2013). While some public health campaigns have increased awareness within transgender communities (such as Ontario's *Check it Out Guys* [Queer Women's Health Initiative, 2010]), these efforts are few and far between. Broad awareness among clinicians is widely thought to be more appropriate and effective.

Trans broken arm syndrome. The presence of transgender identity may also complicate the process of diagnosis. Medical professionals can become fixated on the transgender aspects of care, even when treating unrelated issues. Since transgender identity appears (to the clinician, at least) to be the most salient feature, they may believe it to be the cause of the client's problems.

For example, clinicians have been said to recommend clients stop being transgender to treat everything from broken bones to cancer (Fontaine, 2002). Some transgender activists (Payton, 2015) have playfully dubbed this problem *trans broken arm syndrome*—meaning clinical encounters when unrelated medical problems, such as broken bones, become prematurely attributed to the person being transgender. As described by one participant in the Xavier et al. (2013) study:

> Once they find out that you're transgender, any other illnesses that you may have, they don't tend to address them as strongly as they might if you weren't transgender, because they (believe) that is your main problem, that's something's wrong psychologically with you. (p. 8)

As one transgender participant described, "If we're trying to get help, some doctors blame it on the trans aspect, [even] when there's an actual illness" (Bauer et al., 2009, p. 352). Even when problems are genuinely related to a person's gender or medical transition, clinicians may have difficulty communicating this in an identity-affirming way.

Trans broken arm syndrome can also lead clinicians to express doubts about the efficacy of treatments simply because a patient is transgender. During a 2015 keynote address, transgender icon Kate Bornstein described a painful encounter with an oncologist. By her recounting, this provider appeared to direct his frustration toward her as if, in his view, she had personally chosen to make her treatment more complicated. This practice seems to suggest that some clinicians believe being transgender would make someone biologically less typical or human—as if these patients are already too broken, crazy, or otherwise diseased to merit treatment.

Double bind. Seemingly, in reverse to the trans broken arm problem, transgender individuals also report erasure of their gender identity when another problem is present (Bauer et al., 2009). In these instances, the presence of another symptom is used to explain away a transgender presentation. For example, a transgender person with depression may be incorrectly assumed to be not transgender but merely unusually depressed. While some cases of atypical dysphoria presentation do occur (Baltieri & De Andrade, 2007), they are extremely rare (Hale, 2007; Hepp et al., 2004; Lev, 2013).

Both trans broken arm syndrome and the double bind make clinicians susceptible to misdiagnosis with this population, even when treating issues unrelated to transition. At other times, the clinician may have difficulty articulating their diagnosis and recommendations to clients who perceive their diagnosis as invalidating. Such is the case when the diagnosis is interrelated with some aspect of a person's medical transition. In these situations, it is essential that clinicians' conduct be clear and respectful, especially because many transgender clients often anticipate rejection. One of the reasons why clear and respectful care remains difficult has to do with the unique social and historical context surrounding transgender healthcare, which is covered in the following section.

Social and Historical Context of Transgender Healthcare

Transgender healthcare has historically progressed through cycles of transgender activism, incremental acceptance, and subsequent backlash. Technological advances in medical sciences have opened doors for some transgender people, while political and cultural forces within these professions have closed others. This complicated history places clinicians in a unique position and explains much of why current-day clinicians have difficulty in clinical conversations with transgender clients. This section re-contextualizes this problem, as guided by

transgender history, and also discusses several legal conditions that have uniquely influenced the provision of transgender healthcare in the United States.

History of Mutual Distrust

Quite often, those in healthcare professions view transgender people as impatiently pursuing high-risk medical interventions. By contrast, transgender communities often view medical providers as needlessly delaying access to life-saving care. This section will review the origins of this tension, as described by two transgender historians: Susan Stryker and Julia Serano. Additional work by historian Joanne Meyerowitz (who influenced both Stryker and Serano) is also incorporated throughout. Since the field of transgender history is relatively new (Jaschik, 2016), future work is expected to add considerably to the histories summarized here.

Early days of medical transition. It is difficult to determine precisely when medical transition began. While many physicians have participated in medical transition, the practice was often kept hidden until the beginning of the 1920s. This obscuring of transition-related care was out of necessity. Several legal codes against castration were broadly interpreted as prohibiting transition-related medical care. As a result, transgender people often attempted surgery at home with family members, with veterinarians, or even alone on themselves (Meyerowitz, 2004). As with other back-alley procedures, secrecy often begets exploitation and malpractice. It is also the reason why a definitive linear history of medical transition is difficult to pin down. A paper trail was the last thing such practitioners would want to cultivate.

A significant change occurred when clinicians began advocating for the normalization of medical transition as a legitimate treatment for dysphoria. One of the most prominent early advocates of this process, Dr. Harry Benjamin, described being deeply moved by the transgender patients he encountered (Serano, 2009). To him, these patients appeared both desperate and

highly likely to engage riskier procedures if turned away. Benjamin began consulting with sexologists at the Berlin Institut für Sexualwissenschaft (Institute for Sexual Science) in the 1940s to develop recommendations for medical transition. What is interesting about this period is Benjamin placed great emphasis on alleviating as much dysphoria as possible, using the patient's desire for transition as a guide (Benjamin, 1966). Such progressive recommendations would not be offered again until years after his death, even within organizations that held his namesake.

Why was there such a lag after such an auspicious start? One cause is likely the destruction of the Institut für Sexualwissenschaft by Nazis in 1933. Although some researchers from this institute continued their work through correspondence, considerable resources were lost in the institute's destruction. Efforts to rebuild the institute stalled after the death of the founder a few years later.

Sexology research changes in the United States. With the destruction of the Institut für Sexualwissenschaft and the end of WWII, considerable research power shifted to the United States. Here, many of the most influential sexologists (such as Dr. John Money and Dr. Richard Green) tended to hold more rigidly dichotomous views on sex and gender (Abelove, 2005; Serano, 2009). This worldview is partially due to the effects of colonialism, westernization, and subsequent systemic inequality as manifested in the United States (Lugones, 2007; Najmabadi, 2005; Nanda, 1999). Though the work of extending access to medical transition continued, research on gender diversity took on a different tone. Researchers and clinicians placed far greater emphasis on defining Gender Identity Disorder as a diagnosis with clear excluding factors than on developing effective treatments for dysphoria.

This shift towards accurate diagnosis brought another conundrum. How could clinicians ensure an accurate assessment of the internal sense of gender? Without a clear test, many

clinicians rightly feared their work would invite opposition. The difficulty is that gender incongruity has always essentially been a self-diagnosed condition, even in the days of Harry Benjamin. “There are no visible signs or tests for it; only a transgender person can feel it and describe it” (Meyerowitz, 2004, p. 159). As clinicians and researchers worked to define dysphoria as a diagnosis, they often strayed farther from the lived experiences of transgender people. The result was a concretization of gender treatment that was often at odds with the communities these interventions were initially designed to serve.

Historians have found examples of this estrangement in the high rate of rejections for medical transition from gender transition clinics. For example, Johns Hopkins began openly providing medical transition in 1966 (Stryker, 2008). This marked a huge advancement in the normalization of medical transition. However, in their first year, they approved only 24 out of several thousand requests for surgery. The low rate of approvals in the first year is shocking, though it is possible that there were not enough practical resources available to keep up with demand. Clinic directors may have also been surprised that so many transgender people would apply. However, language in archival documents suggests that political strategies were also at play (Meyerowitz, 2004; Serano, 2009). Many clinicians appear concerned that their work would become the subject of scandal. As the public became more aware of the existence of medically transitioning transgender people, doctors began to face intense public pressure to prevent people from transitioning (Meyerowitz, 2004; Serano, 2009). In these early days of institutional transition, it was not uncommon for members of the press to be present on the day of a transgender person’s surgery (Meyerowitz, 2004).

It was during this period that clinical recommendations shifted further away from alleviating dysphoria and more towards ensuring that the public at large would view medically

transitioned patients as respectable. The inclusion process that emerged strongly favored those who "promised to live quietly" over those who might "publicize" their surgeries (Meyerowitz, 2004, p. 225). As a whole, clinical treatment programs focused more on preventing public knowledge of transgender people than on alleviating suffering.

Less affluent transgender people still accessed medical transition during this period, albeit through riskier methods. As was previously the case, many accessed medical transition through self-surgery, or through underground networks (Vale et al., 2010). Some deliberately injured themselves in order to urgently precipitate medical intervention (Greilsheimer & Groves, 1979).

Backlash during the big science period. The 1970s marked a significant boom in the availability of medical transition. However, this surge was simultaneously marked by backlash. Publications by medical and mental health professionals during this time presented transgender people as pathological and perverse (G. Israel & Tarver, 1997; O'Hara, Dispenza, Brack, & Blood, 2013). Backlash also took the form of police action. Many public transgender meeting spaces and community programs were shut down by police during this period (Stryker, 2008).

This period also marks one of the beginnings of a split within gay and transgender activist groups (Stryker, 2008). For a variety of reasons, gays and lesbians made many gains in this period while rights for transgender people stalled or worsened. Some gays and lesbians deliberately worked against transgender rights (Stryker, 2008). This split is important to note, as many clinicians will mistakenly assume that lesbian and gay support groups will be welcoming towards transgender individuals when, in actuality, these groups share a complex historical tension.

Despite this opposition, the 1970s were also marked by significant community-building gains. By communicating with each other, transgender individuals were quickly learning what clinicians expected to hear. They adapted their disclosures to clinicians accordingly (Serano, 2009). The Civil Rights Movement also had an impact on what transgender communities focused on during this period. Instead of merely offering social support, many groups began engaging in political action. Transgender writing as an academic pursuit also began to grow during this period. This led to significant changes in how transgender communities viewed themselves, relative to medical communities. Increasingly, transgender communities perceived gatekeepers' impositions as an unnecessary barrier to transition, as well as evidence of continued oppression by health professionals (Hagen & Galupo, 2014; Vitelli & Riccardi, 2010).

Just as transgender people were capable of reading the literature written about them, so too were clinicians capable of hearing how medical professionals were described by transgender activists (Hagen & Galupo, 2014). Clinicians gradually became aware that many of their patients were "carefully preparing and rehearsing" their clinical interviews for surgery (Meyerowitz, 2004, p, 226). In response, medical literature began to portray transgender individuals as actively deceptive and impatient, and occasionally as outright liars (Serano, 2009). Clinicians viewed applications for medical transition with increasing scrutiny, despite a lack of evidence to the efficacy of this approach. If anything, available evidence during this period supported a loosening of restrictions. Even though medical transition was becoming more common, accounts of regret after surgery remained extremely rare. And yet clinicians often relied on sexist (and often homophobic) stereotypes to determine which individuals were suited to transition (McBee, 2013). Lou Sullivan's account of difficulty as an openly gay-identified transgender man is an

oft-cited example of how this approach negatively impacted the transgender community (Stryker, 2008). Sullivan described being repeatedly denied for surgery, despite otherwise being sure of his transition goals and well-informed about the risks. Sullivan was denied surgery even after years of being accepted as a man. If Sullivan had kept his gay identity a secret (as many others did during this period), it is believed that he would not have encountered so many surgery denials.

Current tension. Although some improvements to the provision of transgender healthcare have been made, several key points of tension remain (Bockting et al., 2006; Coleman et al., 2012). This continued tension is largely the result of two factors: (a) the marked nature of transgender identity and (b) continued overt opposition to transgender care. These will be explained next.

Marked identities retain stigma. Another reason for widespread anti-transgender stigma could be attributed to their simply being part of a marginalized group. Serano (2017) used Brekhus's (1998) work to describe this possibility. By Brekhus's description, *marked groups* (often minorities) are put under a microscope and viewed as suspicious whereas majorities (in this case cisgender people) remain unmarked (Brekhus, 1998; Trubetzkoy, 1975). This means that the terms used for the minority group embody a separateness that marks them as inherently different. In this context, the term transgender represents the marked group, while the term cisgender represents the unmarked, essentially normal group. Cis identities are so unmarked that they are affirmed without needing to be explicitly verbalized. Whereas cisgender identities are presumed to be normal, real, and natural, transgender identities tend to be viewed as inherently abnormal, artificial, or deceptive.

This phenomenon can be illustrated by examining how cisgender identity goes mostly unexamined. For instance, there is no "Journal of Cisgenderism" because cisgender identities are assumed to be normal and unworthy of scrutiny. Cisgender individuals are expected to be unaware of the term cisgender unless it is brought to their attention, usually from the transgender community. Transgender identities, on the other hand, are viewed with suspicion and curiosity. As a result, there are several publications dedicated to transgender studies such as the *International Journal of Transgenderism*, *Transgender Studies Quarterly*, *Transgender Tapestry*, *Transgender Health*, and *Transgender Community News*. By contrast, there are no "Cisgender 101" resources, except for those that exist for the purpose of satire (Siscombe, 2014).

While this special interest may appear to benefit transgender groups, the downside is that transgender people are only seen as curiosities because they appear unusual or unbelievable from a cisgender perspective. Transgender groups are given special attention, much in the same way a magician or riddle would be given attention. For example, cisgender people often incredulously ask transgender people if they are sure that they are transgender, as if to suggest their experience is unbelievable. Cisgender people, by contrast, are not asked if they are sure they are cisgender. The lack of gender questioning or fluidity experienced by cisgender people is not seen as a sign of illness or delusion.

Another example of this phenomenon can be found in the introduction to *Transgender Histories*: "We can be curious about why someone is gay or transgender… but ultimately we have to accept that perhaps some minor population (perhaps even ourselves) simply *is* 'that way'" (Stryker, 2008, p. 4). Such a suggestion would be unnecessary to direct toward cisgender identities because, as unmarked groups, they are already widely assumed to be naturally "that way."

This markedness can gradually come to describe cisgender clinicians, should they choose to work openly with transgender clients. Though they retain cisgender privilege, the mere association with transgender patients leads to them become somewhat marked over time. As Lev (2013) described, “Clinicians who work with transgender clients are sometimes assumed to be guilty by association as if they must have a ‘reason’ for working with this unusual population” (p. 18). Once a clinician becomes known for working with transgender people, their peers often consider the rest of their greater body of clinical work suspect.

As a combined result of stigma and distrust, many providers refuse to work with transgender patients. Despite recent advancements, transgender people continue to report being needlessly passed off from one medical provider to the next (Bauer et al., 2009). One transgender participant in Bauer et al. (2009) reported:

> I got told by one doctor that I should seek healthcare elsewhere because, for some reason, he did not know [that I was trans] in advance… that wasn’t what I was seeing him for, [but] when he found out, he pretty much said, “Please go someplace else,” so that he wouldn’t have to deal with it. (p. 355)

As this quote illustrates, the personal discomfort experienced by clinicians can have serious consequences for transgender patients.

Anti-transgender opposition is alive and well. Another reason why current tensions persist is that a small (but prolific) set of researchers continue to oppose the work of transgender advocates and allies. A key example can be found in the work of Kenneth Zucker, a researcher known for his work on gender nonconforming children. Zucker’s position is that transgender identity can and should be avoided, especially if it presents in childhood. Zucker’s recommendations bear a remarkable similarity to what has been dubbed *reparative therapy* to

change sexual orientation (Dawson, 2004; Hill, Menvielle, Sica, & Johnson, 2010; Tosh, 2011). For transgender clients, these interventions carry great risk. Even when they appear to changes in gender presentation, they appear to do so as a result of shame (Ryan et al., 2009; Wallace & Russell, 2013). Such interventions are risky given that this population also experiences high rates of suicide.

Although Zucker's arguments lack empirical support (Boenke, 1999; Ehrensaft, 2009, 2012; Hegarty, 2009; Lev, 2006; Nordyke, Baer, Etzel, & LeBlanc, 1977; Rosenberg, 2002; Winkler, 1977; Wolfe, 1979; Wren, 2002; Yunger, Carver, & Perry, 2004), his aggressive publishing strategy and adaptable writing style have made his papers accessible to a wide variety of academic audiences (Hill et al., 2010; Wallace & Russell, 2013). Zucker continues to be invited as an expert speaker at conferences and on television specials about transgender children.

Another common point of contention has been the casual association of transgender identity with sexual problems. For example, psychiatrists have typically listed gender dysphoria and gender identity disorder in the sexual paraphilias section of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Though some positive changes have been made to the fifth edition of the DSM, the broader mental health community often still views transgender identities as primarily sexual or fetishistic (Nadal, Skolnik, & Wong, 2012).

Another problem can be found in how stigma negatively impacts the clinicians who work with transgender individuals. As previously explained, medical professionals often experience stigma by association. Medical professionals even occasionally experience public pressure to stop working with transgender patients (Sanchez, Sanchez, & Danoff, 2009). Recently, a surgeon in Pullman, Washington, was pressured by his hospital to stop offering gender-confirming surgeries (K. Booher, personal communication, July 2017). The hospital opened a public

comment period on whether these surgeries should be offered at all. Comments from the hospital suggest an assumption that medical transition is experimental or ethically questionable, despite an American Medical Association (2008) statement to the contrary.

As a result of this public pressure, those who do work with transgender individuals often do not advertise this aspect of their practice publicly. Providers often engage little or no advertising. Instead, they rely on the *transgender grapevine* to make their practice known (Stryker, 2008). Though this shields clinicians, it also makes it more difficult for transgender individuals to access transition-related care.

Although this historical tension persists, there are signs of improvement. Some transgender people have become clinicians themselves, and transgender people are increasingly present in the panels that make important decisions about transgender healthcare (Coleman et al., 2012; B. Morgan, personal communication, July 2017). It is also worth noting that clinicians who reject transgender-affirming care, such as Zucker, have been met with increasing public opposition precisely because transgender people have gained greater access to the professional arenas in which these professionals circulate (Sharman, 2016; Tosh, 2011; Zoé, 2017). Many cisgender researchers have also become fierce advocates, often highlighting transgender perspectives in their academic work.

Though this is encouraging, it is important to remember that the presence of transgender people alone does not guarantee a fair privileging of transgender perspectives. Even though transgender people are increasingly becoming clinicians and researchers, their presence tends to be greatest at the master's level (Maton, Kohout, Wicherski, Leary, & Vinokurov, 2006). Transgender clinicians operate from a place of recently gained (and therefore conditional) privilege. This tenuous position may lead them to feel less secure in their professional roles

(Davies, 2009). Thus, although there are more transgender clinicians present, they often occupy less influential positions in the field as a whole.

These continuing problems exist within a broader context of both healthcare politics and transgender law in the United States. Both interact to make healthcare access simultaneously vital and uniquely complicated, as the next section will explore.

Legal Barriers Add Urgency, Increase Vulnerability

One of the factors that makes healthcare for the transgender population unique is that medical interventions are often practically necessary, from both a social and a legal standpoint. North American cultures tend to view transgender identities from a medicalized socio-legal frame. In the United States, this means that medical transition is often required to have one's gender legitimized in the eyes of the law. For example, the states of Alabama, Kentucky, Montana, North Carolina, Oklahoma, and Vermont require surgery to change one's gender on a driver's license (National Center for Transgender Equality, 2017). With the exception of Oregon and the District of Columbia, medical attestation of some form is required to authorize gender changes on legal documents. In some cases, these attestations can be brief. However, some require sharing private information such as a detailed description of the person's body.

While the process of gaining legal recognition is arduous and invasive, it is also often practically essential for safety reasons. Without access to identification that matches one's appearance, transgender people are outed continuously. This forced visibility places them at increased risk of violence and discrimination in employment, housing, and public accommodations (Hale, 2007). To change documents, transgender people must first make significant medical changes to their bodies. These changes take time and resources to access. Many clinicians are unaware of this context and, as a result, fail to understand why so many

transgender people feel pressured to transition as fast as possible. No other class of patient has to contend with this combined degree of urgency and close scrutiny. Add to this problem the common experience of fear in initial clinical encounters, and one can begin to understand the importance of getting these conversations right the first time. It is not just that some clinicians are insensitive or clumsy. It is that these mistakes occur in a broader historical context of intense pressure and vulnerability. Even understandable mistakes needlessly increase fear in patients already struggling to find safety.

Defining Unhelpful Responses

While what works well with transgender clients is difficult to quantify, there is a growing body of literature describing what either does not work or causes psychological harm. The first precise definitions arose in 2012. Nadal et al. used a combination of queer theory and qualitative interviews to create a taxonomy of day-to-day microaggressions experienced by binary-identified transgender people. In this context the term *microaggression* means brief and commonplace verbal, behavioral, or environmental indignities that communicate hostile, derogatory, or negative insults toward members of oppressed groups. Microaggressions can occur in rapid succession, or may even escalate into overt aggression. Most of the themes identified by Nadal et al. involve negatively held views towards minorities, discomfort when privilege is pointed out, and poor awareness of group issues overall. When clinicians have established a good relationship, they can often recover from these statements. However, when this relationship has not been established (such as during the initial interview), it becomes much more difficult to recover.

This work on transgender microaggressions by Nadal et al. (2012) was considerably expanded upon two years later by D. Johnson (2014), who included nonbinary transgender

participants. As a nonbinary researcher, D. Johnson added considerable analysis to Nadal et al.'s work, including the addition of several themes. D. Johnson also examined the relationship between these responses and premature therapy termination by asking transgender participants if they felt they had resolved the issues for which they sought therapy, and whether it was their idea alone to stop seeing their therapist. Participants were also asked about their reasons for leaving therapy. Using this approach, D. Johnson was able to isolate some responses as particularly damaging to rapport in clinical settings.

Although D. Johnson (2014) and Nadal et al. (2012) described these themes as microaggressions, several examples appear to describe overt aggression. For example, several participants initially endorsed statements that fall under the microaggression umbrella and then went on to describe acts of physical assault in their elaboration. As a result, these domains will be referred to as *unhelpful responses* for this dissertation.

The themes D. Johnson (2014) ultimately identified include the following: (a) Physical Threat or Harassment, (b) Denial of Bodily Privacy, (c) Denial of Existence of Transphobia, (d) Denial of Individual Transphobia, (e) Discomfort/Disapproval of Transgender Experience, (f) Omitting Gender Matters From Therapeutic Conversations, (g) Endorsement of Gendernormative and Binary Culture or Behaviors, (h) Assumption of Sexual Pathology or Abnormality, (i) Exotification, (j) Use of Transphobic and/or Incorrectly Gendered Terminology, (k) Expecting Clients to Provide Education, (l) Assumption of Universal Transgender Experience, and (m) Expecting Binary Transition Norms, considered initially a sub-theme of (g), and (n) Endorsement of Gendernormative and Binary Culture or Behaviors.

Physical Threat or Harassment

Physical threat or harassment can involve a variety of behaviors, some of which may be overt (such as with physical assault). Others may be subtle (such as nonverbal intimidation or vague suggestion of physical violence). Though none of the participants in D. Johnson's (2014) study endorsed experiencing this rupture, several other studies have described widespread client reports of physical threat and harassment from clinicians (Haas et al., 2014; James et al., 2016; Nadal et al., 2012; Stotzer, 2008). Most troublingly, a Los Angeles study found 6% of the sexual assault reports generated by transgender clients were allegedly perpetrated by clinicians (Stotzer, 2008). It should be noted that none of the participants in D. Johnson's study endorsed this occurring to them personally. However, even if overt physical assaults and harassment by clinicians are rare, they are expected to be especially harmful because of the intimate and powerful role of the clinician, relative to the patient.

It is important to note that some individuals who describe themselves as "accepting" simultaneously express the desire to be violent towards transgender individuals. Researchers have observed this pseudo-accepting stance in the parents of transgender children (Wren, 2002). Though it has not been directly observed in clinicians, some clinicians may also hold this pseudo-accepting view.

When physical threat or harassment occurs in therapy, it should be taken very seriously, since research suggests this type of response is particularly psychologically harmful. A joint study by the Williams Institute and the American Foundation for Suicide Prevention found transgender individuals who experienced threats of physical violence were nearly twice as likely to report attempting suicide (Haas et al., 2014).

Denial of the Existence of Transphobia

Some therapists appear to cope with the existence of transphobia by denying its existence entirely. This was the case in Whitman and Han's (2017) study of mental health professionals' knowledge of transgender cultural competency. Clinicians in these situations may suggest clients try "not to be offended," or may challenge whether their clients' experiences of transphobia "really happened" (D. Johnson, 2014, p. 80). Clinicians may also suggest that the client is the one to blame, as was the case in McPhail et al.'s (2016) research.

In D. Johnson (2014), the Denial of the Existence of Transphobia was even present amongst clinicians who had awareness of cisgender privilege. Clinicians taking this stance might describe having privilege, but deny that their transgender clients are harmed by them having cisgender privilege. These responses are understandable given that most people respond defensively when their privilege is pointed out. Multiple studies have shown that people often respond with avoidance or hostility when they are presented with evidence of personally held privilege (Abrams & Gibson, 2007; Ancis & Sanchez-Hucles, 2000; Brehm & Brehm, 2013; Cohen-Filipic & Flores, 2014; Fontaine, 2002; Garcia, Hoelscher, & Farmer, 2005; Jackson, 1999; Leslie, Perina, & Maqueda, 2001; Steward, Morales, Bartell, Miller, & Weeks, 1998). This phenomenon also occurs when researchers present individuals with evidence of other types of injustice (Lerner & Simmons, 1966).

Though understandable, these reactions are important for clinicians to avoid because they compound the adverse effects transphobia experienced in their day to day life. As a result of their relatively powerful position, a defensive clinician can lead transgender individuals to doubt their own minds or even their right to exist. As one participant in D. Johnson's (2014) study noted:

> I feel like maybe he's right and I am too sensitive, or I don't deserve to be respected, or I am confused and can't trust my own perception of bigotry against me… that made me angry and sad because my therapist should be helping me *not* [sic] feel that way, not reinforcing it. (p. 104)

In this example, the therapist's behavior was harmful because it sent the message that the bigotry the client had experienced was justified. It was especially harmful because of the clinician's role as a healer. In these situations, a client might understandably come to either doubt the intentions of their therapist, or (if they trust the therapist) might come to doubt their own perception. Clients may even come to feel as if they do not deserve respect. In this way, the Denial of the Existence of Transphobia can be especially destabilizing, even though the therapeutic relationship might remain intact.

Denial of Individual Transphobia

Similar to the Denial of the Existence of Transphobia, this unhelpful response involves a defensive response to personally held privilege. With this type of response, clinicians may acknowledge that transphobia exists, but then deny that they have personally engaged in it. For example, a clinician might suggest that a client should "not feel offended" (D. Johnson, 2014, p. 90) by what they say in-session.

As with physical threats or harassment, none of the participants in D. Johnson's (2014) study said that they personally experienced this type of unhelpful response. However, the above qualitative comments suggest this domain was at least somewhat present. This phenomenon has also been observed in other studies, such as the one conducted by Nadal et al. (2012).

Discomfort and Disapproval of Transgender Experience

Several participants in D. Johnson's (2014) research said their therapist appeared uncomfortable with them because they were transgender. Prior research has identified this as a common problem in multiple healthcare settings (Bauer et al., 2014; James et al., 2016). Clinicians have been described as using hurtful language, ridiculing clients, and outright refusing care (Bauer et al., 2014). If left unresolved, this type of response can be one of the most strongly associated with premature termination of the relationship. Similar findings were also present in T. Israel, Gorcheva, Walther, Sulzner, & Cohen's (2008) study. When discomfort with or disapproval of transgender experience was present, therapists had difficulty establishing and maintaining a working alliance with transgender clients.

Discomfort and Disapproval of Transgender Experience can be communicated in many ways. Clinicians may send the message that they disapprove through subtle body language, or they may state their discomfort outright. Clinicians may also communicate discomfort or disapproval via the types of interventions they suggest. Whitman and Han (2017) and D. Johnson (2014) both found examples of clinicians suggesting heterosexual dating as a potential curative for transgender identity, even though these clients were not seeking a way to stop being transgender. As one participant in D. Johnson's (2014) study described, "I felt as though it didn't matter to her, and that somehow I could address my other concerns by removing my trans identity" (p. 109). Not only are such interventions unlikely to be effective, but they also send the message that transgender identities are unhealthy and morally wrong.

Clinicians may also suggest that transgender people are unlikely to be accepted or may suggest that their gender identity is less real or valid than cisgender identities. For instance, clinicians may ask why a patient wants to be transgender, in this way implying that being

transgender is (a) a choice and (b) a potentially misguided choice. Clinicians may also send this message through passing tips or suggestions meant to coach gender-conforming behavior. This type of response can be acceptable when a client asks for them but can be interpreted negatively if offered unsolicited. In this case, such a response could arguably fall under Endorsement of Gendernormative and Binary Culture or Behaviors and Expecting Binary Transition Norms.

In some cases, discomfort or disapproval may take the form of Omitting Gender Matters From Therapeutic Conversations, another of D. Johnson's (2014) themes. Therapists may signal that they believe gender is unimportant by interrupting the client when gender is brought up, or by a general refocusing of conversations away from the topic of gender. Clinicians may also attribute the cause of their difficulties to factors other than gender. Clients reported often perceiving these evasions as evidence of discomfort or disapproval (D. Johnson, 2014). In this way, clients may expect discomfort or disapproval in the absence of overt support. For example, clients may interpret unrelated negative signals or silence as being directly related to their gender (Fraser, 2009). Such responses make sense given the pervasive marginalization this group faces.

Clinical training supervisors should note that many clinicians may not be aware that they appear uncomfortable to clients. Implicit bias and difficulty with transgender terminology are expected to be present to some extent among even the most well-meaning clinicians. Well-intentioned clinicians may occasionally come across as uncomfortable with transgender identity when, more accurately, they are uncomfortable with the possibility that they might appear uncomfortable (Dovidio, Gaertner, Kawakami, & Hodson, 2002; Shelton, Richeson, Salvatore, & Trawalter, 2005).

Omitting Gender Matters From the Therapeutic Conversation

Many clinicians avoid the marginalized aspects of client identity (Chan, 2014; Malgady, Rogler, & Constantino, 1987; Mazzula & Nadal, 2015; Owen, Tao, & Rodolfa, 2010; Schafer, 2015; Spengler, Miller, & Spengler, 2016). This occurs due to a combination of factors such as widespread stigma, systematic oppression, and erasure. Clinicians may avoid the topic of gender, even when the client views it as critically related. For example, a transgender woman quoted in Sperber et al.'s (2005) research described clinicians repeatedly avoiding the gender issues she brought up during treatment for substance abuse, "[It was] ironic, as [gender issues] had everything to do with it" (p. 82). These responses can seem ambiguous to the clinician, but nonetheless, minimize important aspects of the client's identity, and often miss key areas of clinical focus. These minimizations can arise out of discomfort or lack of awareness, or from an avoidance or denial of personally held privilege.

In some cases, these minimizations can occur in attempts to offer reassuring statements. For example, a transgender man quoted in Sperber et al.'s (2005) study described feeling insulted by a therapist who repeatedly told him, "You're just a different kind of woman" (p. 82). Such a statement was likely meant to reassure the client that he is normal, but in so doing this therapist also invalidated his identity as a man and avoided the importance of being transgender.

Avoidance of gender is also a problem because, as described earlier, in the absence of explicit affirmation, many transgender patients report assuming rejection is either silently present or imminent (Fraser, 2009). This pervasive anticipation is expected to negatively color otherwise neutral encounters (Lev, 2013).

Endorsement of Gender Normative and Binary Culture or Behaviors

Many clinicians assume cisgender identities are more valid, healthy, or normal than transgender ones. This is due to the widespread nature of cissexism in the United States. As a result, clinicians often endorse gender normative behavior in an attempt to improve the health of transgender clients. These unhelpful responses can take many forms such as suggesting concealment of or change from transgender identity. Clinicians may also suggest that clients stop being transgender. For example, a transgender man in Sperber et al.'s (2005) research described a therapist asking him, "Why don't you just stay a woman?" (p. 82). Others might encourage clients to make drastic changes to avoid detection, such as getting divorced and moving to another city. This type of response is unsurprising since such recommendations used to be universal (Serano, 2016a). Of respondents who discussed gender identity with medical professionals in James et al.'s (2016) study, approximately one in five (18%) said the professional attempted treatments to stop them from being transgender. As one participant in James et al.'s (2016) research described, "An OB/GYN forced me onto birth control pills to 'fix' me into thinking I was a woman again. I ended up in the psychiatric ward of my local hospital" (p. 110).

Endorsement of gender normative behavior may also be present among clinicians who support transition on the condition that the transgender person follows binary gendered expectations. For example, a clinician may permit transition only in transgender women who appear submissive or conventionally attractive: in this way, rigidly adhering to gender norms of stereotypical behavior for women (Serano, 2015). These responses may be based on the assumption that the transgender person desires to be more conforming and would benefit from instruction. However, even when offered charitably, this type of response is often received

poorly. For example, one participant in D. Johnson's (2014) research complained of a therapist pressuring them to "work harder to conform to gender expectations and stereotypes of the gender I was transitioning to" (p. 99). A clinician may also encourage medical transition when it is unnecessary or may advocate for certain types of surgery. Clinicians may also favor surgical options with more conventionally cisgender-appearing results over others that preserve sensation or fertility.

Some examples of the Endorsement of Gender Normative and Binary Culture or Behaviors are unique to work with nonbinary transgender clients. For example, some participants in D. Johnson's (2014) study described being pressured to transition in a gender-conforming way that was incongruent with their identity. Clinicians may endorse being supportive of transgender identity but expect clients to identify as either a man or a woman. One D. Johnson (2014) participant described having to "justify" (p. 98) their genderqueer identity to a therapist after they had transitioned. As one participant described the pressure to act in gender-confirming ways, "It made me feel like my identity didn't exist." (D. Johnson, 2014, p. 109). D. Johnson ultimately coded this phenomenon as a distinct sub-category: Expecting Binary Transition Norms. Although this type of response poses the most direct harm to nonbinary transgender individuals, it could also lead clinicians to be suspicious of binary-identified transgender people who do not fit stereotypical expectations for gender or gender transition (Bauer et al., 2009). For example, a transgender woman might be pressured to wear makeup, behave passively, and exclusively date men. Since such pressure to conform to stereotypical expectations for women would be inappropriate with cisgender women, it is also inappropriate to expect of transgender women (Serano, 2016a).

The Endorsement of Gender Normative and Binary Culture or Behaviors may also take the form of denying other essential aspects of a client's identity, such as intersections with ethnicity, religion, or disability. Previous research has suggested clinicians have greater difficulty with clients whose identities are seen as complex, especially when this pertains to sexual orientation, gender, or ethnicity (T. Israel et al., 2008). One example of how this can manifest was expressed by transgender author Ziyad (2017), who wrote:

> I used to write about my gender journey all the time—constantly having to re-explain how a person can be non-binary… recently, however, I've taken to discussing my gender much less…No matter how much I explained, the world never seemed to make enough room for my being. I am only now realizing that this is because Blackness ruptures the laws of gender just like the laws of the state seem intent on rupturing Black life. My gender is Black. (para. 4)

As Ziyad explains, their experience of gender and their experience of Blackness were inextricably linked; to avoid one is to avoid the other. This example shows that avoidance of ethnicity also negatively impacts a clinician's ability to affirm the client's gender (American Psychological Association, 2015; T. Israel et al., 2008; Singh et al., 2014).

Assumption of Sexual Pathology or Abnormality

This theme, like many others, can manifest in a variety of forms and overlaps with several other unhelpful responses. One of the reasons why this response is so common is because researchers in the United States have historically conflated transition and gender nonconformity with sexual pathology (Fontaine, 2002; McBee, 2013; Vitelli & Riccardi, 2010). Clinicians may also inadvertently send pathologizing message in other ways. For example, clinicians may assume transgender patients have sexually transmitted infections. This was the case for one

participant in Nadal et al. (2012) who described being publicly harassed by medical practitioners who assumed she had HIV.

The Assumption of Sexual Pathology or Abnormality can also manifest via misattribution of gender identity as the main cause of a client's problem. For example, clinicians may assume that seemingly unrelated problems (such as sinus infections, uterine disorders, or physical injuries) are the result of the person having sexually deviant behavior. The phenomenon is similar to trans broken arm syndrome, described previously. The effects of this type of rupture can be profound. One participant in D. Johnson's (2014) study who experienced this rupture described feeling "just too damaged for therapy to do any good" (p. 107).

Conversely, the assumption of pathology can also take the form of denying the validity of a transgender person's gender identity by explaining away their gender identity as simply a symptom of another illness. For example, a clinician may assume a transgender client is not transgender but merely manifesting depression in an atypical way (Edwards-Leeper & Spack, 2012; Lev, 2006). Others point to complications in those with both autism spectrum traits and signs of gender dysphoria (Edwards-Leeper & Spack, 2012). Differentiation from body integrity disorder is another common concern (Vale et al., 2010). Although it is possible for gender dysphoria-like symptoms to manifest as a result of other disorders, it is thought to be rare (De Cuypere et al., 2006; Dhejne, Öberg, Arver, & Landén 2014; Y. Smith, Van Goozen, Kuiper, & Cohen-Kettenis, 2005). As a result, this assumption is expected to be more strongly associated with pathologization than with legitimate diagnostic concerns.

Transgender writers have proposed that the fear of mistaken gender dysphoria may, at root, be better explained as a failure by cisgender clinicians to relate to the experience of gender dysphoria. As Serano (2016c) writes:

> Having not experienced [gender dysphoria] personally, [they] often refuse to take trans people's gendered experiences seriously… they will sometimes invent ulterior motives or condescending theories to explain our desire to transition—e.g., that we transition to try to "fit in," or to obtain male privilege, or because we're sexual deviants, or because we are confused/clueless/gullible and thus easily swayed by nefarious ideologies. (para. 28)

As Serano (2016c) points out, much of the suspicion regarding transgender identities and fearful gatekeeping of the transgender-related diagnoses has more to do with a privileging of cisgender attitudes and perspectives than of empirically established risk or treatment complications.

Leaders in the field of transgender care currently tend to encourage resolving complex presentations by proceeding with any desired medical transition slowly and with additional consultation (Edwards-Leeper & Spack, 2012). Preventing or reversing medical transition is not recommended as doing so also carries significant risk (Bouman et al., 2014; Edwards-Leeper & Spack, 2012; Hale, 2007).

Denial of Bodily Privacy

Many clinicians make the mistake of invading the bodily privacy of transgender clients. For example, clinicians may ask abrupt and inappropriate questions about a client's genitals immediately upon discovering their client is transgender. They may also persist in this line of questioning even after their client appears uncomfortable or uninterested in the topic. Transgender participants have described feeling "exposed" after clinicians made these types of questions (Applegarth & Nuttell, 2016, p. 70).

Unfortunately, the Denial of Bodily Privacy appears both pervasive and uniquely harmful. James et al. (2016) found such complaints in 33% of the 27,000 transgender participants involved in their study. It was also the most common specific complaint identified

by D. Johnson (2014). This type of response was also among those most strongly correlated with premature termination, as measured by client's description of whether their goals were achieved or not and whether they unilaterally decided to end therapy.

This problem may arise because clinicians mistake personal curiosity for medical necessity. This error would make sense given that clinicians often misattribute the cause of unrelated illnesses to someone being transgender. Clinicians may also underestimate the invasiveness of such questions. This may occur if clinicians take the disclosure that one is transgender as synonymous with disclosing information about one's genitals. A parallel response exists in the common assumption that the disclosure of being gay or bisexual identity is explicit. This hypersexualization of disclosure can occur when clients are simply describing the makeup of their family. Heterosexual disclosures are not interpreted as sexual or graphic because they are presumed to be more common, natural, or healthy (Brekhus, 1998; Serano, 2017).

Since this is a particularly common unhelpful response, many transgender patients will likely be on guard for this to occur (Bauer et al., 2009; Nadal et al., 2012). There are some socio-legal reasons for this problem. Most jurisdictions in the United States require transgender people to announce their name change in a newspaper. Doing so puts many transgender people at risk of exposure. Those who do not wish to list their name and gender change publicly also risk exposure through the continued use of identification documents (such as a driver's license, student ID, or debit card) that appear incongruent. The use of incongruent identification can also be practically unsafe as it often means private details about their bodies are essentially disclosed each time the identification is used. In many instances, a transgender person's privacy may have already been violated at reception, before the clinical conversation even begins (Donatone & Rachlin, 2013).

Exotification

Briefly put, Exotification is a type of dehumanization that occurs when people are treated as unusual objects of interest. This type of unhelpful response could manifest as hypersexualization (such as by viewing the client as hyper-sexual) or tokenization (such as by viewing the tolerance of transgender clients as proof of exceptional personal virtue). This unhelpful response is expected to have practical overlap with the Denial of Bodily Privacy. For example, if a clinician is viewing a transgender client in an exoticized fashion, the threshold for asking invasive questions would likely be lower.

No participants in D. Johnson's (2014) study endorsed this particular theme directly. However, this could have been due to the narrow wording of the prompts provided, such as "My therapist asked about my sexual experiences as a transgender person when it was not relevant," "My therapist stared at me because of my gender presentation," and "My therapist wanted to engage in a sexual act with me because of my gender presentation" (p. 80). Several elaborative responses included in D. Johnson's (2014) research could arguably fall under this category. For example, one participant described a doctor persistently asking about the size of their breasts when it was not relevant. The description included continuing in this line of questioning far beyond the participant's comfort or consent. Clinicians may also ask more detailed questions about a client's sexual behavior than they would with other clients (Hanssmann et al., 2008; D. Johnson, 2014; Whitman & Han, 2017), or may ask such questions when it is clinically irrelevant. Such invasions often seem to be motivated by a sense of entitlement to information about transgender bodies as a source of intellectual interest or curiosity. In this way, a clinician might engage in non-sexual lines of inquiry that are, nonetheless, exotifying.

These types of unhelpful responses can also emerge during case conceptualization. For example, a clinician may view gender nonconformity as inherently sexual or may view gender nonconformity as trendy or provocative. Clinicians may signal such conceptualization through body language, such as staring with an open mouth. A nonbinary participant in McPhail et al.'s (2016) qualitative study described such a response. In this example, the participant described going to the emergency room after having been physically assaulted for being gender nonconforming. The physical violence they had experienced had made wearing a binder (a garment worn to minimize the appearance of breasts) painful. The participant described going to the emergency room because they were concerned that the binder discomfort was medically dangerous. In this encounter, the participant described a breakdown in communication with the emergency room physician concerning the importance of wearing a binder:

> He paused and was like, "Okay, so then you could just stop wearing it, right?" And I was like, "No, no, no. I just said when I go out in public, I can't, I don't, I don't feel comfortable not wearing it." And then he just kind of stared at me for a while. And it was a weird kind of stare, and there was this weird distance. (p. 74)

The participant went on to say that the physician seemed eager to discharge them as fast as possible soon after this happened. This exchange suggests that while the emergency room physician was uncomfortable, they were comfortable enough in their discomfort to let it show (via staring). Alternatively, they may have been so unaware of their discomfort that they did not effectively moderate their response. Such open staring seems to suggest the physician found the patient strange, baffling, or otherwise unusual.

This type of unhelpful response has also been observed in several other qualitative studies with transgender participants, such as those conducted by Bauer et al. (2009) and Sperber

et al. (2005). Participants described feeling treated like an exhibit in a freak show, or like a research animal. The experience of Exotification by medical providers has also been described by transgender authors such as Eli Clare (2003, 2015) and Julia Serano (2016a). Clare, who writes as a transgender person with a disability, described the importance of pride as a response to being exploitatively gawked at: "We've posed for anthropologists and cringed in front of doctors, jumped through hoops and answered the same questions over and over, performed the greatest spectacles and thumbed our noses at that shadow they call normal" (2003, p. 257). From Clare's vantage point, interactions with doctors can often be especially exploitative because the subject rarely gains fair compensation. Self-proclaimed freaks in a show, by comparison, could often set their own price from the people who gawk (Clare, 2015). Similarly, Serano (2016a) described how transgender people are often featured in documentaries in a dramatic, voyeuristic fashion. As she describes:

> There are plenty of programs that feature nonsurgical makeovers… but they tend to have a more laid-back and informative feel, seducing the audience with their you-can-do-this-yourself attitude… the audience is not encouraged to gawk over their before-and-after pictures in the same way that they do with the subjects of plastic surgery and sex reassignment programs. (pp. 56–59)

As Serano (2016a) describes, gawking makes sense only within a society that collectively (but unknowingly) assumes that changes in gender are impossible. She continues,

> When I tell someone that I used to be male, they are often dumbfounded at first, as if they have difficulty reconciling that someone who seems so naturally female to them could have once been something they consider to be so completely different. The fact that a single individual can be both female and male… at different points in their life challenges

> the commonly held belief that these classes are mutually exclusive and naturally distinct from one another. (pp. 56–59)

Here, Serano also describes another important aspect of why gawking is perceived so negatively by many transgender people. Shock only occurs if the gawker expects the transgender person's identity is impossible—an uncomfortable position since transgender people are also frequently accused of deceit (Serano, 2009, 2016b).

In addition to observations shared by transgender patients, researchers have also found this type of response when studying clinicians directly. Hanssmann et al. (2008) explored clinicians' responses to a basic transgender training via exit interviews. They found several practitioners who appeared to engage in gawking. One clinician, seemingly aware of how they were coming across, made a defensive statement to this effect:

> I would like to see pictures… like, this is who your patients are, and this is who we're talking about… I mean pictures sounds so, like, animals in a zoo… I don't mean to come off like that, I just mean… to make it more real. (p. 12)

Although this clinician appears aware enough to retract their statement partially, the word choice bears a remarkable similarity to the gawking described by Clare, Serano, and many others.

Use of Transphobic and Incorrectly Gendered Terminology

Transgender people are diverse and, as a result, the sensitivities and preferences of transgender people vary. At times, the language preferred by some transgender people may be at odds with the preferences of others. Additionally, many of the terms currently used by the transgender community are relatively new, having been in common usage for just a few decades (Serano, 2014; Stryker, 2008). Discursive injustice—silencing that occurs through the failure of a privileged community to understand the underprivileged—also plays a role, accelerating the

evolution of preferred terminology (Kukla, 2014; Serano, 2014). It should come as no surprise then that clinicians have difficulty keeping up with preferred transgender terms (O'Hara et al., 2013). Though it may be quite difficult, the use of respectful terminology is also essential to effective clinical communication (Burnes et al., 2010). Without this, clients are much more likely to terminate prematurely, and avoid necessary care in the future (James et al., 2016; D. Johnson, 2014).

Transphobic and Incorrectly Gendered Terminology can take a wide variety of forms. For example, a clinician might refer to a client using outdated language now considered slurs, or they may continue to use the wrong name or pronoun despite correction. Regardless of intent, the felt impact is often intense for transgender people. As a participant in James et al.'s (2016) study described: "I was consistently misnamed and misgendered throughout my hospital stay. I passed a kidney stone during that visit. On the standard 1–10 pain scale, that's somewhere around a 9. But not having my identity respected, that hurt far more" (p. 96). As this quote illustrates, misgendering was more than a minor annoyance; it caused psychological pain comparable to that of a medical emergency. In sharp contrast is a positive hospital experience described by a participant in Hagen and Galupo's (2014) study, who described being addressed correctly and respectfully, "never having to explain" himself (p. 28). This "never having to explain" oneself appeared important in that he described it making him feel safe and in a better position to "focus on recovery without worrying" (p. 28).

At times, inappropriate terminology persists even after the patient has offered corrections. Transgender participants in Hagen and Galupo's (2014) study described staff members who chronically used the incorrect name, even when forms provided a place for a preferred name. Another Bauer et al. (2009) participant added:

> Multiple medical professionals have misgendered me, denied to me that I was transgender or tried to persuade me that my trans identity was just a misdiagnosis of something else, have made jokes at my expense in front of me and behind my back, and have made me feel physically unsafe. I often do not seek medical attention when it is needed because I'm afraid of what harassment or discrimination I may experience in a hospital or clinic. (p. 96)

As this quote illustrates, negative experiences can lead transgender people to avoid necessary medical care in the future.

Bauer et al. (2009) explored this phenomenon in "'I Don't Think This Is Theoretical; This Is Our Lives': How Erasure Impacts Care for Transgender People." They found transgender erasure could be passive (such as on intake forms) or active (such as with habitual use of the incorrect pronoun). Both forms had profoundly negative impacts on transgender patients. Even when it is possible to describe oneself as transgender on a new patient form, many transgender patients fear that they will be rejected by their provider if they do (Hagen & Galupo, 2014). This is one reason why many recommended providers preemptively signal their competence by using correct and respectful terminology throughout their practice (Donatone & Rachlin, 2013). This involves more than simply providing a transgender box to check (GenIUSS Group, 2014). When forms ask about transgender identity in simplistic ways, it can lead to confusion. For example, two transmasculine participants in Hagen and Galupo (2014) described negative encounters in which their medical providers assumed they were transgender women:

> I went to a new gynecologist, and on my first visit I mentioned penetrative sex, and she was like, "You mean anally?" and I kept saying no, but she seemed really confused, and I

> ended up just being like “I was born with a vagina.” She had assumed I was a trans woman coming to her wanting surgery… I didn’t go back there. (p. 24)

Another participant in Hagen and Galupo’s (2014) research described a staff member incorrectly changing the gender entered into their system from *female* to *male*, presumably assuming that since he appeared male, he must be male. Though *male* would likely be the most respectful form of address for this patient, the change caused a problem with his insurance claim, which had “female” associated with both his billing information and the purpose of his visit. Presumably, the staff member made the change based on the assumption that he was a cisgender man, not out of an effort to be respectful of his identity. In this example, the patient described having to make several lengthy calls to resolve the issue.

One reason for this problem is that both language and medical culture are rich with the assumption that biological sex is unproblematically binary (Hagen & Galupo, 2014; Spade, 2011). Unknowing assumptions or missteps on the part of the clinician may, regardless of intent, be experienced by transgender patients as an erasure of their identity. Another problem the quote above illustrates is that transgender individuals often end up having to provide more graphic descriptions of their bodies in order to bridge communicational gaps. In this way, such a response could easily develop into a Denial of Bodily Privacy.

By contrast, when appropriate and affirming terminology is used, transgender people often respond quite well (Donatone & Rachlin, 2013). In one study of gendered experiences in healthcare settings, transgender participants volunteered several specific positive experiences at Planned Parenthood locations across the country (Hagen & Galupo, 2014) even though the researchers had not asked any direct questions about Planned Parenthood. In particular, the open-ended nature of questions on Planned Parenthood intake forms (which allow clients to describe

some preferred terminology) was spoken of very positively. This is no accident, as Planned Parenthood has taken deliberate steps to ensure they provide inclusive services nationwide (Planned Parenthood, 2006). Sexual history questions on intake forms were worded in such a way as to be medically clear without being narrowly gendered. Additionally, Planned Parenthood staff members were trained in the importance of consistently using respectful language. As one transgender participant in the Hagen and Galupo (2014) study described, "They had really inclusive forms… instead of trying to minimize [and] it wasn't always gender specific… it was amazing and *they were actually questions I could answer*" (emphasis added; p. 27). As this quote illustrates, the use of appropriate language is both clearer and more courteous.

Expecting Clients to Provide Education

There is a difference between asking for clarification and asking for free education. For example, it is often considered appropriate to ask what a client's experience of being genderqueer has been, or what the term means to them. It is another to ask clients to explain what genderqueer means. While the first approach provokes answers specific to the client, the former asks the client to speak on behalf of their community. Such questions also serve as an exploitative request for emotional labor as transgender people are (a) already in a vulnerable position, relative to the clinician and (b) are typically not compensated for providing education. One participant in D. Johnson's (2014) research noted, "I felt willing to talk about it but wanted him to do the work to educate himself. It's not my job" (p. 100). This quote demonstrates that compensation (or the lack thereof) is part of why these responses are inappropriate in clinical settings. Not only are transgender patients not paid for their labor, but they are also typically paying the clinician in time lost during their visit. Sadly, since visibility is vitally important to

the survival of transgender communities, many transgender individuals feel compelled to comply with requests for education (Ericson, 2013; Kenziera, 2015; Punlich, 2016).

Another problem with educating one's clinician is that it can be uncomfortable. Often the pressure to provide education can feel similar to an invasion of privacy. Some participants in D. Johnson's (2014) study alluded to feeling researched, saying, "I felt like I was being studied in some way that I did not consent to" (p. 101). Even well-intentioned clinicians can be susceptible to overzealous curiosity.

At times, clinicians may aggressively ask for education, suggesting the transgender person explain themselves. Though their requests may appear civil, such demands are better characterized as a provocation (Fritinancy, 2014). It can be difficult for transgender individuals to tell which requests for education are well-meaning and which constitute a prelude to such an attack. At times, questioning itself can constitute aggression. For example, some may use sealioning, a way of disguising provocation as a sincere request for civil debate (Malki, 2014). In these cases, clinicians inundate transgender clients with seemingly polite but naïve questions with the goal of imposing their perspective by overwhelming the conversation. Transgender participants in Hagen and Galupo's (2014) study described avoiding disclosure with clinicians because they anticipated it would precipitate a "barrage of questions that just aren't medically relevant" (p. 26). This is why it is important to remember that the simple anticipation of this unhelpful response can be enough to negatively impact clinical conversations.

The discomfort could also be the result of how the clinician controls the conversation. Researchers have found coercively steered clinical conversations often ended in rupture (T. Israel et al., 2008). For many transgender clients, the process of explaining their identity is already unpleasant because having to explain highlights the ways in which transgender identities

are marginalized and invisible. Having less control over the direction of these conversations can make these exchanges even more uncomfortable.

The dilemma is that it is also important for clinicians to avoid clarifying questions. What is it that makes some clarifying questions inappropriate? One key difference lies in whether clinicians are asking clients to speak on behalf of their group, as opposed to asking about their individual experience in said group. For example, one participant in D. Johnson's (2014) study described a therapist asking for "all the facts about how we (genderqueer people) are and how we act" (p. 101). In this example, the element of asking about the client's people suggests they are asking the client to speak on behalf of all genderqueers. Several clients in D. Johnson's (2014) study described feeling therapy progress more slowly because of similar questions.

It is also possible for clinicians to indirectly pressure their clients for education. For example, clinicians may successfully avoid inappropriate clarifying questions, but still send the broad message that they are uninterested in seeking consultation from transgender experts. Such a message could be sent if, over the course of several sessions, the clinician continues to stumble through easily searchable terms the client has used in prior sessions. This can be disruptive because it sends the message that clinicians cannot be bothered to educate themselves. In these cases, clients seem to have three options: (a) to try to personally educate the clinician; (b) to endure their broad lack of knowledge; or (c) drop out of therapy. In this way, many clients end up experiencing indirect pressure to provide education.

Clients can also have more poignant emotional reactions to clinicians' expectations. For example, when the interpretations offered by clinicians are dramatically off the mark, clients may end up feeling as if they are uninterpretable. As one participant in Benson's (2013) study noted, "I just had therapists who have crazy, off-the-wall ideas and just not really understood

who I was or really taken the time to understand" (p. 29). Another participant in D. Johnson's (2014) research alluded to a broad lack of understanding amongst therapists; "I think for the most part they don't know beans about what makes a transgender person tick" (p. 30). As this quote illustrates, transgender clients may feel their provider is not only inexperienced but grossly misinformed. This phenomenon was also described by a participant in the *Virginia Transgender Health Initiative Study* (Bradford et al., 2013; Xavier et al., 2013): "When we walk into a place… we feel alienated and feel shunned from the beginning, because typically they don't understand what we're all about" (Xavier et al., 2013, p. 8).

Unfortunately, the vast majority of psychiatrists and psychologists have not received training in transgender identities, medical issues, or culture (American Psychological Association Task Force on Gender Identity and Gender Variance, 2009; Bess & Stabb, 2009). When transgender issues are discussed, it is usually within a brief diagnostic overview, or within perfunctory gay and lesbian categories (Benson, 2013; Lev, 2013; McPhail et al., 2016). It should come as no surprise that clinicians often rely on their clients for education.

It is also possible for clinicians to put forth the effort to educate themselves, but to have little to show for it. As addressed in *Social and Historical Context of Transgender Healthcare*, most literature written for a clinical audience takes a pathologizing stance that directly conflicts with the views and values of many transgender communities (Bess & Stabb, 2009; Lev, 2013). Writings that are more congruent with the views of transgender authors tend to be inaccessible to clinicians due to their highly theoretical nature (Benson, 2013). As with many academic disciplines, discipline-specific jargon can make quality research inaccessible to those who need it most (Gossa, Fisher, & Milner-Gulland, 2015). This means that clinicians who try to educate themselves encounter little that is practically helpful. In many ways, information may be

inaccessible by design since work with this population remains highly stigmatized. Researchers may make their work deliberately indecipherable so as to avoid close scrutiny from hostile audiences.

Assumption of Universal Transgender Experience

This theme concerns assumptions of a dominant transgender narrative to the exclusion of all others. Clinicians may mistakenly assume that all transgender people are aware of their identity from a young age, despise anything associated with their sex assigned at birth, urgently desire genital surgery, and will rigidly identify as either a man or woman upon transitioning (D. Johnson, 2014). This theme has considerable conceptual overlap with the Endorsement of Gendernormative and Binary Culture or Behaviors, as it anticipates all transgender people are binary-identified and will present themselves in a way that comports with prevailing gender norms.

Clinicians engaging in this style of response may pressure clients to have surgery as quickly as possible or to behave in other ways that conform with stereotypical expectations such as with clothing, speaking patterns, relationships, occupations, and more. Clinicians may try to dissuade transgender clients from professing nonbinary identities, or from being broadly gender nonconforming. They may also doubt the legitimacy of transgender individuals whose narratives do not fit dominant expectations. For example, clinicians may view transgender people who do not desire surgery or who come out later in life with more suspicion. Gay or bisexual transgender people may also be viewed more suspiciously since heterosexuality is often a part of what many consider to be gender-conforming behavior. As a reminder, many of these dominant expectations have more to do with the social and historical context of transgender healthcare as it developed in the United States than with what is more common, healthy, or accepted within transgender

communities. When clinicians make these dominant assumptions, it can be extremely frustrating for clients. As one participant in D. Johnson's (2014) study noted, "It made me feel as if no matter how hard I tried to articulate myself, she would always see my experiences and feelings through the framework she already knew" (p. 110).

This mistake can occur from a place of good intentions. For example, clinicians may attempt to demonstrate that they view a client's gender is authentic by reflecting back dominant transgender narratives. For example, clinicians might abruptly offer statements such as, "So, you feel you are trapped in the wrong body?" immediately upon discovering a client is transgender. Several transgender writers have offered critiques of this particular phrase (Mock, 2012, 2014; Talusan, 2014; Thom, 2015). Chiefly, these critiques point to how the phrase reduces transgender experience into something thought digestible to cisgender audiences. By repeating back what amount to clinical stereotypes, these clinicians inadvertently reify the (incorrect) assumption that only some types of transgender experience are valid. Clinicians who endorse problematic constructs often do so without the awareness that these assumptions arose during a period of mutual distrust between transgender and healthcare communities.

Returning to more conventionally academic work on the topic, a transgender participant in Applegarth and Nuttall's (2016) research noted, "It felt to me, like they… used their theories as a jumping off point…. They were trying to fix me back into what they thought it should be" (p. 71). In this way, the impact is similar to having one's actual gendered experiences ignored and coercively replaced with a more acceptable fiction: an experience that many in the transgender community already experience all too often (Fraser, 2009). In the example from Applegarth and Nuttall's (2016) study, the transgender client reported feeling invalidated. As

therapy continued, the client became more destabilized and, ultimately, began to question whether their feelings were valid.

Expecting Binary Transition Norms

The expectation of binary gender norms involves expecting all transgender people who desire to transition to do so in a binary fashion, meaning they will either transition to be a man or a woman, will behave in a manner congruent with stereotypical expectations for this gender, and will hold this identity for the rest of their lives. Although this type of response can impact all gender nonconforming transgender people, it affects nonbinary people the most directly.

In many ways, nonbinary people represent a twice-marginalized population, even though they make up approximately a third of the transgender community (Harrison, Grant, & Herman, 2012; Kuper, Nussbaum, & Mustanski, 2012). Compared to their binary-identified peers, nonbinary transgender people experience higher levels of psychological distress (James et al., 2016). Many express within-community oppression, as evidenced by a nonbinary participant in D. Johnson's (2014) research who described receiving unhelpful responses from a binary-identified transgender therapist. This suggests that just because a clinician is transgender does not automatically guarantee that they will work well with nonbinary clients.

Although nonbinary people have been accessing medical transition for as long as it has been available, clinical lore has tended strongly to discourage nonbinary individuals from undergoing transition until very recently (Serano, 2009; 2016a). This means that clinicians may pressure medically transitioning clients to adhere to a binary identity. For example, some nonbinary D. Johnson (2014) participants described being pressured to transition in a gender-conforming way that was starkly incongruent with their identity. Clinicians may also try to stop

or slow the medical transition of nonbinary individuals, as was the case for the primary researcher.

There are many different acceptable paths to transition. Nonbinary people may transition in a different order and with different procedures, or they may transition for a time and then stop. Their transition may be exclusively social (meaning, they do not pursue medical transition at all). Alternatively, they may also transition similarly to binary-identified transgender people but express their gender somewhat differently.

One of the reasons why this problem persists is that nonbinary identities remain largely invisible. As a result, many nonbinary identities are challenged more frequently. For example, a transgender participant in Hagen and Galupo's (2014) study said, "I have to convince people that I'm gender variant. I'm a mythical creature that doesn't exist" (p. 26). One participant in D. Johnson's (2014) research described having to "justify" (p. 98) their genderqueer identity to a therapist after they transitioned. As one participant described the pressure to act in gender-confirming ways, "It made me feel like my identity didn't exist" (p. 109). Although binary transgender people also face erasure, the erasure of nonbinary identities is currently more pervasive. As a result, nonbinary individuals often have to be much more vocal than their binary counterparts.

Rupture Recoveries

D. Johnson (2014) demonstrated a relationship between unhelpful responses with transgender clients and premature termination. However, this relationship only held when the resulting rupture went unaddressed. This is excellent news, as it suggests clinicians need not be perfect so much as responsive. So long as clinicians can identify that a rupture occurred and respond appropriately, premature termination can be avoided. However, this is no simple task.

Clinicians must be able to identify that a rupture has occurred, then avoid defensive responses, and then finally craft an appropriate response to re-start the conversation (Donatone & Rachlin, 2013; Fehr & Gelfand, 2010; Safran, Muran, & Eubanks-Carter, 2011).

While supervision can often be useful for guiding trainees through minor ruptures such as the ones described, the dilemma is that many transgender clients drop out of therapy before supervisors have an opportunity intervene. Clinicians may not encounter another transgender client during their training. This makes growth from experience difficult and complicates the use of clinical supervision to resolve the issue. Even when expert supervisors can be identified, by the time a rupture occurs it is often too late. Such late intervention also adds distress for trainees who, understandably, often respond more defensively (Wise et al., 2015).

Principle A of the American Psychological Association Ethics Code (2017) states that psychologists strive to benefit those with whom they work, and take care to do no harm. While some harm is unavoidable in the learning process, steps should be taken to reduce risk of harm when providing services—especially since transgender people represent an already vulnerable population. This should also extend to harm experienced by trainees during supervision. If likely-harming clinicians can be identified before they work with transgender clients, significant harm to both may be avoidable. Early identification may also make it easier to attend to trainee's beliefs and developmental stage (Cohen-Filipic & Flores, 2014).

Evidence-Based Training and Evaluation Efforts

Literature on the mistreatment of transgender clients by clinicians often concludes with the recommendation that clinicians simply need more training. Unfortunately, there has been little progress in defining what "more training" entails. Attempts to address transgender education within broader multicultural competency frameworks have proved difficult to

evaluate. In addition, some training efforts appear to have little positive impact on clinician awareness, attitudes, or behavior. In some instances, attempts at multicultural training make the problem worse by providing misleading information, or by inducing emotional reactance. This section will address this problem.

Problems with the Multicultural Competence Approach

Trainings on transgender-specific skills typically fall under the broader umbrella of Multicultural Competency. This construct has proved popular, but difficult to enforce. Although several promising multicultural training models have emerged (such as the tripartite model and cultural humility), gatekeepers to the clinical professions still encounter difficulty when trying to operationalize multicultural training goals (Cohen-Filipic & Flores, 2014; Enochs & Etzbach, 2004; T. Smith, Constantine, Dunn, Dinehart, & Montoya, 2006). Attempts to rely on client outcomes as a measure of competence have been unsuccessful. Although the expectation has been that multicultural competence would improve overall counselor competence, this too has been difficult to confirm empirically (Worthington, Soth-McNett, & Moreno, 2007).

While it may be tempting to subsume transgender training efforts under the broader umbrella of multicultural competency, this carries risk. Transgender training efforts, like multicultural training efforts, are expected to remain difficult to define and even more difficult to verify.

Ceilings are more difficult to evaluate than floors. Part of the problem may be that multiculturalism and competence are fairly broad constructs. Although this broadness allows for flexible application, it also makes multiculturalism practically unenforceable. A possible solution may be to shift the focus from detecting competence (which may be a lifelong endeavor) to

detecting critical incompetence: essentially a shift from ceilings to floors. In this way, clinical training programs may be able to make meaningful gatekeeping decisions with trainees.

Protect training programs by making "floors" clear. Most clinical training programs already have a minimum of sorts, below which trainees are not permitted to practice. However, these minimums are often unclear, especially with regard to cultural aspects of clinical work. This makes training programs vulnerable to poor follow-through and can even make them vulnerable to legal challenges from trainees who are identified as having unsatisfactory or irremediable performance (Cohen-Filipic & Flores, 2014; Enochs & Etzbach, 2004; T. Smith et al., 2006). This is important as many trainees interpret attempts to enforce a minimum of culturally sensitive work (for example, with transgender clients) as an attack on their personally held beliefs (Cohen-Filipic & Flores, 2014). Though attitudinal changes are also important, policies that describe clear expectations for professional behavior (such as avoiding very harmful responses with clients) are expected to be more practically enforceable. As described previously, the unhelpful responses explored here have been tied to poor client outcomes and, as such, are more objectively grounded in clinical training goals than multicultural measures that are grounded in values or unconscious beliefs.

Special Population, Special Skills

Transgender communities have several distinct features that are difficult to adequately address within a broad multicultural approach to clinical training. As noted previously, transgender communities currently experience poor health outcomes, at times as a direct result of the unhelpful responses made by clinical professionals. This problem is not unique to transgender clients. What sets transgender communities apart from many other marginalized groups is that transgender individuals are essentially required to interface with medical systems

if they wish to gain social (and legal) legitimacy. If they do not, it is likely that most of their identification documents will not match their identity or often their appearance. This leads to widespread discrimination in public life.

In addition, clinical work with this population has been complicated by a history of mutual distrust. This makes transgender communities both uniquely treatment-seeking and, simultaneously, underserved. Transgender communities are also more vulnerable as a result of their horizontal nature, which is to say that most transgender people are not born of transgender parents (Solomon, 2012). Transgender individuals often cannot rely on their immediate families for guidance on what it means to be transgender. As a result, transgender individuals experience a kind of diaspora. This combination of circumstances makes it essential that clinicians develop culturally specific skills for working with this population.

Misplaced Confidence

It is often those with the lowest level of skill who are the most unaware of their deficiencies. This phenomenon has been demonstrated in a wide variety of domains. Tests of driving (Kunkel, 1971), humor, logic (Kruger & Dunning, 1999), social skills (Fagot & O'Brien, 1994), and cultural sensitivity (Whitman & Han, 2017) all indicate unknowing ignorance amongst the lowest quartile of performers. Even after observing their peers or receiving feedback from testing, people with the lowest levels of competence appear unaware of their relatively poor performance (Kruger & Dunning, 1999). Although misplaced confidence is also present in those considered experts, the effects are subtler and more amenable to correction (such as by viewing peers' performance or receiving feedback). Misplaced confidence in those with low levels of skill, however, tends to be both more dramatic and more functionally debilitating because of the

combination of low skills with low awareness. Since these individuals have difficulty self-monitoring these skills, they also encounter fewer opportunities to learn and improve.

The problem of misplaced confidence has been well documented for several domains, including transgender care. This question was demonstrated in a novel study by Whitman and Han (2017). They recruited 53 mental health practitioners to respond to three brief vignettes involving transgender client scenarios. Participants also completed a brief transgender terminology test created for the study, as well as a measure of self-rated competency.

The results were troubling. Clinicians endorsed expecting to have difficulty in several areas—such as working with intense body dysmorphia, or with using a client's preferred name and pronoun. More concerning, the vast majority of clinicians reported viewing themselves as competent or effective, despite having never received transgender-specific training. For example, practitioners who endorsed the item "The lifestyle of a TGNC (Transgender or gender nonconforming) client is unnatural or immoral," also tended strongly to state that they feel competent working with these clients (Whitman & Han, 2017, p. 163). This is a dangerous combination. Similarly, practitioners who described transgender identities as "mental disorders or sins" (Whitman & Han, 2017, p. 164) also endorsed feeling competent to work with this population. Even in cases where participants reported a lack of professional training, they were also hesitant to refer clients to another provider due to fears that other mental health providers would be less "open-minded" (Whitman & Han, 2017, p. 166) than themselves. In this way, these practitioners appear not just unaware, but also unaware of their unawareness. This is one of the reasons why an objective assessment tool of basic readiness for work with this population is urgently needed. The clinicians and trainees with the lowest levels of readiness are expected to be largely unaware of their unpreparedness.

It is important to note that, though early identification of misplaced confidence is important, confrontation is not an effective means of intervention. Research suggests that this typically results in increased defensiveness (Kruger & Dunning, 1999; Kulik, Pepper, Roberson, & Parker, 2007). Instead, identified trainees should be given additional support to build concrete skills. It is this skill acquisition (rather than confrontation) that seems to best improve self-assessment (Kruger & Dunning, 1999; Kulik et al., 2007).

Possible causes of misplaced confidence. Part of the problem may be due to a lack of accurate feedback in day-to-day clinical practice. Since transgender individuals are already marginalized, they are in a poor position to directly confront their providers when problems arise. Instead, transgender people are more likely to respond indirectly, such as by terminating care prematurely or via broad noncompliance with treatment. Such responses have been observed in other marginalized groups (Johnson-Hood, 2017). Since the clients of lower performing clinicians may not provide feedback, these clinicians may persist in the same mistakes with each transgender patient they encounter. These clinicians never get the opportunity to learn from their mistakes because they appear largely unaware that mistakes have occurred.

Clinicians may also hold misplaced confidence due to broader problems with the application of multicultural values. Though many clinicians report believing in the importance of multiculturalism, few put those beliefs into practice. This was the finding in the Hansen et al. study (2006), which compared the stated multicultural beliefs and behaviors of 149 professional psychologists. Though the majority of psychologists said they believed in multiculturalism, many did not engage in multicultural behaviors. This suggests that for many, multiculturalism is soley aspirational.

Clinicians may also hold misplaced confidence because transgender issues have been subtly erased from instructional content. For example, the acronym “LGBT” has been increasingly used in brief segments of medical, social science, and psychology textbooks (Moll et al., 2014). However, this content tends strongly to focus on issues related to gay men, often leaving bisexual and transgender issues out entirely (Bauer et al., 2009; Benson, 2013). Practitioners who have been exposed to such content may mistakenly assume that they are LGBT-competent, unaware that information provided pertains primarily to gay men. This is another reason why an objective measure of readiness for work with transgender clients is necessary. It is anticipated that such a measure could be used to highlight this discrepancy.

Training Efforts That Backfire

Although transgender trainings are becoming more accessible, not all trainings are created equal. Some training efforts can even make things worse. Trainees may leave with increased animosity towards difference and a more rigid adherence to their original beliefs (Anand & Winters, 2008; Lowery, 2011; Mio & Awakuni, 2013). This is concerning as many training programs respond to struggling trainees by recommending they participate in awareness-raising or privilege-checking exercises. Such programs may then consider the matter settled, unknowingly passing along trainees with worsened aptitude. The following section will discuss the risks involved with attempts to train clinicians in transgender topics.

Emotional reactance. A possible explanation of why some trainees worsen after training efforts is that of psychological reactance (Brehm & Brehm, 2013; Lowery, 2011). Psychological reactance theory suggests that trainees react negatively to training efforts because they perceive it as a threat to their freedom to have private beliefs. This type of response may be understood as a form of existential self-preservation, albeit misplaced. Trainees similarly react negatively to the

suggestion that they may have subscribed to closed-minded behavior and thinking (Lowery, 2011). This defensiveness can make it more difficult to think carefully about challenging material. Studies have demonstrated a decrease in cognitive functions after individuals are confronted with their own bias (Richeson & Shelton, 2003).

One of the perennial difficulties in raising visibility is that while it can generate community and dispel myths, it also makes these communities more visible to those who are intent on harm. In this way, increased visibility is often accompanied by increased risk of violence. The shock experienced by those with privilege during these times is perhaps unsurprising since those with the lowest levels of awareness are also the most unaware of their lack of awareness (Kulik et al., 2007). During the initial encounters with difference, many are bound to react in a profoundly negative fashion. In a transgender training context, this could take the form of denying transphobia ("I'm not transphobic, they're just too sensitive"), pathologization ("but isn't this crazy?" or "I'm not transphobic, just being realistic"), rigid adherence to gender norms ("but they'll never be a *real* man/woman"), and exotification ("deep down, folks like that are probably perverted"), in addition to subtler forms of resistance and dehumanization.

One way to avoid this problem is to make trainings voluntary, thereby decreasing the exposure of this group to those who may have the most strongly negative reactions (Kulik et al., 2007). Although this may prevent some of the most reactive participants from attending, it also perpetuates the problem by allowing those with critically low skills to continue clinical work with this population. Self-selection for transgender training also does nothing to address how this population is already underserved. Since clinicians serve for the public good (BEA Virtual

Working Group on Restrictions Affecting Diversity Training in Graduate Education, 2015), it is troubling to think that some may be able to opt out of training to provide basic transgender care.

Reactance may also result from difficulty encountered when clinicians try to educate themselves. Transgender literature written for clinicians is often written from an advanced theoretical or political perspective (Benson, 2013). The other form the literature takes is diagnostic, focusing primarily on clinical (as opposed to community) constructs (Benson, 2013). Writings that focus on diagnosis can reinforce the misconstrual of gender diversity as a pathology (Fraser, 2009). Diagnostically focused writings also tend to reinforce concerns about misdiagnosis, stoking fears that patients may regret transitioning if too many are permitted to obtain it (Bess & Stabb, 2009). As was discussed previously, these tendencies exist within a history of mutual distrust between clinicians and transgender communities, in contrast to available empirical evidence. Regret after transition appears to have remained rare, even as the number of people transitioning has increased (Boenke, 1999; Ehrensaft, 2009, 2012; Hegarty, 2009; Lev, 2006; Nordyke et al., 1977; Rosenberg, 2002; Winkler, 1977; Wolfe, 1979; Wren, 2002; Yunger et al., 2004).

Learning versus gawking. While training efforts can be powerful, they can also unknowingly leave trainees with incorrect information. This was one of the findings in a mixed methods pre- and post-evaluation of a transgender 101 training program (Hanssmann et al., 2008). Researchers used surveys and open-ended interviews to evaluate what clinicians learned from these fairly standard introductory trainings. Although self-evaluations of knowledge before and after the training suggested an increase in knowledge overall, qualitative data obtained after the training suggest several problems continued, such an overly narrow, rigid, or otherwise

incorrect understanding of several commonly used transgender terms. For example, one participant defined *transgender* versus *transvestite* as follows:

> [A transvestite] either identifies themselves as female or feels female sometimes [but is] a male… has male genitalia. And so then, either lives most of their life or part of their life dressed up as a female… As opposed to a transgender person… who's taking more steps by taking hormones or doing surgeries or really transforming the physical nature of their body to be the gender that they think they are. (Hanssmann et al., 2008, p. 11)

Much is troubling about this statement. For one, such a response suggests a conflation of the umbrella term "transgender" with the desire to physically change one's body. As stated previously, many within the transgender community do not seek medical transition. Such an assumption could lead this practitioner to minimize the gender identities of many transgender people. This type of response would also fall under D. Johnson (2014)'s themes of Use of Transphobic and Incorrectly Gendered Terminology, in addition to the Assumption of Universal Transgender Experience.

Additionally, the last part of this comment, "to be the gender that they *think* they are" [emphasis added], suggests the clinician assumes the gender identity of transgender people is less valid than a cisgender person's (which, presumably, wouldn't be thought, it would just be obvious; Brekhus, 1998; Serano, 2017; Trubetzkoy, 1975). Though it may appear subtle, the use of "that *they* think they are" (emphasis added) could also suggest that the trainee believes the transgender person is alone in their conviction. This could be seen to fit within D. Johnson (2014)'s theme of Endorsement of Gendernormative and Binary Culture or Behaviors in that it suggests transgender identities are less real or natural than cisgender identities.

Similarly, some participants seemed to believe they could detect or identify transgender people by visual cues alone. One participant said, "[A] transvestite walks into your office, and… you can get a good sense that… *it's either a female dressed as a male or a male dressed as a female*" (emphasis added; Hanssmann et al., 2008, p. 11). This comment seems to suggest that this trainee is expecting that transvestites will be easy to distinguish from transgender individuals because they do not appear convincing or passable, whereas transgender people would appear passable. This is troubling for many reasons. If this clinician assumes they can distinguish transgender people from transvestites based on passability, they may doubt the authenticity of transgender patients who do not pass: an example of Endorsement of Gendernormative and Binary Culture or Behaviors (D. Johnson, 2014). Such an assumption could lead the clinician to assume that gender presentation in non-passing clients is for the purpose of entertainment or sexual gratification, which are often associated with transvestitism but would be inappropriate to suggest of a transgender person's identity. Such a suggestion would fall under D. Johnson (2014)'s themes of Exotification and also the Assumption of Sexual Pathology or Abnormality.

The comment concerning the ability to distinguish transvestites from transgender people is also problematic because these categories are not mutually exclusive. Individuals may move in and out of either identity or may even occupy both at the same time. To assume that one can distinguish between the two based on visual cues alone would be to assume universal transgender experience, another of D. Johnson (2014)'s common unhelpful responses.

Another risk highlighted by Hanssmann et al. (2008) was the mixed effect of having a transgender person present in the trainings. Although having transgender people involved was often perceived by trainees as both helpful and powerful, trainees also appeared to become rooted to these first impressions. For example, participants seemed to come away with the

assumption that most other transgender people would be the same as the presenter. One participant said,

> [W]hen [the trainer] finally identified himself as FTM [female-to-male], that was the first time that it struck me… you know, *this is what an appointment's going to look like, and this is what a transgendered person looks like* [emphasis added] … I'm sure my jaw just dropped to the table! … It was not who I was envisioning … and I guess I wasn't really thinking … that there was a large female-to-male population. (Hanssmann et al., 2008, p. 12)

The shock evident in this comment suggests that they discarded at least some preconceived notions about the appearance of transgender people. Chiefly, this trainee appears to have previously believed that (a) transgender people were mostly transgender women and (b) transgender people would be easy to detect. Several other comments suggest an expectation that the next transgender people they would meet would also be White, passing, and transmasculine (Hanssmann, Morrison, Russian, Shiu-Thornton, & Bowen, 2010). While the knowledge gained by trainees was important, the image that took its place was still overly reductive. Having never knowingly met another transgender person, the addition of one or two transgender people meant that their concept of what it meant to be transgender was still fairly limited. This is one of the reasons why it is important to evaluate skills; it is entirely possible that a trainee could continue having problems even after enthusiastic participation in training.

Additionally, the trainee's comment about their jaw dropping to the table suggests an element of *gawking* or viewing the transgender person as a shocking spectacle. Such a response fits well into D. Johnson's (2014) theme of Exotification. Though troubling, this response is also understandable given the pervasive expectation that gender and biological sex are stable and

immutable. People often respond with surprise when they first knowingly encounter a transgender person who passes well for this reason. Overall, the qualitative examination of these comments reveals that although overall knowledge may have increased, many trainees came away with a take-home message that was incorrect.

The illusion of open-mindedness. Clinicians can also run into trouble when they mistakenly believe themselves to be more open-minded than others. This was the finding in a study by Whitman and Han (2017). Like Hanssmann et al. (2008), Whitman and Han (2017) used a mixed-methods design to examine the training experiences of healthcare providers participating in a transgender 101 training. They also constructed a knowledge assessment instrument, essentially a brief transgender vocabulary test. Participants also responded to several vignettes of clinical cases that involved transgender issues. The use of a knowledge assessment instrument makes this paper particularly unique as most other studies of its kind rely entirely on self-report measures.

Whitman and Han (2017) found trainees were able to gain knowledge after participating in the training. Self-reports of comfort and confidence also increased after training. However, as discussed previously, careful analysis revealed several concerning features. Similar to Hanssmann et al. (2008), opportunities for open-ended answers revealed areas of incomplete or inaccurate knowledge. More troublingly, the clinicians who offered the most problematic answers also expressed high levels of confidence in their ability to work with transgender clients. These same clinicians also expressed a reluctance to refer clients to another, more experienced provider. Whitman and Han's analysis suggested that these clinicians viewed themselves as uniquely open-minded and nonjudgmental, despite evidence pointing to the contrary.

The Problem with Openness and Positive Intent

In the failure of self-report or outcomes-focused multicultural assessment measures, some have argued for a shift towards measuring dispositional values towards difference (Hook, Davis, Owen, Worthington, & Utsey, 2013). The theory goes that if clinicians strongly value the importance of cultural humility, they will be more interpersonally sensitive and more motivated to pursue cultural learning opportunities in the long term. This approach has broad appeal in training contexts since it can be applied to work with many different types of clients—something that has been difficult to achieve with other multicultural competency concepts. However, there are drawbacks to this approach. As described previously, many clinicians appear to consider themselves open-minded, even when their behavior demonstrates otherwise. Many also mistakenly believe themselves to be more open-minded than their peers. As with other self-report measures, approaches that focus on self-assessed cultural humility are bound to run into problems with *virtue signaling*, meaning inauthentic attempts to appear moral or charitable. Even when clinicians intend to appear humble, their lack of awareness can put them at greater risk of harming transgender patients (Lev, 2006).

The essential point is that there is a difference between knowing that sensitivity is important and knowing how to demonstrate it with special populations (S. Johnson, 1987). A humble person may still appear inconsiderate if they lack skills for demonstrating humility with a special population. As demonstrated in the section *Social and Historical Context of Transgender Healthcare*, several distinct sociocultural events complicate the provision of transgender healthcare beyond the problem of societal rejection. Another problem with positive intent is that it often remains just that: intent. Without ways of operationalizing cultural humility, one would

expect poor follow-through to be common (Hansen et al., 2006). As with many things, if one cannot measure it, it does not count.

The Problem with Self-Led Education

When the stakes for cultural trainings are high, trainees often become defensive. Training problems can resolve this problem by making aspects of cultural training optional. This is the case with Safe Zone trainings on LGBT issues (Killerman & Bolger, 2016). While voluntary trainings are thought to help reduce the risk of emotional reactance, there is a cost. Trainees with low levels of ability often do not participate, or may physically attend with lackluster or superficial participation. In this way, voluntary and low-stakes trainings often lead those who are skill-rich who become richer while the rest gain little or worsen (Kulik et al., 2007).

This relates to both training settings and evaluation. One cannot assume that self-led evaluation efforts (such as via individual use of the proposed instrument) would be effective. Those with low levels of skills or awareness are unlikely to seek out such evaluations. In addition, those who do are likely to disregard their results. Returning to Kruger and Dunning's (1999) work on unknowing ignorance, most participants with low levels of ability disregarded signs that they were low performers. This suggests that if an individual low-performing clinician or clinical trainee self-administered the proposed instrument, they would be unlikely to take their results seriously. However, these results could still be taken seriously by their supervisor or clinical training director.

This suggests that the proposed instrument will need to have clear administration guidelines. Instead of merely sharing the results with test-takers, the scores and recommended interpretation should also be sent to the test administrator (presumably, a supervisor or clinic

director). This administrator could then make the ultimate decision as to whether the clinician or trainee is ready to work with transgender clients.

Another important lesson from Kruger and Dunning's (1999) work was that self-assessment only improved after low-performers' skills improved. For example, while confrontations with performance results did not change self-assessed skills, participants could accurately self-evaluate their skills as their proficiency approached average levels. In other words, it was only after participants' skills improved to the point that they were no longer low-performers that they were able to assess themselves correctly. As such, self-led evaluation (for example, with the proposed instrument) is unlikely to be effective, as low-performing trainees are unlikely to be motivated by evidence of their poor performance.

Additionally, while trainers should take poor performance seriously, confrontation is unlikely to be effective. Such confrontations are more likely to lead to escalation than motivation for change. Instead, supervisors are recommended to set serious limits in a clear, but non-confrontational way. Ladany, Friedlander, & Nelson (2005) provide a good example. Trainers should be attentive to the emotional state of their supervisees and make ample use of reflection and empathy before offering evaluative information. When evaluators take this approach, they may be able to provide clear feedback while also taking concrete steps to protect transgender clients.

Although the main goal of the proposed instrument is to distinguish clinicians and trainees who are ready to work with transgender clients from those who are not, there are a few additional features that may be added at a later date. For example, since items are tied to specific unhelpful responses, it may be possible to generate specific training recommendations based on an individual's pattern of responses. In such a case, it may be appropriate for test takers to view

automatically generated recommendations for further reading based on their performance, provided that such recommendations be otherwise non-evaluative. It should be noted that this feature of the proposed instrument will not be addressed within the current study, but is an anticipated stage of future development.

What Works Better in Trainings

While, in most ways, trainers and curriculum authors have had little guidance as to what works in trainings (Curtis & Dreachslin, 2008), curriculum developers can make a few educated guesses. Trainings that are integrated and developmental appear to be more effective than those that are not (Anand & Winters, 2008). When trainings begin with a self-assessment and start with fundamental building blocks, there tends to be less resistance and better application (Anand & Winters, 2008; Kulik et al., 2007). Increasing accountability for trainings is also important, both for implementation and motivation during the training itself. Industrial research supports the active involvement of supervisors in training, as opposed to those led by third-party trainers brought in from outside the institution (Kalinoski et al., 2013). When trainees feel a sense of responsibility to put recommendations into practice, they are more adept at learning the material (Hanssmann et al., 2008). At the moment, most transgender 101 trainings have virtually no accountability system associated with them. They tend to be offered by third parties who come in for one-time training sessions. Follow-up after trainings is rare.

Accountability can be incorporated indirectly by making the benefits of changing attitudes or behavior explicit (Kalinoski et al., 2013). For example, training programs could still use an outside trainer provided that the expectations for learning be clear, actionable, and presented by a figure of authority. Such transparency and consistency are critical for diversity training efforts. Without this clarity, it becomes very difficult to address trainees who are

struggling, especially when trainees experience their struggle as a values conflict (BEA Virtual Working Group on Restrictions Affecting Diversity Training in Graduate Education, 2015; Cohen-Filipic & Flores, 2014). This is one of the reasons why descriptions such as "helpful" versus "unhelpful" are expected to be more effective. This conceptualization is more directly tied to clinical treatment goals, as opposed to aspirations of multiculturalism, political correctness, or personal beliefs.

Having a proximal focus may also make outcomes measurement more tenable—something that has been a problem with prior multiculturalism research (Kalinoski et al., 2013). For example, measures that are overly broad may not be sensitive enough to detect the level of change trainers can reasonably expect to result from their efforts. Small changes can still have a big impact, especially for those at critically low levels of skill. The hope is that trainees who would otherwise be at risk of causing psychological harm and premature termination might be able to establish good enough working alliance to make use of supervision and learn from experience.

Other trainer-specific traits can also be important. Specifically, trainers who are bicultural, flexible, and good at linking activities to readings and assignments appear more effective in multicultural trainings than others (de Anda, 2007). These traits appear useful in helping trainers translate cultural issues with sensitivity to how uncomfortable the learning process can be. This might suggest that trainers who are members of both clinical professional communities and transgender communities may be more adept than those who are not. On the other hand, research also supports trainers who hold positions of authority as being more effective than those who come from third parties (de Anda, 2007). Both approaches have benefit. The relative efficacy of using third-party transgender trainers must be weighed against the

benefits of using authority figures as trainers. Co-led trainings may make it possible to reap the benefits of both approaches.

The format of training also appears important. Interactive trainings that are at least four hours in length appear more effective than those that are briefer or purely didactic (Kalinoski et al., 2013). Many believe highly integrative trainings (as opposed to weekly seminars or solitary classes) are more effective (Kalinoski et al., 2013). Some specific teaching methods also show promise. For example, Role-plays and clear how-to guides are both popular with doctors (Hanssmann et al., 2010). However, methodological problems (such as an over-reliance on self-report measures) make it difficult to evaluate precisely which training approaches are the most effective at this time (Kalinoski et al., 2013).

Since prior evaluation efforts have relied heavily on self-reporting, the use of an objective skills-based measure may yield a clearer understanding of what works best in transgender trainings. In this way, it is hoped that the proposed measure may improve training efforts. Though this application is beyond the scope of this dissertation, it is worth mentioning here to illustrate future intended applications.

Identifying Resistant or Debilitating Problems Early

As established previously, it is often very difficult for those with low levels of skills to self-monitor. This means that those with the most difficulty working with transgender clients are also the most unaware that they hold this difficulty. Because of this, it is critical that gatekeepers to clinical professions take their evaluative role seriously (Cohen-Filipic & Flores, 2014; Toporek & Reza, 2001). Unfortunately, most clinical training programs do not assess for population-specific skills (Curtis & Dreachslin, 2008). When these aspects are assessed, it is typically in done on a case by case basis, or only in response to obvious problems in class or with

a marginalized client. Clear or systematic preemptive approaches are all but absent (Worthington et al., 2007).

One key area of focus is the identification of problems that are either debilitating (meaning they are either likely to cause harm or make progress unlikely) or resistant to remediation (meaning that problems persist despite reasonable effort on behalf of the trainee and the training institution). This is one of the problems that the proposed measure is intended to address. Trainees who perform poorly on the proposed instrument are presumed unready for work with transgender clients. This "ready" versus "unready" distinction sets clear minimums for performance, without having to put transgender clients at risk. In addition, if trainees continue to perform poorly on the proposed measure, even after efforts to intervene, their skills deficit could be understood as clearly resistant to remediation.

At times, supervisors may detect hints at larger problems, but have few means of addressing them until after the trainee is paired with a client from that population. If a problematic trainee is never paired with a transgender client, they may pass through their program without intervention (Singh & Chun, 2010). While supervisors and such trainees may be relieved by not having to confront issues with actual transgender clients, the danger is that this robs both trainees from the opportunity to grow and robs supervisors of the opportunity to intervene should the problem be serious. A benefit to the proposed instrument is that it may allow supervisors the opportunity to screen for problems without having to first subject transgender clients to trainees who would do them harm. Such screening could be initiated as soon as the supervisor learns the trainee is to be paired with a transgender client. Alternatively, such screening could be universally implemented as trainees first begin clinical work.

Defining Transgender Care

Over the years, there have been several guidelines defining competent to excellent work with transgender clients. As a reminder, the focus on competence suggests a higher level of skill than is of focus for the proposed instrument. Nonetheless, these guidelines are useful to review because they represent the most coherently organized prevailing professional opinions on transgender care. This section will briefly review these guidelines and recommendations. This section will also present the training and evaluation difficulties associated with these expectations.

World Professional Association for Transgender Health (WPATH). The most influential professional association defining the standards of transgender care is currently WPATH. The organization was originally known as the Harry Benjamin International Gender Dysphoria Association (HBIGDA), so named because of Dr. Harry Benjamin's leadership role in promoting transition-related care during his life. WPATH regularly reviews the Standards of Care it releases at international symposia, the most current of which is the *Standards of Care Version 7* (Coleman et al., 2012). These standards are extensive, covering recommendations for assessment, physical intervention (such as binding and tucking), psychotherapeutic intervention, hormonal intervention, and surgical intervention.

The WPATH guidelines also recommend that clinicians be capable of discerning between mental disorders and gender dysphoria. This guideline is notable since D. Johnson (2014) and Whitman and Han (2017) suggest that clinicians commonly have difficulty with this distinction. In addition, WPATH also recommends that clinicians have specific knowledge and awareness of gender nonconforming identities, as well as knowledge and awareness of gender dysphoria treatment. As a reminder, D. Johnson and Whitman as well as Han found widespread difficulty

in these areas, as evidenced by clinicians who reacted to passing transgender people with shock, and those who asked invasive bodily questions.

WPATH also recommends that clinicians have continuing education in assessment and treatment of gender dysphoria. As established previously, practical training can be difficult for many clinicians to find, and although trainings are increasing in number, there are few formal processes for evaluating the efficacy of these trainings (Kalinoski et al., 2013).

The American Psychological Association (APA). The APA has weighed in on transgender healthcare in a variety of ways. Before summarizing the stances of the APA, it is important to review how psychology ethics relate to the provision of transgender care.

Psychology ethics and personal beliefs. Within the APA Ethics Code (2017), several standards highlight the importance of ensuring competent work with special populations. To provide benefit and avoid harm, psychologists must practice within the bounds of their competence (Standard 2.01). Essentially, psychologists must only provide services that are consistent with one's training, expertise, and experience (with some exceptions for emergencies). Psychologists must obtain appropriate training before providing services to a population that is novel to the clinician, and take reasonable steps to ensure competent services when research for that population is unclear or emerging. Psychologists must also work to eliminate the effect of biases in clinical work (Principle E).

When personal beliefs conflict with psychologists' duty to the public. The difficulty is that, for some either in the profession or in training to join the profession, the work of eliminating personally held biases can feel like an attack on personally held values (Cohen-Filipic & Flores, 2014). This problem was highlighted by two recent legal cases in which trainees sued their educational institutions because of LGBTQ training requirements. During the

appeals process, it was argued that the students should have been given the opportunity to refer LGBTQ clients out to another provider (Hancock, 2014). This result is troubling as it seems to suggest it is appropriate for a clinician to withhold service based on prejudicial beliefs (Fischer & DeBord, 2007).

Subsequently, several psychology groups have waded into this dilemma. While not yet reaching the level of APA policy, the recommendations that are emerging emphasize the importance of protecting the client and challenging trainees' preconceived notions of human behavior (BEA Virtual Working Group on Restrictions Affecting Diversity Training in Graduate Education, 2015; Wise et al., 2015). The justification is that health professions, such as psychology, are unique in that they are for "the good of the public" (BEA Virtual Working Group on Restrictions Affecting Diversity Training in Graduate Education, 2015, p. 269). Psychologists provide a public service, so for them to be discriminatory impedes the full participation of marginalized people from public life. As a result, health professionals must be prepared by their training to work non-injuriously, even with diverse clients. This is why clinicians cannot simply refer transgender clients out (Hancock, 2014).

This raises a new dilemma. Since referring out is not an option, clinicians may instead opt to work outside of their competence (in this case, with a special population they are at risk of harming). Though it is clear that training programs should intervene when a clinician or clinical trainee's beliefs interfere with the provision of care, there remains little clarity about what level of risk should be tolerated (BEA Virtual Working Group on Restrictions Affecting Diversity Training in Graduate Education, 2015; Hancock, 2014). This lack of clarity in itself creates problems. Trainees who are identified for remediation may feel as if they were singled out arbitrarily. The level of change from them may also seem arbitrary.

Lesbian, gay, and bisexual guidelines. The APA periodically releases recommendations for clinical work with special populations. The first of these was the *Guidelines for Practice with Lesbian, Gay, and Bisexual Clients* (2015) adopted initially in 2000 and updated in 2011. Instead of listing culturally specific information about a marginalized group as previous guidelines had done, these guidelines were created to facilitate the development of culturally sensitive care within the profession as a whole (Noriega, 2012).

Transgender and gender nonconforming guidelines. After these lesbian, gay, and bisexual (LGB) guidelines were released, the APA convened a task force concerned with examining transgender concerns (American Psychological Association Task Force on Gender Identity and Gender Variance, 2009). They found transgender people have unique health, social, and advocacy needs, beyond what was mentioned by other prominent professional recommendations for this group. These early findings were used to initiate a new special population guide in 2015 for transgender clients. These guidelines, dubbed the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (American Psychological Association, 2015), included a total of 16 points, covering a broad range of fundamental concepts from the difference between orientation and gender identity to the need for interdisciplinary and intersectional care. Special sections on youth and elderly concerns were also included, something overlooked by the American Counseling Association guidelines published six years previously (Harper et al., 2013). Part of what makes these 2015 APA guidelines unique is the deliberate involvement of diverse transgender people in the writing process. Historically, guidelines have been by cisgender clinicians alone.

Groundbreaking though these recommendations are, their aspirational and vague nature makes them difficult to use for evaluation. While several of the guidelines describe specific

actionable behaviors (such as providing written affirmations for identity documents, normalizing reactions to oppression, introducing narratives written by transgender authors, and so forth), many of the recommended behaviors are quite broad (including language such as “be aware” or “be sensitive”). This ambiguity is difficult to operationalize. These guidelines also stand as recommendations, not requirements. As such, trainees may challenge the use of such guidelines as an enforced minimum standard.

Approaches to Skill Measurement

Just as multicultural conceptualizations have been gaining traction, so too have multicultural assessment tools (Gamst, Der-Karabetian, & Liang, 2011). Several broad measures of multicultural competence have been developed, primarily in the 1990s. These measures largely follow the tripartite model of multiculturalism, which involves knowledge, attitudes, and skill (Arredondo & Perez, 2006; Sue, Arredondo, & McDavis, 1992; Sue et al., 1982, 1998). The most well-known of these measures include the Cross Cultural Counseling Inventory (LaFramboise, Coleman, & Hernandez, 1991), the Multicultural Awareness Knowledge and Skills Survey (D’Andrea, Daniels, & Heck, 1991), the Multicultural Counseling Inventory (Sodowsky, Taffe, Gutkin, & Wise, 1994), the Multicultural Counseling Awareness Scale (Ponterotto, Gretchen, Utsey, Rieger, & Austin, 2002; Ponterotto, Sanchez, & Magids, 1991), the Multicultural Supervision Competence Indicator (Buchanan, 2006), and the Cultural Humility Scale (Hook et al., 2013). Most focus on attitudes, although fewer incorporate skills (Priester et al., 2008). It is interesting that the most skill-focused of these scales (the Multicultural Counseling Awareness Knowledge and Skills Survey) found training tended to have the smallest impact on skills (D’Andrea et al., 1991). This finding may reflect a tendency to emphasize the number of special groups covered in trainings, rather than the skills necessary to work with

specific groups (Priester et al., 2008). The addition of improved skill assessment tools may make it easier to improve the quality of training efforts systematically.

All of these scales rely on self-reporting, which, as previously established, is unreliable for those who have lower levels of ability. Self-reported items are also vulnerable to the ways in which such items are numerically presented (scales from -5 to 5 tend to be answered differently than those from 0 to 10; Schwarz, 1999). Some researchers have incorporated scales that assess social desirability in order to control for this problem (Bidell & Whitman, 2013; Kocarek, Talbot, Batka, & Anderson, 2001). However, independent observer ratings tend to show a lack of improvement, even with these and similar scales (Cartwright, Daniels, & Zhang, 2008). The desire to present a positive self-image or socially desirable responding may be more intense in evaluative settings (Constantine & Ladany, 2000; Constantine, Ladany, Inman, & Ponterotto, 1996).

A few population-specific assessment tools have been developed specific to clinical work with lesbian, gay, and bisexual clients. These include the Sexual Orientation Counselor Competency Scale (Bidell, 2005), Attitudes Towards Lesbians and Gay Men Scale (Herek, 1998), the LGB Affirmative Counseling Self-Efficacy Inventory (Dillon & Worthington, 2003), the LGB Working Alliance Self-Efficacy Scale (Burkard, Pruitt, Medler, & Stark-Booth, 2009), and the Ally Identity Measure (Jones, Brewster, & Jones, 2014). Like the various multicultural scales, these also rely on self-report of behaviors, attitudes, confidence, or skills. Overall, they tend to focus on self-reported attitudes more than on specific skills, which, as mentioned previously, are vulnerable to socially desirable reporting.

A few studies have modified scales for clinical work with lesbian, gay, and bisexual individuals so they, instead, refer to transgender individuals (O'Hara et al., 2013), though these

were used for individual studies. The instruments themselves have not been subject to peer review. The psychometric properties of these modified instruments have also not been established. In a similar vein, Walch, Ngamake, Francisco, Stitt, and Shingler (2012) have proposed a brief 20-item Attitudes Toward Transgender Individuals Scale. A similar scale measuring transphobic attitudes was developed by Hill and Willoughby (2005). However, as with the other scales described, these relied on self-reporting and also included outdated language. Researchers have also created brief transgender terminology quizzes to assess for knowledge more objectively in single studies, though these have not been rigorously evaluated (Whitman & Han, 2017).

There are also methods of assessing unknown or implicit bias (Greenwald, McGhee, & Schwartz, 1998). This method involves presenting categorical target stimuli (typically on a computer screen) and then measuring differences in reaction times on sorting tasks associated with stereotypes. The expectation is that longer reaction times with cross-stereotypical pairs suggest implicitly held attitudinal differences. The approach shares some history with Trubetzkoy's (1975) marked and unmarked concept (Brekhus, 1998), examined previously. This approach has been used to examine heterosexist attitudes (Cochran, Peavy, & Cauce, 2007; Sabin, Riskind, & Nosek, 2015). Researchers are just beginning to create implicit tests to examine transphobic, transmisogynistic, or cissexist attitudes (Wang-Jones, Alhassoon, Hattrup, Ferdman, & Lowman, 2017; see also Olson, Key, & Eaton, 2015). Though implicit tests may be used to raise self-awareness, it is not expected that they would be accepted as an actionable means of evaluating preparedness.

Test Development

This section reviews the prevailing approaches to test development and introduces the constructs as currently defined for this project.

Prevailing Approaches to Test Development

The *Standards for Educational and Psychological Testing* defines *test development* as the process of producing a measure of some aspect of an individual's knowledge, skills, abilities, interests, attitudes, or other characteristics (American Educational Research Association, American Psychological Association, and National Council on Measurement in Education, 2014). Tests are developed in an iterative process, with adjustments and revisions made after results from repeated trials and evaluations of test content and format. The goal is to ensure that test content (including both items and format) aligns with intended interpretation and that there is sufficient evidence to support the validity of these interpretations.

The process can vary but typically proceeds in three broad stages. First, developers focus on the development and evaluation of the specifications of the testing instrument (context, intended audience, intended examinees, and rationale). Next comes the development, tryout, and evaluation of the proposed items. After this has been completed, developers assemble the final items and supplimentary materials such as administration and scoring materials. Several iterations of review and revision are typically employed at each step.

The Current Study

The review of the literature suggests transgender people are currently underserved, in part due to common unhelpful responses from clinicians. Current training efforts are lacking, and can often backfire, especially for those clinicians with particularly low skills. Additionally, current methods of evaluating clinicians' basic readiness to work with transgender individuals are

insufficient, due to a lack of focus on critical skills and vulnerability to inaccuracies in self-assessment.

Several domains of unhelpful response have been identified and explored from both clinician and transgender client perspectives. These domains include Physical Threat or Harassment, Denial of Bodily Privacy, Denial of Existence of Transphobia, Denial of Individual Transphobia, Discomfort and Disapproval of Transgender Experience, Omitting Gender Matters From Therapeutic Conversations, Endorsement of Gendernormative and Binary Culture or Behavior, Assumption of Sexual Pathology or Abnormality, Exotification, Use of Transphobic and Incorrectly Gendered Terminology, Expecting Clients to Provide Education, Assumption of Universal Transgender Experience, and Expecting Binary Transition Norms. These responses are associated with higher rates of premature termination, except when clinicians were able to identify and address their mistakes.

This study involved the initial development of an instrument to assess clinicians' ability to avoid these unhelpful responses in their conversations with clients and patients. Such a measure is intended to be a test of minimum skills essential for respectful clinical work with this population, below which supervisors are strongly advised to refer transgender clients to another provider, and focus on sensitively building skills in the trainee.

CHAPTER III: METHODS

Overall Test Development, Steps and Progression

As explained in Chapters I and II, this study involved the development of an instrument to assess clinicians' ability to avoid common unhelpful responses in their initial conversations with transgender clients. The test development process began with a pilot study to create the test construct, format, and first iteration. This was followed by two-step process of revision using expert review. This process began content validation for specific items and the test as a concept overall. Future work has been planned to further refine and empirically validate the test for use in clinical training. This chapter provides an overview of the overarching test-development process in addition to details about test development completed thus far.

The overall development process was broken into several steps, as outlined in Table 1.

Table 1

Overall Development Methodology

Pilot project		
1.	*Planned Overall Project*	Drafted overall plan Defined construct, rationale Defined intended audience Defined intended examinees
2.	*Drafted First Iteration*	Drafted test format Drafted items
Current Study		
3.	*Preparation for Review*	Organized items, formatted for review Recruited Subject Matter Experts Screened potential participants (phone) Selected Subject Matter Experts Elicited written feedback on Iteration #1
4.	*Analysis 1*	Reviewed participant characteristics Reviewed quality and completeness of feedback Reviewed feedback fidelity Review for other important themes germane to content review Flagged items for revision

Overall Development Methodology

5.	*Revision 1*	Proposed revisions to item lines with scoring problems Proposed revisions for objectionable content, problematic dissent Organized proposed revisions for 2nd review (Iteration #2) Elicited feedback from Subject Matter Experts
6.	*Analysis 2*	Reviewed quality and completeness of feedback Summarized findings
7.	*Summary*	Consolidated Iteration #3 Summarized areas in need of additional review Prepared for next iteration

Future directions

8.	*Small field test*	$n < 30$ of intended examinees. Performance to be compared with Objective Structured Clinical Exam with transgender mock client
9.	*Development of scoring*	Establish cutoff score(s), Key
10.	*Development of test score reports*	Scoring and interpretation guide
11.	*Development of test security procedures*	Consult with psychometric publisher for recommendations. Finalize permissions, intentions for copyright.

Pilot Project

Planned Overall Project

This planning stage set out the intended purpose, construct, rationale, audience, and examinees for the test. This structure was created to flexibly guide decision-making throughout the iterative development process beyond the current study.

Defined construct and rationale. Transgender clients represent a vulnerable and underserved population, in part due to historical tension between medical and transgender communities. A variety of challenges in training and evaluation make it difficult to prevent harm using traditional supervision alone. This problem manifests in a variety of forms in transgender care, including several common unhelpful statements and questions in initial clinical encounters. These unhelpful responses have been described by microaggressions research and transgender population health studies (Applegarth & Nuttall, 2016; Bauer et al., 2009; Grant et al., 2011;

Haas et al., 2014; James et al., 2016; D. Johnson, 2014; Mikalson et al., 2012; Xavier et al., 2013). The content of these studies was interpreted and summarized by the primary researcher who brings both personal and professional experience as a transgender emerging clinician. These studies, and analysis by the primary researcher, provide theoretical construct for the proposed test.

What has not yet been established is whether the ability to avoid unhelpful responses on the proposed test will predict an ability to avoid these statements in person. This will require empirical validation at a later date.

Defined intended audience. The intended audience describes the intended administrators for the test. In this case, the audience includes supervisors and clinical training directors in the field of mental health (psychology, psychiatry, counseling, social work, or marriage and family therapy). Though other clinicians (such as nurses and primary care physicians) may at some point be considered appropriate audiences, the audience has been limited to the field of mental health for this project. The intended audience is assumed to have the desire to appear supportive of transgender clients, though not necessarily the skill.

Defined intended examinees. Test examinees are intended to be clinical trainees or supervised clinicians who may soon encounter a trans client. Examinees are assumed to have basic clinical interviewing skills. Examinees are also assumed to have had exposure to common aspects of mental health work, such as intakes, case formulation, and counseling. Examinees are assumed to have at very minimum a sixth grade English reading level. Examinees are also assumed to desire to at least appear well-intentioned towards transgender clients, whether they harbor implicit bias against this population or not.

Drafted First Iteration

Drafted test format. The format was designed in such a way as to realistically resemble initial clinical conversations such clinicians might have with transgender clients (Appendix D). Test content was organized by *item lines*, meaning each line of the instrument as opposed to scored problems and answers only. This was done to make marginalia easy to review in an organized fashion, and to allow room for review of possible answers independent from items as a whole. Readability of the test was kept to the sixth grade in order to reduce emotional reactance (Lowery, 2011). Similar to an Objective Structured Clinical Exam (OSCE; Harden & Gleeson, 1979) the test was designed in the style of a vignette. The test opens with a hypothetical first encounter with a transgender client. Examinees are given options for ways to gather information and establish rapport during this hypothetical first conversation. They are then asked to describe whether several possible responses are expected to be generally "helpful" or "unhelpful." However, unlike an OSCE, it was designed to be easy for non-experts to score and interpret. In this way, the instrument operates more as a screening tool than comprehensive exam.

This vignette style was adjusted slightly to add item lines that directly address the microaggressions of Denial of Bodily Privacy and Terminology (Item Line 55). This was done because emerging research suggests mistakes of these types are both common and particularly harmful (D. Johnson, 2014).

Scoring format. Since the goal is to identify clinical trainees who are unprepared even with supervision, examinee performance was designed to be evaluated in a binary fashion. Clinicians are assumed to either be ready to conduct such clinical conversations, or they are not. The cutoff score, as well as other additional scoring details such as item weighting, are planned for future development (Table 1).

It is expected that with the published iteration the results of testing will be sent to the test audience, not to the examinees themselves. This is because self-led assessment for this topic is expected to be ineffective (see The Problem With Self-Led Education). Supervisors are to be given instructions for interpreting test results. These instructions will be developed at a later date (Table 1).

Drafted items. Test content was inspired by actual statements made by clinicians as described in prior research (Applegarth & Nuttall, 2016; Bauer et al., 2009; Grant et al., 2011; Haas et al., 2014; James et al., 2016; D. Johnson, 2014; Mikalson et al., 2012; Xavier et al., 2013) and by professional and personal experience of the primary researcher. Some responses were written with the assumption that they would be considered helpful by most transgender clients and expert clinicians (see Defining Transgender Care). Others were written with the assumption that they would be considered unhelpful by most transgender clients and expert clinicians (see Defining Unhelpful Responses).

Since the intended population to be tested is assumed to have taken exams previously, items were constructed to account for the problem of *test-wiseness* (Lane et al., 2016). Specifically, item structure was designed to account for the possibility of correct answering via unrelated knowledge, skills, and abilities (such as the use of process of elimination). For example, while an examinee might not be able to detect “Are you gay?” as likely harmful, they may be able to after seeing “How would you describe your orientation?” as a possible answer. This problem was accounted for by including multiple possible correct answers and several potentially ambiguous decoy items (unscored). Examinees who endorse these items will not be penalized for their responses. These items were labeled as such to aid participant readability during Subject Matter Expert review.

The Current Study

This section details the methodology within the bounds of the dissertation. This involves examining the content validity of the format and proposed items by way of systematic expert review.

Preparation for Review

Items drafted in the pilot study were organized into a packet useful for eliciting in-depth content review (Appendix D). The packet contained a brief introductory letter, which consisted of two pages providing context and rationale for the proposed test. The items on the test were organized into an expanded format to provide room for questions about individual items, as well as several open-ended questions about the test as a whole. The packet also included a page summarizing several common microaggressions (D. Johnson, 2014; Nadal et al., 2012). This page provided sample shorthand for these microaggresions that participants were encouraged to use in their written feedback. After feedback from the first two participants, subsequent participants were encouraged to print this page out separately for reference during their review process (Appendix D).

Recruitment

First, subject matter experts in transgender counseling, transgender identity, and clinical training (n=10) were recruited (Appendix A). Interested parties with experience beyond that of the primary researcher were invited to participate. Experts in transgender identity, transgender counseling, and supervision were sought. Interested parties were recruited by reaching out to the authors of papers on transgender counseling and microaggressions, transgender clinical consultation groups, and the extended professional network of the primary researcher. No

participants with personal or professional relationships with the primary researcher were included.

Following completion of the informed consent form (Appendix B) fit was assessed via a 30-minute phone interview (Appendix C). This phone interview screened for fit, expertise, and ability to emotionally tolerate proposed content. Participants were also given the opportunity to ask questions about the study, and what to expect from participation. Answers focused on clarifying the process of test development for the current study. The need for diverse points of view in feedback (as opposed to praise or support) was also emphasized. Responses were de-identified and encrypted by the primary researcher. Informed consent forms were stored in a hard-copy format in a locked cabinet at the residence of the primary researcher. Identification information was stored separately in a secure note using LastPass, a cloud-based storage system.

Elicited Written Feedback

Approved reviewers were provided with a packet of the proposed instrument, rationale, and scoring instructions, and request for feedback (Appendix D). This packet was provided on the same day of the phone interview. Participants were prompted through email after two weeks if they had not yet returned the packet. Feedback was collected during February and March of 2018. Transcription was completed as packets were returned. Feedback from subject matter experts was de-identified and entered into a consolidated raw data spreadsheet, then organized item-by-item. This spreadsheet was then uploaded to Dedoose for coding, with the ultimate goal of using Dedoose exports for quantitative analysis.

Analysis 1

Analysis proceeded in several steps (Table 2). A Pragmatic design (Henderson, 2011) was used to guide the systematic process. This approach involves linking the method of analysis

directly the purpose and nature of the research questions (Armitage, 2007; Creswell, 2003; Henderson, 2011). While post-positivist in philosophy, this approach is more grounded in utility than in a search for ultimate truth, a common approach in mixed method studies. This means that the depth of analysis was focused on utility to revision, as opposed to proof of validity.

Analysis focused on detecting serious problems with the proposed format, content, and use of the test, in addition to detecting feedback constructive to the revision process. Serious problems, in this case, were defined as any problems large enough to suggest the project was not feasible. This approach was chosen because the proposed instrument is in a relatively early stage of development.

The bulk of the analytic work involved organizing data into a format that allowed for review of the proposed test as a whole, within-item feedback, and the relationship between data and participant expertise. A Microsoft Excel spreadsheet was used for this purpose, as inspired by the use of Microsoft Excel by Mulick (2016) for phenomenological analysis. Second to organization, considerable work was also spent reading, re-reading, transcribing, and reviewing collected data.

Primary researcher process. The primary researcher's identity was important to account for during analysis. Much of the content reviewed overlapped with personal experience. This was notable both with data analysis and during literature review. It was also important to consider how the primary researcher's identity (white, passing, nonbinary, trans male) was both a benefit and a limitation. The insider knowledge of one individual cannot account for all trans experience. Feedback that initially appears confusing or incorrect may be little more than unexpected. The bounds of "practical utility" can also be influenced by the primary researcher's

position. As a graduate student, there was incentive to limit analysis to allow for timely graduation.

To account for this positioning, the process of review involved reflecting on four main questions: “Did I understand the feedback,” “Did the reviewer understand the question,” “Is this feedback helpful for this stage of test development,” and “Is there sufficient expertise to make a revision decision.”

Table 2

Two-Step Systematic Expert Review

1. Evaluated Participation
    - 1a. Reviewed Participant Characteristics (Based on typed summaries of brief phone interviews)

2. Determined Quality & Completeness of Feedback
    - 2a. Reviewed Completeness (Quantitative, Descriptive Statistics)
    - 2b. Reviewed Fidelity (Dissent count, Open-ended feedback, Descriptive Statistics of microaggression theme use)
    - 2c. Reviewed Quality of Open-Ended Expert Feedback (Identify themes in open-ended feedback)

3. Identified Themes in Feedback Germane to Content Revision

4. Identified Items to Revise
    - 4a. Items with Objectionable Content (Described as offensive or associated with emphatic response)
    - 4b. Items with Scoring Problems (Participants scored contrary to expectations)
    - 4c. Items with Problematic Dissent (Inconsistent scoring)

5. Tentative Revision and Second Review
    - 5a. Drafted Revised Items
    - 5b. Organized Format for Review
    - 5c. Brief Participatory Review of Revision
    - 5d. Reviewed Feedback from Participatory Review

Reviewed participant characteristics. The first goal was to determine if feedback on the proposed measure was of sufficient quality and quantity to cap participation for this stage of analysis. Participant characteristics were transcribed during the phone interview process (Appendix B). The de-identified transcripts were summarized to create a spreadsheet generally

describing the clinical experience, gender identity, and area of expertise across participants. For statistical analysis purposes, gender identity was grouped according to the following labels: "cisgender" vs. "transgender," "transmasculine" vs. "transfeminine," and "binary" vs. "nonbinary." These groupings were used to make comparisons for differing positions with regard to gender, and differing areas of expertise. Though these differences in identity are common areas of focus within transgender research (Haas et al., 2014; Salkas, Coniff, & Budge, 2018), it should be noted that these groupings were created for statistical analysis only. It should not be assumed that these groupings equate to separate or specific gender identities in of themselves (Salkas et al., 2018).

A simplified spreadsheet with de-identified responses from each participant was created for reference. This spreadsheet described concrete characteristics (such as degree type and years of experience). Generalizations about described experience were also summarized in this table. These descriptions emerged naturally from the phone interviews themselves. For example, participants were described as having predominantly transgender identity experience, versus transgender counseling experience, or supervision on transgender topics. When relevant, details about their clinical experience were included (such as if they indicated they worked "primarily transgender people of color" or "transgender children").

Reviewed quality and completeness of feedback. Completeness was examined in both Dedoose and in the consolidated raw data spreadsheet. To describe completeness, the following codes were used: "Complete," "No Response Needed," and "No Answer." This was quantitatively analyzed using spreadsheet exports from Dedoose. Descriptive statistics were pulled in SPSS for all items, items in specific sections, and items as completed by individual participants. Due to the small overall number of participants (n=10) and complexity of

participant characteristics, visual comparison with the participant demographic and experience spreadsheet was used to check for relationships between completeness and participant characteristics.

The quality of expert opinion was examined next by detecting the presence of objectionable content not caught by the primary researcher (as evident in open-ended comments and unexpected scoring suggestions, particularly if responses were well-reasoned).

Reviewed feedback fidelity. Consistent and careful adherence to prompts (hereafter referred to as *fidelity*) was examined using descriptive statistics for patterns of dissent. This was done in both Dedoose and in the consolidated raw data spreadsheet. Each format presented slightly different visual presentations of the data. The spreadsheet was used to examine patterns of dissent in scoring on each item (more visually apparent in Dedoose), and on the test as a whole (more visually apparent in the consolidated raw data spreadsheet). Responses in the consolidated raw data spreadsheet were color-coded red for "unhelpful," green for "helpful," and yellow for "ambiguous." Since the terminology section of the instrument had a different scoring format (multiple choice), green was used for answers that corresponded with the primary researcher's intentions for the item, red was used for responses that did not correspond with intentions, and yellow was used for tentative or ambiguous feedback. Open-ended comments were used to clarify coding when responses were ambiguous, unclear, or otherwise inconsistent. Scoring feedback across all participants for each item was also labeled as "Unanimous," "Mostly Unanimous" (1–2 dissenters), or "Mixed" (3+ dissenters).

Descriptive statistics for participant use of D. Johnson (2014) codes in feedback was also incorporated at this stage via Dedoose, using the same coding system provided to participants

(Appendix D, Appendix G). Descriptive statistics were run in SPSS for code use overall and for code use by participant.

Reviewed for other important themes germane to content revision. In this step, other items in need of revision were identified based on findings as they emerged from analysis of open-ended comments. For example, themes related to emphatic content, open-ended comments on microaggression types, and use of personal disclosure were examined at this stage.

Flagged items for revision. Flagged items were organized into tables based on the type of problem they were most strongly associated with (scoring problems, problematic dissent, and objectionable content). Problematic dissent refers to items with feedback that suggests problems with the proposed scoring (as opposed appropriately mixed dissent, such as for ambiguous decoy items). Objectionable content in this context means any prompt or helpful item that participants described as offensive, or described in negative emphatic terms. Constructive comments were summarized for each flagged item.

Revision 1

Drafted revisions to item lines. Redundantly flagged item lines were condensed into overlapping tables to simplify review and reduce the likelihood of creating new redundant items during revision. These tables included brief summaries of expert feedback. The condensed tables and the guiding statements from the Pilot Project were used to guide revision. A separate table was created to summarize revision decisions.

Organized proposed revisions for second review. The revised items were organized into a four-page packet (Appendix F). Each revised item was presented along with the original item for comparison. Transgender identity expert reviewers were contacted again via email to get feedback on revised items. This feedback period was kept open for one month.

Analysis 2

Since only two of the original experts responded to feedback during this round, analysis was brief. Feedback was organized so that it was visually possible to see feedback from both participants simultaneously. Tentative findings were summarized.

Summary

Revised item lines were incorporated into this study's third iteration. Areas in need of additional review were highlighted, and findings from Analysis 1 and 2 were summarized. The future directions section of the Overall Development Methodology was revisited. Additional research steps were added to accommodate obstacles that emerged during the current study.

CHAPTER IV: RESULTS

This project proposed an objective instrument for assessing a mental health clinician or clinical trainee's ability to discriminate between helpful and unhelpful responses commonly made in the initial clinical encounters with transgender clients. As explained in Chapters I and II, this work is necessary to improve clinical work with this underserved population, especially as it relates to training and supervision. Since the current study represents the first instrument of its kind, the two primary goals of this study were to get feedback on the feasibility of the proposed test as a concept, and on the content validity of specific items.

As described in Chapter III, a group of ten subject matter experts was recruited and provided with a packet containing the proposed test and instructions for review. They were provided with information about the D. Johnson (2014) microaggression constructs used to develop items and were also asked open-ended questions about their impressions of the test as a whole. This chapter reviews the results of their feedback and the process by which this feedback was analyzed and incorporated into the next iteration.

Participation Characteristics

The experts selected for this study described having a broad experience with transgender identity, counseling, and supervision (Table 3).

Table 3

Participation Demographics

Expertise	*n*
Transgender counseling experts	9
Ph.D. or Psy.D.	3
Master's level with 6+ years' experience	5
Transgender identity experts	6
Identifies as transgender	7
Transgender People of Color experience	3
Nonbinary experience	5
Transgender children experience	2
Transgender seniors experience	3
Supervision, Consultation, or Teaching	4
Supervision	2
Consultation	2
Teaching	2
Gender Identities	
Cisgender	3
Transgender	7
Nonbinary	5
Transmasculine	3
Transfeminine	2
Total	10

Participants included both Master's and Doctoral level clinicians with an overlapping range of expertise areas. The most common combination of skills was having both transgender counseling and transgender identity experience (*n*=5). Though some participants described having experience providing supervision or transgender-specific consultation (*n*=2), this tended to be a minor portion of their clinical practice overall. Among clinicians, participants described working with a wide variety of ages and points of identity development. Clients were described as ranging from as young as five to eighty years old. It is also worth noting that participants described experience working with a wide range of nonbinary identities such as *gender fluid, demigender, pan-gender, agender, aporogender, gender mermaid,* and more. Clinicians also

spoke of work with clients whose gender identity was strongly grounded in their ethnic identity. In addition, participants also described working with clients at different points of gender identity development. For example, they described experience with clients who were questioning their gender, thinking about starting social or medical transition, actively transitioning, and those who were either uninterested in transitioning or considered themselves post-transition. Participants also described working with clients whose transition process fell outside dominant expectations, such as transitioning in a less common order (for example, having surgery before or without hormones). Clinicians also described working with clients transitioning toward a mixed genital configuration for identity congruence (as opposed to available surgical or medical techniques).

The participants themselves also represented a range of identities. Amongst transgender participants (*n*=7), more identified as nonbinary (*n*=5) than binary (*n*=2), though some indicated that the nonbinary aspects of their identity were only selectively disclosed to others. Since nonbinary issues and perspectives are currently underrepresented in clinical literature, no additional binary-identified participants were recruited. It is also worth noting that slightly more participants identified as transmasculine (*n*=3) than transfeminine (*n*=2). Since transfeminine communities experience higher rates of violence (Edelman, 2011; James et al., 2016; National Coalition of Anti-Violence Programs, 2011; Saffin, 2011), their perspectives sometimes differ from those of transmasculine transgender people. For this reason, a transfeminine non-clinician was included in the participant pool.

It is also interesting to note that several participants expressed that it was difficult to describe their gender identity. For example, some spoke of not resonating with dominant gender concepts, or indicated that their gender identity was fluid or still evolving. Participants also

described problems finding words that sufficiently conveyed their experience of gender to those who were binary.

Cisgender participants (*n*=3) described having a close friend or family member who was transgender. Two out of the three cisgender participants voluntarily described themselves as members of the greater LGBT or queer community, though this was not a question that was directly asked.

Participants often described seeking additional transgender training early in their career. Most described themselves as transgender experts within their local practice. Others described being selective about disclosure as an expert with local colleagues, but extensively involved with transgender counseling issues via research, advocacy with their own clients, and conferences. Most participants practiced in liberal metropolitan areas, though one described spending a considerable portion of their career in a conservative suburban area. Three described having extensive experience with transgender people of color (TPOC), meaning these clients made up the majority of their practice. Participant characteristics did not contribute to obvious differences in feedback.

Quality and Completeness of Feedback

Completeness

Completeness varied more by section than by participant, though some participants provided more complete packets than others (Figure 1). For that reason, analysis focused on within-section completeness, as opposed to completeness overall.

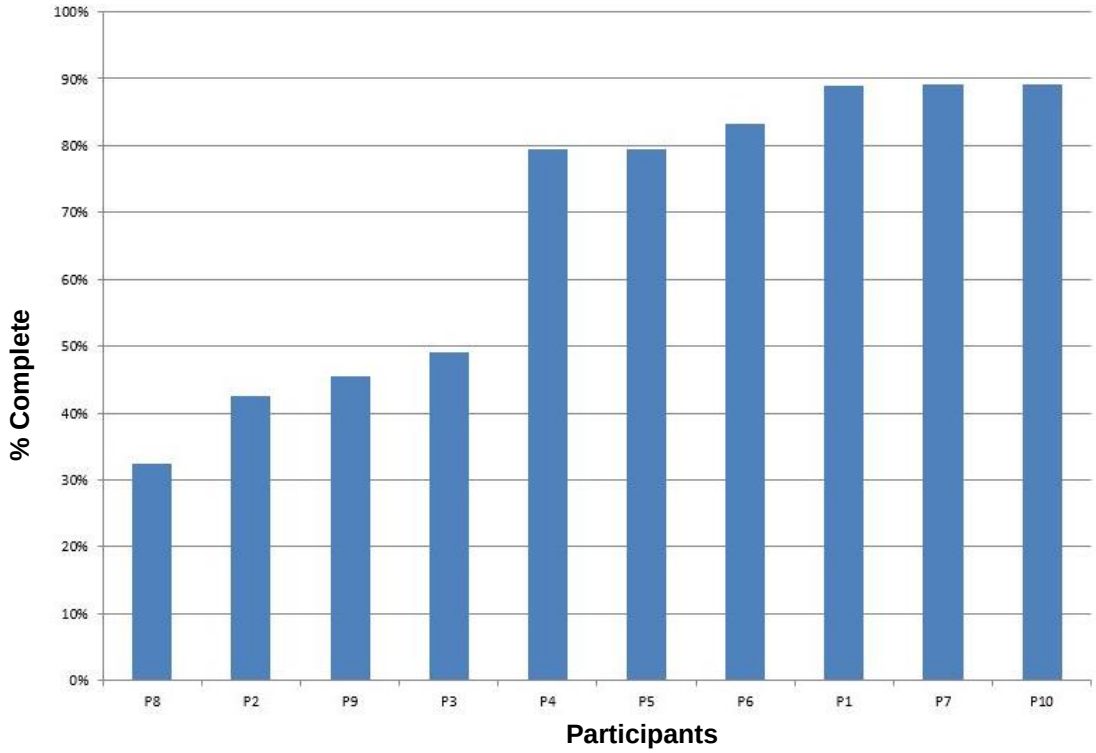

Figure 1. Completeness by Participant Overall

Vignette section completeness. Most participants completed the first section (Vignette) skipping items only occasionally. Of the 52 item lines requiring a response, 30 (57.7%) had responses from all ten participants. Of required item lines with a blank response, most (18, 81%) had a response from at least eight participants. One participant (P8) was responsible for most of the skipped items in the Vignette section. This participant indicated that they were aware their feedback was incomplete, and wanted to submit what they could within the time provided.

Terminology section completeness. Completeness decreased sharply in the second section (Terminology). Though this section is brief (40 simple item lines compared to 60 complex item lines in Vignette), five out of the ten participants gave unusable responses to the entire section. This may have been due to a combination of fatigue and an abrupt change in item style. One participant described these items as “helpful” or “unhelpful.” Though this was asked

of the 60 item lines preceding it, this was not what was asked in this section. Though completeness varied between participants, there were no clear relationships with participant characteristics for this section. Completeness was deemed unsatisfactory for this section.

Fidelity

Vignette section fidelity. Most items in this section had Unanimous feedback (29, 59%), meaning all participants who answered the item scored it the same way ("helpful" or "unhelpful"). Scoring for other item lines was Mostly Unanimous with one or two participants dissenting from the majority opinion (13, 27%). Others were essentially Mixed with three to five participants dissenting (7, 14%).

Terminology section fidelity. Acceptable fidelity, meaning uniform and faithful response to prompts, was not reached for the Terminology Section, in part due to problems with the higher rate of incomplete answers for this section. Participants also gave dissenting responses. For example, one participant (P1) scored the item line "Someone who describes themselves as genderqueer was probably _____" (Item Line 84) as "None." All other responses to this item line were "Any of the above." No other comments were added in this response. A second area of possible dissent was that one participant (P10) selected "Other transgender people" as a possible additional correct answer to several items in this section. Another (P6) offered responses that corresponded with the majority opinion but indicated they were unsure of their answer with question marks. Feedback for this section was deemed insufficient to proceed with further analysis.

Overall fidelity: Dissent. Counting by item line and excluding all-blank item lines, most participants *dissented* (disagreed with the majority response) once or twice overall (Average 2.2, Median 2, Mode 2, Figure 2). The max number of times dissenting was 5. One participant (P8)

with relatively low completeness never dissented. Dissent overall fit normal distribution by Shapiro-Wilk test and visual appearance (Appendix G).

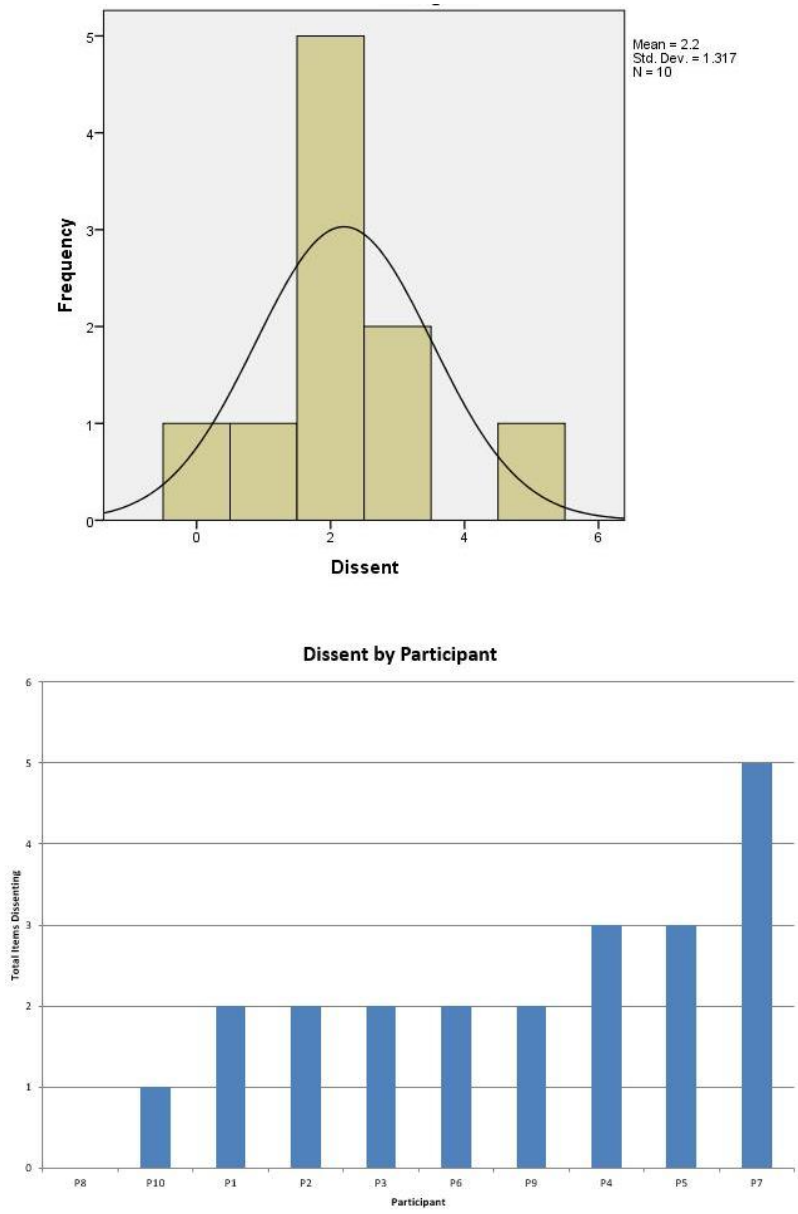

Figure 2. Dissent Overall

If a participant left a comment in the same response that suggested they did not follow the prompt, their response was not counted as dissent. Accounting for this, there were still times when dissent was ambiguous. For example, a few items were marked as “helpful” and then clarified as “potentially unhelpful” by the same participants in open-ended feedback. Agreement in open-ended comments was used to weigh otherwise conflicting feedback. When this was not possible (for example, if the dissenting participant added no supporting argument or detail), greater confidence was given to the majority response. Ambiguity was most common for item lines that were Mixed overall. It should be noted that Mixed dissent does not challenge the validity of all item lines the same as some items were constructed to be ambiguous (see Pilot Instrument, Drafted Test Format).

There were no obvious trends in participant characteristics associated with dissent. Excluding items lines where no answer was needed, 53% were Unanimous, 27% Mostly Unanimous, and 14% were Mixed. Of Unanimous item lines, only two items were identified as unanimously helpful (Item line 45: “Reflect, ‘it sounds frustrating that it's still happening,’” and Item line 51: “Ask what they have been doing to cope.”).

Fidelity of overall instrument feedback. In addition to confusing or incomplete responses to the Terminology section, several open-ended comments on the instrument as a whole suggest a few participants may have been confused about the intended format and use of the final test. For example, one participant (P7) suggested that asking trainees to list the microaggression types would not be helpful. This task was included for content review only and is not to be included in the final test. Other participants may have also held the mistaken assumption.

Quality of Open-Ended Expert Feedback

In addition to scoring patterns, participants also contributed by way of open-ended comments in response to specific items, and the proposed instrument as a whole. Emphatic content and personal disclosure gave clues about the quality of feedback overall.

Emphatic and personal content. Participants often used emphatic punctuation (*n*=40), sometimes capitalization (*n*=9), and occasionally expletives (*n*=6). Use of sarcasm and humor was also present. Sarcasm and the use of *scare quotes* (quotations added for sarcastic reference, as opposed to citation) was used 42 times overall. These feedback elements often overlapped. For example, P2 left the comment "GAH! Unhelpful" as a part of their response to Item Line 11 ("I am sorry, I am unable to help you. I am going to have to end the session now"). Excluding the Terminology section, most item lines had emphatic comments from at least one participant (37, 71.1%). Some item lines garnered three or more emphatic comments (6, 11.5%).

At times, participants added recommendations such as additional steps a counselor might take to improve the conversation after a mistake, or why they felt a counselor might make a given mistake. Similarly, comments occasionally included personal experiences with clients and other clinicians.

Certainty in feedback. Some participants had strong opinions on some items, writing at length and including personal experiences in much of their feedback to support their position. Others tended to give more tentative feedback, expressing that they were unsure. Very often tentative feedback was thoughtful, suggesting experts could see scenarios from multiple perspectives. In some cases, participants added exceptions or modifications that would lead them to interpret content differently. This feedback illuminated areas where items and instructions could be re-worded for clarity. On a few occasions, this feedback strayed from the limitations of

the test, such as by suggesting alterations to the proposed instrument that would make it impossible to use as a screening tool.

Use of D. Johnson themes. Participants tended to endorse multiple microaggressions for each unhelpful item (Figure 3).

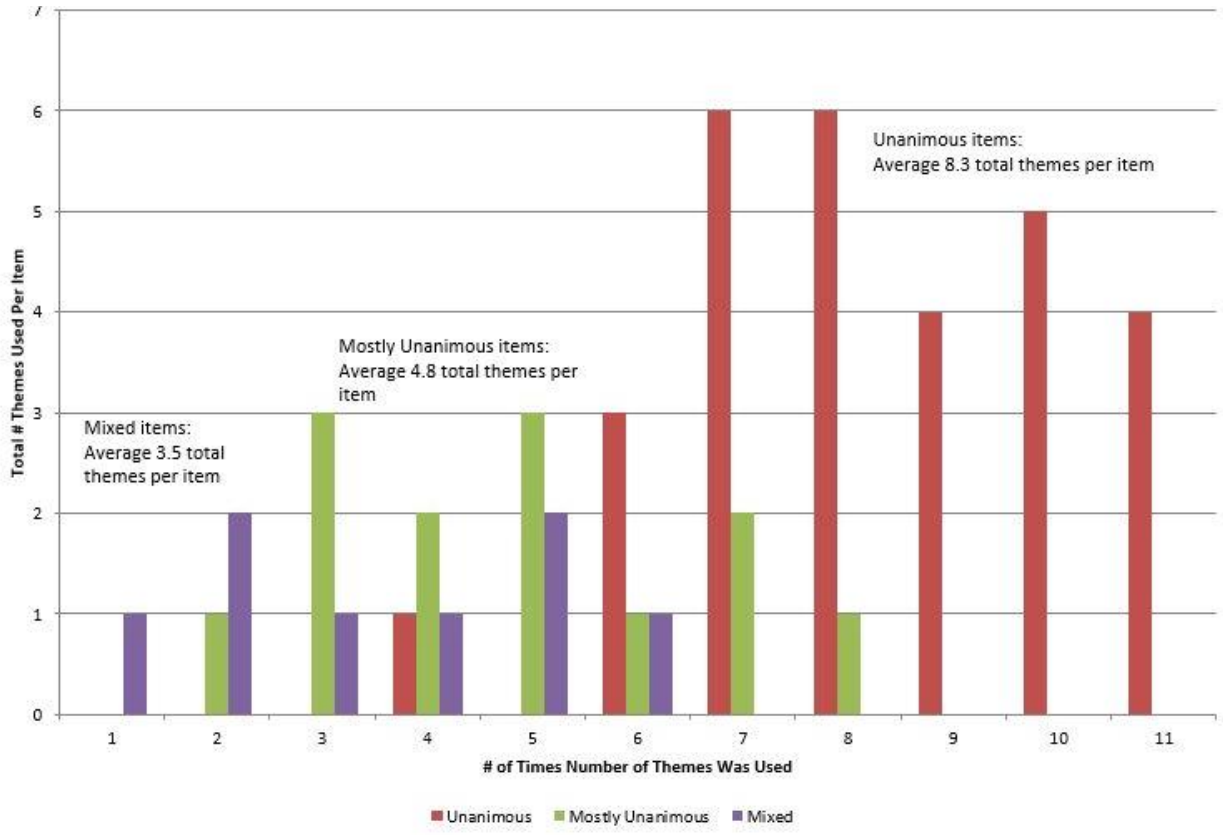

Figure 3. Theme Use by Agreement Category

For items with the broadest agreement (Unanimous items), the average number of microaggressions used was 8.3. This made between participant-participant comparisons for each of the 110 total item lines untenable. However, broad trends in microaggression use on the test overall could be described. Themes that were conceptually close (such as Endorsement of Gendernormative and Binary Culture or Behaviors and Expecting Binary Transition Norms)

were endorsed within one standard deviation of each other. This means themes that constituted similar mistakes tended to be endorsed a similar number of times as each other. An exception was Physical Threat or Harassment and Discomfort and Disapproval of Transgender Experience. These were more than two standard deviations apart. Overall code use fit within a normal distribution by visual appearance and Shapiro-Wilk test (Df 13, Sig. 0.997).

Emphatic content was deemed constructive to the review process because arguments were often well-reasoned and congruent to the intended intensity of the item. Themes with a strong association with negative outcomes also appeared more frequently in items tagged with emphatic content (particularly for Physical Threat or Harassment, Denial of Bodily Privacy, and Assumption of Sexual Pathology). The only exception was item line 46: "Encourage them to transition further or faster." With the exception of Physical Threat or Harassment (which had an *n*=0 in D. Johnson, 2014), these themes were associated with higher rates of premature termination. For this reason, emphatic content was deemed constructive for the current study.

Quality of feedback on the proposed test as a concept. A few participants left open comments on this topic consisting of several paragraphs. Others gave brief answers or left this section blank. Other comments related to the proposed test as a concept were present in open comments for individual item lines. For more on these comments and interpretation, see Chapter V for discussion.

Summary of Quality and Fidelity of Open-Ended Feedback

Overall, participants raised many points that had not been considered by the primary researcher. The presence of thoughtful dissent made it possible to identify areas of possible objectionable content for revision. Though the primary researcher has extensive experience with transgender identity, participants were nevertheless able to identify problems that were not

caught before review. This suggests the feedback methodology was successful for this stage of test development.

However, there were also content areas that garnered vague or incomplete feedback. For these items, participants occasionally described their position, but not their reasoning. Some participants skipped several items in a row, though this was limited mainly to the Terminology section.

Identified Items to Revise

Items in need of revision were identified based on the presence of three factors: Dissent (Mixed and Mostly Unanimous), Objectionable Content, and Scoring Problems. Tables for each category were created to organize item lines flagged (Appendix E). Redundantly flagged item lines were condensed to simplify review. Since the Mixed table overlapped completely within Scoring Problems, these tables were condensed into one (Item Lines with Scoring Problems, Table 4). Since Objectionable Content that was unanimously scored as “unhelpful” needed no revision, these items were removed to a separate table (Uncomplicated Emphatic Content, Table 5). The remaining Objectionable Content item lines overlapped with both Scoring Problems and Mostly Unanimous tables. As such, a separate table for Objectionable Content was deemed unnecessary. The remaining tables were Item Lines with Scoring Problems (Table 4) and Item Lines Scored Mostly Unanimous (Table 6).

Table 4

Item Lines with Scoring Problems

Item Line	Content	Feedback summary
15	Have you taken any steps to transition?	*"Have you"* presupposes that transitioning is the goal, but may be necessary in formal interviews.
16	What steps have you taken so far to transition?	Similar feedback to 15, assumes that transition is a goal.
19	When did this first come up for you?	Suggestive of an "origin story" (P3). Only appropriate within a WPATH context, and complicated then too.
22	Have you told anyone else before?	Shaming tone, presupposes someone is newly transitioning.
28	I have had some training on this issue, but everyone is different.	Phrase "this issue" flagged as problematic phrasing. Suggests being transgender is an issue.
35	Before we finish, I'd love a chance to get feedback on how this visit went for you. But you should know that it's also not your job to have to educate me.	Could constitute a backhanded request for reassurance or education. Overall gestalt of the item described as "awkward" (P4, P9).
37	I am not an expert in that, but I would be happy to help you with other problems.	Though some indicated it would be helpful, unhelpful endorsements were clearer and had no preconditions (such as providing adequate referral).
38	Feel free to let me know if something I say doesn't come out right. I have had some training, but there's always room for improvement.	Some saw as a helpful invitation for feedback, but it also makes a "big deal" of the clinician's education (P4).
59	Never (in response to "When is it generally helpful to ask about a transgender person's genitals?")	Only appropriate in some contexts and, even in those contexts, there are other options. P3 pointed out that this information can be shared by describing what groups of people generally seek.
60	After I have asked them if it is ok to ask and they consent.	Power imbalance complicates ability to consent. Overlaps with feedback about Item line 59.

Table 5

Uncomplicated Emphatic Content, All Unhelpful (No Revision Needed)

Item Line	Content	Feedback Examples
23	Have you had the surgery yet?	*…not all trans folks have any one or any surgeries! And not all intend or hope to do so! And you don't get to ask about people's genitals, that's so rude! (P2)* *"the surgery" is offensive outdated terminology…objectifies trans folks and treats their bodies as objects of curiosity to study (P3)* *Don't even get me started on this question! (P9)*
34	You can talk to me, hardly anything shocks me anymore.	*Implies that trans identity is "shocking." (P2)* *implying that not cis genders are abnormal/unacceptable. (P3)* *expecting that trans identity would be shocking to a "normal" person (P8)*
40	I would be happy to help you feel more like a real man (or woman, if applicable).	*…sending a message that gender conformity is the goal (P3) conflates cisgender identity with being a "real" (binary) many or woman.* *What about genderqueer people? (P4)* *Real is a word that can trigger a lot of transgender folks…How is the therapist supposed to do this? What the hell is a "real" man/woman? (P9)*
43	Explore strategies for appearing more convincing to other people	*…you have to convince people that your gender is real! This is usually pretty invalidating (P2)* *not every trans person wants to pass (P6)* *this is classic gaslighting…"convincing" people makes it sound like transgender people are "liars" or "deceitful" (P9)*
46	Encourage them to transition further or faster.	*Unhelpful!!!... implying that experiences of being misgendered are the client's fault (P3)* *For nonbinary people transition may be non-linear or non-existent (P4)*

Table 6

Item Lines Scored Mostly Unanimous

Item line	Content	Feedback summary
6	Is there a different name you'd like to be called by?	Helpfulness depends on how gender is addressed on intake forms. Wording could be both more open and more specific ("What name…" instead of "Is there a different name…")
7	What pronouns would you like me to use to describe you?	Terms "describe" and "prefer" both flagged as problematic.
10	Would you like to use a different name in your records?	Helpful, but (as with Item line 6) has the potential for backfiring depending on how gender has been expressed up to this point.
18	Where do you think these feelings come from?	Nearly unanimously unhelpful (as intended). Sole support for this item being helpful was also described tentatively "I have never asked this question" (P7).
30	Your gender is your choice.	Nearly unanimously unhelpful (as intended). None endorsed as helpful, but were instead varying degrees of tentative about it being unhelpful. Described as a more of a general counseling error versus failure to rapport build with transgender clients.
43	Explore strategies for appearing more convincing to other people	Nearly unanimously unhelpful (as intended). None endorsed as helpful, but were instead varying degrees of tentative about it being unhelpful. Could potentially be helpful in some contexts, such as when talking about harassment in public.
48	Ask why they feel the need to be seen as the victim.	Nearly unanimously unhelpful (as intended). None endorsed as helpful, but were instead varying degrees of tentative about it being unhelpful. Could potentially be helpful in some contexts, such as deeper interpersonal work with some clients. Should not be used early in treatment.
49	Refer them to someone else and politely ask them to leave the office.	Nearly unanimously unhelpful (as intended). None endorsed as unambiguously helpful. Better than engaging in more overt transphobia but still not good.
52	Explain why others may have difficulty using their chosen name.	Nearly unanimously unhelpful (as intended). None endorsed as helpful, but were instead varying degrees of tentative about it being unhelpful. Some therapeutic relationships could tolerate such a discussion. May be possible to explain without justifying or excusing.
53	Explore whether they are committed to transitioning.	Nearly unanimously unhelpful (as intended). None endorsed as unambiguously helpful. Half skipped. Could be helpful if client has not been given the opportunity to seriously consider fertility treatments as a part of transition, or explore concerns about public safety as an out transgender person.
61	Before making recommendations for preventative screenings or other physical interventions.	Potentially invasive or beyond provider's scope of practice.

Tentative Revision and Second Review

Revised Items

The condensed tables (Table 4 and Table 6) and the guiding statements as described in the Pilot Instrument were used to make decisions about which flagged items needed revision (Appendix E). The summarized feedback from these condensed tables was used to draft new items. The revision decisions are summarized in Table 7, with revised items summarized in comparison to the original items in Table 8.

Table 7

Revision Decisions

Item Lines with Scoring Problems

	Item Line	Feedback summary	Revision decision
15	Have you taken any steps to transition?	*"Have you"* presupposes that transitioning is the goal.	Removed from item pool (redundant)
16	What steps have you taken so far to transition?	Similar feedback to 15, presupposes transition is a goal.	Changed to "What has it been like so far?
19	When did this first come up for you?	Suggestive of an "origin story" (P3). Only appropriate within a WPATH context, and complicated then too.	Changed to "How did this first come up for you?"
22	Have you told anyone else before?	Shaming tone, presupposes someone is newly transitioning.	Changed to "Are there others in your life who know?"
28	I have had some training on this issue, but everyone is different.	Phrase "this issue" flagged as problematic phrasing. Suggests being transgender is an issue.	Changed to "I have had some training on gender diversity, but I'd like to know what it is like for you."
35	Before we finish, I'd love a chance to get feedback on how this visit went for you. But you should know that it's also not your job to have to educate me.	Could constitute a backhanded request for reassurance or education. Overall gestalt of the item described as "awkward" (P4, P9).	Changed to "How did this conversation go for you?"
37	I am not an expert in that, but I would be happy to help you with other problems.	Though some indicated it would be helpful, unhelpful endorsements were clearer and had no preconditions (such as providing adequate referral).	Retained as unhelpful item (weighed quality of feedback in decision making)

38	Feel free to let me know if something I say doesn't come out right. I have had some training, but there's always room for improvement.	Some saw as a helpful invitation for feedback, but it also makes a "big deal" of the clinician's education (P4).	Selected as a new unscored ambiguous item
59	Never (in response to "When is it generally helpful to ask about a transgender person's genitals?")	Appropriate in some contexts. However, even in those contexts there are other options. P3 pointed out that information can be shared by describing what people generally seek.	Retained, No change to scoring. Remains Unscored as an Ambiguous Item
60	After I have asked them if it is ok to ask and they consent.	Power imbalance complicates ability to consent. Overlaps with feedback about Item line 59.	Changed scoring from "Helpful" to "Ambiguous"

Item Lines Scored Mostly Unanimous

6	Is there a different name you'd like to be called by?	Helpfulness depends on how gender is addressed on intake forms. Wording could be both more open and more specific ("What name…" instead of "Is there a different name…")	Changed to "What name would you like me to use when we meet?"
7	What pronouns would you like me to use to describe you?	Terms "describe" and "prefer" both flagged as problematic.	Changed to "What pronouns would you like me to use for you?"
10	Would you like to use a different name in your records?	Helpful, but (as with Item line 6) has the potential for backfiring depending on how gender has been expressed up to this point.	Retained as helpful item (expected to be clearer with clear instruction that hypothetical visit is a first encounter)
18	Where do you think these feelings come from?	Nearly unanimously unhelpful (as intended). Sole support for this item being helpful was also described tentatively "I have never asked this question" (P7).	Retained as unhelpful item (weight of feedback)
30	Your gender is your choice.	Nearly unanimously unhelpful (as intended). None endorsed as helpful, but were instead varying degrees of tentative about it being unhelpful. Described as a more of a general counseling error versus failure to rapport build with transgender clients.	Retained as unhelpful item (weight of feedback)
43	Explore strategies for appearing more convincing to other people	Nearly unanimously unhelpful (as intended). None endorsed as helpful, but were instead varying degrees of tentative about it being unhelpful. Could potentially be helpful in some contexts, such as when talking about harassment in public.	Retained as unhelpful item (expected to be clearer with clear instruction that hypothetical visit is a first encounter)

48	Ask why they feel the need to be seen as the victim.	Nearly unanimously unhelpful (as intended). None endorsed as helpful, but were instead varying degrees of tentative about it being unhelpful. Could potentially be helpful in some contexts, such as deeper interpersonal work with some clients. Should not be used early in treatment.	Retained as unhelpful item (expected to be clearer with clear instruction that hypothetical visit is a first encounter)
49	Refer them to someone else and politely ask them to leave the office.	Nearly unanimously unhelpful (as intended). None endorsed as unambiguously helpful. Better than engaging in more overt transphobia but still not good.	Retained as unhelpful item. (dissent pertained to 1st half only, agreement on 2nd half of the statement – as intended)
52	Explain why others may have difficulty using their chosen name.	Nearly unanimously unhelpful (as intended), but comments suggest this was tentative. Some therapeutic relationships could tolerate. May be possible, but as an advanced skill.	Retained as unhelpful item. (expected to be clearer with clear instruction that hypothetical visit is a first encounter)
53	Explore whether they are committed to transitioning.	Nearly unanimously unhelpful (as intended). None endorsed as unambiguously helpful. Half skipped. Could be helpful if client has not been given the opportunity to seriously consider fertility treatments as part of transition, or explore concerns about public safety as an out transgender person.	Retained as unhelpful item (expected to be clearer with clear instructions that hypothetical visit is a first encounter)
61	Before making recommendations for preventative screenings or other physical interventions.	Potentially invasive or beyond provider's scope of practice.	Changed to "If it is unclear and a client is directly asking about their options for genital dysphoria."

Table 8

Revised Items Summary

Original Item	**Revised Item**
Is there a different name you'd like to be called by?	What name would you like me to use when we meet?
What pronouns would you like me to use to describe you?	What pronouns would you like me to use **for** you?
What steps have you taken so far to transition?	What has it been like so far?
When did this first come up for you?	**How** did this first come up for you?
Have you told anyone else before?	Are there others in your life **who know?**
I have had some training on this issue, but everyone is different.	I have had some training on gender diversity, **but I'd like to know what it is like for you.**
Before we finish, I'd love a chance to get feedback on how this visit went for you. But you should know that it's also not your job to have to educate me.	How did this conversation go for you?
When is it generally helpful to ask about a transgender person's genitals? (Select all that apply) - If they have not told me yet and it's not in their file. (Unhelpful) - If I cannot tell by appearance. (Unhelpful) - If I am unsure which pronouns to use - Never (Not scored) - After I have asked them if it is ok to ask and they consent. (Helpful) - Before making recommendations for preventative screenings or other physical interventions. (Helpful)	When is it generally helpful to ask about a transgender person's genitals? (Select all that apply) - If they have not told me yet and it's not in their file. (Unhelpful) - If I cannot tell by appearance. (Unhelpful) - If I am unsure which pronouns to use - Never (Not scored) - After I have asked them if it is ok to ask and they consent. **(Not scored)** - **If it is unclear and a client is directly asking about their options for genital dysphoria interventions**. (Helpful)

Some problems were resolved by changing the proposed scoring (such as with item lines 38 and 60). Other times, problems pointed to specific wording that could be changed (such as with items 6, 7, 16, 19, 22, 28, 35, and 61). One item line (15) was removed from the item pool due to it being redundant with another (16). There were also some flagged item lines (10, 18, 30, 37, 43, 48, 49, 52, 53, and 59) that were not revised. These items were either near-unanimous and had

supportive arguments that were well-reasoned relative to dissent, or are expected to be clarified by adding detail to the introduction to the Vignette section. Proposed revisions were shared with the original participant pool for a second round of review (Appendix F).

Feedback from Participatory Review

The second round of feedback was limited (Appendix E). This round was designed to collect feedback on drafted revisions (Table 8). Only two participants were available to participate. Feedback concurred with proposed revisions for some item lines (6 and 7) with minor qualifications or suggestions for item lines (35, 60, and 61). However, feedback suggested improvements were minimal for other three item line revisions (16, 19, 22, and 28). These items were flagged as areas for closer scrutiny in this study's final consolidated iteration (Appendix H).

Results Summary

Both dissent and objectionable content were present in feedback from subject matter experts. These experts represent a broad range of clinical expertise with transgender patients, many of whom also identified as transgender themselves. Feedback was rich, personal, and often long. Experts tended to endorse multiple microaggression themes for each unhelpful item. This complicated quantitative review, but also showed participants' reasoning for each scoring decision. Some fidelity was lost in the second section, due in part to incomplete feedback. Despite these setbacks, there was sufficient feedback to make several revision decisions.

CHAPTER V: DISCUSSION

This project concerns the first stages in development of an objective instrument for assessing a mental health clinician or clinical trainee's ability to discriminate between helpful and unhelpful responses in clinical conversations with transgender clients. Development of the instrument was grounded in both empirical literature on the topic and the experiences of the primary researcher as a transgender person. Subject matter experts with experience beyond that of the primary researcher were recruited to provide feedback on the proposed instrument. Mixed methods analysis of expert feedback focused on detecting serious problems with the proposed test, and on making meaningful use of this feedback for revision. This chapter expands on these results, offering tentative interpretation and applications to both the next iteration of the test and test development methodology.

Quality of Feedback

Though the primary researcher has extensive experience with transgender identity, participants were nevertheless able to identify otherwise undetected objectionable content in the proposed instrument. This suggests this review was successful. However, some aspects of this review could have been improved, namely with regard to participation, completeness, and the clarity of instructions to participants.

Participant Characteristics, Impact on Review

The number of experts included was 10, comparable to similar studies (Ermis-Demirtas, 2018). While transgender and nonbinary participation was adequate (5 out of 10), transfeminine representation was relatively low (2 out of 10). This is notable since multiple population studies suggest significant differences exist for these groups, particularly as it relates to experiences of violence (Edelman, 2011; James et al., 2016; National Coalition of Anti-Violence Programs,

2011; Saffin, 2011). For this study, low transfeminine representation was tempered by the fact that all other participants described having extensive experience working with transfeminine clients. In addition, comments providing specific examples specific to transfeminine issues were present in written feedback. More broadly, comparisons in feedback from transfeminine participants to others revealed few differences. This suggests transfeminine issues were represented. Provided that transfeminine participation continues to be considered in future iterative reviews of the proposed instrument, this was deemed adequate for the current study.

A potentially greater problem exists in the lack of feedback from experts in supervision. Even amongst participants who offer supervision, all described supervision as a minor portion of their professional activities. It was hoped that experts would have prior experience navigating supervision ruptures related to clinical work with transgender clients. Though supervisors included were versed in transgender clinical issues themselves, they had not knowingly supervised any trainees who struggled with transgender clients. Several described problems with colleagues with regard to transgender issues. It may be necessary to pursue recruiting in this area more aggressively before proceeding to the next stage of development.

Another important area to address is the presence of cisgender participants. Several participants explicitly described experiencing problems with overly confident gay and lesbian clinicians. This problem has also been noted in prior research (Whitman & Han, 2017). Historically, there have been several points of tension between these groups (Stryker, 2008). At times, advancement for gays and lesbians has come during periods of increased animosity towards transgender communities (Stryker, 2008).

This is a problem for projects where self-selection is used as the only means of assessing expertise. For this study, it is assumed that the primary researcher’s transgender identity and use

of screening interviews mediated this problem (Galupo, 2017). Great care should be taken if this methodology is replicated with another group, especially if the primary researcher is not a group member themselves.

Completeness and its Impact on Review

Completeness was a clear problem in the second half of the review packet (Terminology section). Half of the participants left this blank or followed the prompt incorrectly. Several factors are suspected to have played a role. Firstly, the overall length of the packet may have led to fatigue and carelessness. The packet was over 30 pages long and included over 100 item lines. Experts were not compensated for their participation. Feedback on individual item lines ranged from one or two words to several paragraphs. Most of these items had a similar format for review, but this format changed for the last five questions. This change is where completeness dropped off. It may be that participants became comfortable responding in a certain way and might not have noticed the change in format at the section break.

Participant confusion. Open-ended comments suggest some problems with completeness may have been related to confusion about (a) the intended purpose and format of the instrument and (b) what was being asked of them as experts. The presence of this confusion raises some questions about the validity of the feedback received. Challenges raised to some items appear to be at least partially related to this confusion. To this end, additional review has been planned.

Another area of confusion has to do with the role of timing in clinical conversations. Many pointed out how some unhelpful items may be helpful in situations with more rapport, such as with clients one has been working with for years. An additional statement to this effect in the introduction may prevent confusion in the next iteration. Ideally, responses in the Vignette

are to be taken as an initial conversation with no other opportunities to gather information or build rapport.

When alternatives strayed from purpose of the test. Some participants described alternative wordings for several items. This was very helpful during the revision process. However, at times these suggestions strayed from the intended purpose of the test. For example, P7 suggested using an open-interview format between supervisor and supervisee. Though the open-interview format is interesting, it is also only expected to work with supervisors who are transgender experts themselves. As recruiting efforts for this study demonstrate, such experts are hard to come by. This would seriously compromise the utility of the proposed test.

In addition, an interview with open-ended questions would take considerably more time than a screening test. Others made similar suggestions adding more open-ended questions for the test itself, or a more flexible scoring format than "helpful" vs. "unhelpful." While this would allow for a richer understanding of an examinee's level of understanding it would also likely require expert-level interpretation and would likely take considerably longer to score. Such approaches would be appropriate (when possible) for examinees who were identified by a screening test when expert interpreters are available.

Multiple Microaggression Themes Per Item

It was assumed that most participants would choose one or two microaggression themes for each item line. However, participants instead tended to select multiple microaggression types for each item line they found "unhelpful." For unanimous items, the average number of microaggressions tagged was over eight. This was far more than expected and limited the options available for quantitative analysis. It also represented a possible threat to content validity.

It should be noted that these items may still be considered valid, even if they fit multiple microaggression domains. For example, it is possible that this pattern of multiple themes reflects something essential that has been missed in the microaggressions construct itself. It has been thought that the microaggression themes represent discrete categories. However, the possibility of conceptual overlap has not been explored. It is possible that the themes presented in D. Johnson (2014) overlap. This would explain why so many microaggressions were selected for each item line. Additional validation of these microaggression themes, separate from efforts to validate the proposed instrument, could clarify this point.

It is worth noting that most conceptually close D. Johnson (2014) microaggression themes were endorsed a similar number of times. For example, Endorsement of Gendernormative and Binary Culture or Behaviors and Expecting Binary Transition Norms were endorsed within one standard deviation of each other. Overall code use fit within a normal distribution by visual appearance and Shapiro-Wilk test (Df 13, Sig. 0.997). However, there was an important exception. Discomfort and Disapproval with Transgender Experience was endorsed more often than Physical Threat or Harassment by more than two standard deviations, though one would expect these two themes to occur together to a similar degree. This could be due to a difference in perceived severity of microaggression. An argument could be made that Physical Threat or Harassment is fairly overt aggression, not a microaggression at all. While these themes are conceptually close, they may differ in severity enough to explain the different patterns of endorsement.

This pattern of responses also makes sense within the greater context of microaggressions. Part of what makes microaggressions so insidious is their ambiguous nature.

Unlike overt assaults, microaggressions often leave the target guessing about the intentions of the aggressor. In this way, conceptual overlap may be a feature of the concept, rather than a flaw.

Though this study used microaggressions as theoretical rationale, it is possible that test content remains powerful even without this construct. Test content was inspired by real statements by clinicians as encountered by the primary researcher or read in literature review. This realism may be worth what is lost in theoretical clarity. Empirical analysis of the instrument's predictive power will clarify this point.

Assessment of the Current Study

Confirmation of Concept

Though there are areas in need of additional revision and review, the feedback collected made meaningful revision possible for most of the proposed instrument. Participants described many aspects of the instrument as clear and important. Emphatic content also revealed several items that may be good candidates for double-weighting (Table 5). Not only were many of these items scored unanimously, these items also represent statements that commonly emerge in clinical work with transgender clients (D. Johnson, 2014).

Beginning of Iterative Review Process

Improvements to instructions needed. Many times when participants indicated they were unsure about an item, they indicated that the context of the greater conversation or therapy relationship could tip the item either way. However, the goal in development was to account for this by making the vignette describe a first encounter in which trust had not been established. The vignette includes some wording to this effect ("Imagine you are working with a new client who tells you that they are transgender. You are surprised that they describe themselves this

way…"). However, given timing was a reoccurring theme in feedback, it may be necessary to clarify the prompt further in the next iteration.

Similarly, it may be helpful to include additional instructions to acknowledge the ambiguity of what someone should or should not say in any clinical context. Often there is no perfect response possible. If included as part of the introduction to the test, this reassuring statement may help normalize discomfort during the test-taking process, and could clarify intended scoring and interpretation for expert reviewers.

Clear interpretation guidelines. Several participants raised concerns that examinees may misinterpret a passing score on the proposed instrument as a sign that they have expertise for working with transgender clients. It will be important to carefully market the instrument to avoid this impression. While this is always a risk, clear guidance in test interpretation materials are expected to help. Both the interpretation materials and marketing materials are to be developed at a later date.

Clearer review process. As previously described, the presence of confusion in feedback suggests the instructions to participants were unclear. A few simple modifications are expected to improve review quality. For example, a longer introduction to the purpose of the proposed test as a screening instrument may have been helpful. It may also have been helpful to introduce participants to the process of test development. To this end, use of a live feedback process may have been more effective. Approaches, such as the Talk Aloud procedure (Fonteyn, Kuipers, & Grobe, 1993), provide opportunities to clarify points of confusion in real time. Similarly, use of Discriminant Content Validity (Johnston et al., 2014) could make it possible to more clearly weigh the power of some items over others.

Problems with some privacy-related items. One area that received surprising feedback had to do with how clinicians navigate questions about physical interventions, including but not limited to surgery. While some found these questions necessary, others found them inappropriate. Several noted that a client might feel coerced into answering unhelpful questions. At the same time, clinicians who avoid this topic may miss critical areas of transgender health. For example, the World Professional Association of Transgender Health Standards of Care Version 7 (Coleman et al., 2012), mental health professionals are encouraged to "educate clients about the various options available to alleviate gender dysphoria" (p. 180) and specifically mentions binding, padding, tucking, and the use of prosthetics along with surgical and hormonal interventions (p. 172). These options would be very difficult to offer without first assessing the client's needs.

This paradox has no simple solution. However, there a few guidelines emerged from the current study. As with many other items, timing is critical. When the first question after disclosure of transgender identity is "Have you had the surgery?" this was unanimously perceived as "unhelpful." Other privacy-related items posited later in the hypothetical conversation had more ambiguous feedback. Questions could also be posed in a more sensitive order. For example, clinicians gathering social history might first ask clarifying questions about gender as experienced presently, gender assigned at birth, followed by any history of interventions. While it is possible that some transgender clients may still find these questions uncomfortable, this framing is expected to more sensitively uncover what is necessary for clarity.

Several noted that a client might still feel coerced into answering unhelpful questions, even when they consent to answering difficult questions for the purpose of acquiring a letter of support for transition. This is worth noting, especially given historical tensions between

transgender and medical communities (see Social and Historical Context of Transgender Healthcare).

There may also be ways to avoid potentially uncomfortable or inappropriate questions. One participant (P3) offered a novel suggestion that involved having clinicians provide broad information about what many transgender people commonly seek. For example, clinicians might speak generally about how people with vulvas might transition. In this way, clinicians may provide information without needing to invade an individual client's privacy. Clinicians may also make access to transition-related resources available via handouts or psychoeducational books, essentially avoiding these questions by referring clients to educate themselves.

While this approach is fairly acceptable, there are limitations. The options for physical transition are highly variable and change often. This applies both to medical transition (hormones, surgery, and hair removal) as well as to other physical interventions (prosthetics, binders, shapewear). Misinformation remains a perennial problem in transgender health, in part because the complexity of transgender healthcare changes often. In addition, the resources currently available often surpass patient literacy (Cook et al., 2017).

Another option may be to take steps to decrease the power imbalance, thereby making intimate questions less coercive. However, this is expected to be an advanced skill, often requiring both advanced interpersonal and collective action within multiple health professions. For example, a clinician may be skilled at owning, bracketing, and mitigating their personal position of power in clinical relationships. Clinicians may also advocate for the dismantling of gatekeeping systems that make it unnecessarily burdensome to access transgender healthcare. At present, these are not reasonable expectations for clinicians just beginning clinical work with this population. As such, it is considered beyond the skills assessed by the proposed test.

It is possible that mixed feedback for this item could have more to do with the inclusion of the word “genitals” in the text of the item. This may have suggested a more inappropriate connotation than intended. There are many ways that clinicians may ask invasive questions about genitals while still only referencing them indirectly. For example, questions about surgical status can stray into this territory. This type of mistake is assumed to be more common than clinicians overtly asking “What genitals do you have?” It is possible that this may have been what experts pictured when reading this item.

It is also likely that feedback for privacy-related items was mixed because this is an area with low consensus. Perhaps, simpler interventions could emerge from future collaborative research with identity, counseling, and supervision experts.

Problems with helpful items. There was considerably more consensus on items intended to be “unhelpful” than “helpful.” For many reasons, it is simpler to identify what not to say, than what is generally acceptable to say. As the present iteration stands, there are very few helpful items. The development of additional helpful items is recommended.

This difficulty arose in part due to concerns about helpful items having problematically high face-validity. If helpful items were too obviously helpful, it is anticipated that examinees could identify unhelpful items by using unrelated test-taking skills, rather than the knowledge, skills, and awareness the test is intended to measure. Such a problem would reduce the predictive power of the test. To counteract this problem, helpful items were written with a degree of subtlety that, unfortunately, also complicated consensus.

Benefits and Risks of the Proposed Test

Potential benefits of the proposed test. Reviewers described the overall test as “necessary” (P4) and “a great tool” (P5). At times, participants emphasized specific items (such

as item lines 11, 29, 48). The term “important” was used five times to describe specific item lines. For several of these items, participants added comments suggesting these items alone may be sufficient to identify unready trainees.

Even amongst participants who raised concerns about this iteration of the test, participants emphasized the importance of improving training and assessment. This was most evident in personal disclosures, present in both written feedback and also in phone interviews. Participants described encounters they experienced personally as clients, as overheard by colleagues, and as experienced through their clients. Four participants (P3, P4, P6, and P9) raised concerns about harm done specifically by cisgender clinicians, including those who are gay, lesbian, or bisexual. Participants expressed concern that overly confident clinicians may be at greater risk of harm, often giving specific examples of times they had personally observed this happening. It is worth noting that two out of the three cisgender participants also described themselves as queer or gay.

Participants also described the importance of getting initial conversations right because of the many systemic barriers transgender clients face. Since transgender clients cannot “shop around” (P8), more harm may result from merely mediocre clinical relationships. Unlike many other clients, transgender clients may feel they have few other options.

Perceived risks of the proposed test. Though participants described the proposed instrument as “important,” concerns were also raised about the problem of overly systematized and institutional approaches to transgender care. Participants linked this to the problem of overconfidence. For example, participants described harm resulting from clinicians who attend a single *trans 101* training and assume all transgender people must be a certain way (P3). This problem has been documented in other studies (Hanssmann et al., 2008; Whitman & Han, 2017).

Some participants made a direct link to this problem with the greater problem of white supremacy in mental health (P3, P8). Participants also noted the importance of allowing for the developmental stage of trainees and the potential for improvement with added conversation and training. On this note, some suggested the use of an open-ended interview format.

One way to curtail the risk of misinterpretation could be to make scoring interpretation overtly competence-blind. For example, if the administration guide speaks of specific training recommendations for each score, as opposed to readiness, the risk of misperceived competence may be lessened. Such decisions are kept speculative at this point, pending empirical analysis of the predictive power of the instrument. Administration materials are to be developed at a later date.

Areas of Greater Concern: Additional Review Needed

Terminology section. Much of the Terminology section was withheld from revision pending an additional feedback. Taking this methodological problem into consideration, there were responses to this section worthy of discussion.

For example, Item Lines 90–102 ask "Transgender men who describe themselves as straight are most likely attracted to_____" with the options of "Men," "Women," "Men and Women," "Other Transgender People," "None of the above," and "Any of the above" as possible answers. There are several other items of a similar format in this section. Though most selected the same response ("Women"), one participant (P6) indicated that "Other transgender people" would also be a correct response. While this answer is technically true, it does not represent the best answer because transgender women are included under the umbrella of women. It is unclear whether inconsistent scoring should be attributed to readability of the item, level of expertise, or some other factor. That this item seems difficult even for the expert panel suggests it may be

inappropriate in a test screening for basic skills. Since feedback was generally incomplete for this section, fatigue is a possible explanation.

Other participants made broad comments about the importance of asking for clarification when it comes to terminology. This raises an important point. As described in Chapter I, preferred terminology changes as a result of the continuing effects of power and privilege. While many tests in production require periodic updates and revision, the terminology section may require more frequent revision. Instead, it may be more constructive to focus on items associated with methods of asking for clarification. Several proposed items have already been coded with this domain by participants in the current study. With this in mind, it may be possible to drop the Terminology section completely without compromising the utility of the instrument as a whole.

Future Directions

One problem that emerged from the current study was that unhelpful items were easier to construct than helpful ones. The development of additional helpful items will resolve this problem. One way to do this could be to conduct a brief qualitative study asking transgender clients about particularly helpful questions they have experienced. Possible prompts may include, “Can you think of a helpful question asked in a first session with a therapist?” “Have you been asked helpful questions about being transgender that had nothing to do with medical transition?” or “What kinds of questions tend to make you feel at ease with a new doctor or therapist?”

Additional methodological changes are also expected to clarify content validity. Two procedures are also being considered to clarify item content validity: Discriminant Content Validity (Johnston et al., 2014) and the Talk Aloud procedure (Fonteyn et al., 1993). The Discriminant Content Validity approach involves asking expert judges to scale the importance of

each item in assessing the test construct. These scaled responses can then be used to weigh the relative importance of individual items in the test. This is expected to help clarify which items are the most important to the instrument as a whole and which may be dropped. This is expected to clarify whether the Terminology section is critical to retain, especially if additional supervision experts are recruited as judges. A similar scaling approach can be used to determine relative unhelpfulness or helpfulness for each item line.

The Talk-Aloud procedure involves asking a group of experts to solve items while thinking out-loud. These comments are then qualitatively analyzed. Since feedback is collected live, this approach makes it possible to catch points of confusion. This may aid in getting clearer feedback with participants who are unfamiliar with content validation as a process. These two approaches may be fairly easily combined by adding the Discriminant Content Validity questions during the talk-aloud process. Given some of the participant characteristics at this study, it would be beneficial to aggressively recruit experienced clinical supervisors. It is recommended that supervisors from both Master's-level and Doctoral-level training centers be recruited. The procedure could be done with a selection of local supervision experts, or could be done via videoconference. The latter is expected to be more appropriate since many videoconference platforms make it easy to record sessions.

One difficulty that arose in this study was that of completeness in participation, particularly in the second round. This is understandable as participants dedicated considerable time to the study, without compensation. Incentivized participation in future studies should resolve this dilemma. Small grants for this purpose are available.

Provided this additional round of content validation is completed, test production is expected to otherwise proceed as originally planned, with a few modifications (Table 9).

Table 9

Revised Overall Development Methodology

Pilot project

1.	*Planned Overall Project*	Drafted overall plan Defined construct, rationale Defined intended audience Defined intended examinees
2.	*Drafted First Iteration*	Drafted test format Drafted items

Current Study

3.	*Preparation for Review*	Organized items, formatted for review Recruited Subject Matter Experts Screened potential participants (phone) Selected Subject Matter Experts Elicited written feedback on Iteration #1
4.	*Analysis 1*	Reviewed participant characteristics Reviewed quality and completeness of feedback Reviewed feedback fidelity Review for other important themes germane to content review Flagged items for revision
5.	*Revision 1*	Proposed revisions to item lines with scoring problems Proposed revisions for objectionable content, problematic dissent Organized proposed revisions for 2nd review (Iteration #2) Elicited feedback from Subject Matter Experts
6.	*Analysis 2*	Reviewed quality and completeness of feedback Summarized findings
7.	*Summary*	Consolidated Iteration #3 Summarized areas in need of additional review Prepared for next iteration

Future directions

8.	*Draft additional items*	As informed by qualitative feedback from transgender clients
9.	*Talk-Aloud* *Discriminant Content Validity*	Finalize selection of items from item pool Formally validate content
10.	*Empirical analysis*	Compare performance on instrument to performance in an Objective Structured Clinical Exam transgender mock client, Implicit Bias testing
11.	*Development of scoring interpretation protocols*	Establish cutoff score(s) Create interpretation guides
12.	*Development of test security procedures*	Technical review of administration Technical review of scoring procedures
13.	*Finalize for publication*	Complete administration guide Complete interpretation guide Complete technical manual Establish schedule for release of new editions Publish

Ultimately, the predictive power of the test will require comparisons with examinee performance. This may be assessed by comparing performance on an OSCE with a transgender mock client. For example, a selection of trainees may be recorded having an intake with a mock client, observed by two raters. In an ideal OSCE, the same mock client, presenting issue, and raters are used for each trainee. Data is traditionally collected in the same day, with mock interviews completed in quick succession. This helps prevent participants from sharing details of the mock encounter with each other. Such an OSCE may be done in conjunction with implicit bias testing (Wang-Jones et al., 2017). Since OSCEs are a fairly elaborate event to organize, consultation with an experienced OSCE event planner has been planned.

The measure is intended to be used first by clinics and training environments with a transgender-specific focus. Several such clinics have been identified. Ultimately it is hoped that the completed measure may be used in a wide variety of training environments by supervisors with and without transgender-specific expertise. If successful, this methodology may be replicated to create instruments that assess basic skills for working with other marginalized populations.

Summary

This project involved the preliminary development of a screening measure to identify clinical trainees at risk of harming transgender clients. Content was developed using literature on transgender counseling and identity as a guide, particularly literature on transgender microaggressions. Ten subject matter experts with experience beyond that of the primary researcher were recruited to provide feedback on the proposed instrument. Mixed methods analysis focused on detecting serious problems with the proposed test, and on making meaningful use of feedback for revision. Though the primary researcher possesses personal and

professional experience with this population, subject matter experts were able to identify objectionable content. Revisions to test content were provided to the same subject matter experts. However, very few of the original experts were available to provide additional feedback in the second round. As such, an additional round of review is necessary. Additional problems identified in this study suggest additional work is needed to develop “helpful” (versus “unhelpful”) items. One section (Terminology) garnered inconsistent and incomplete feedback and may be dropped in the future, pending review. The overall plan of development was adjusted to accommodate these findings.

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Appendix A:

Recruitment Flyer

ANTIOCH UNIVERSITY
SEATTLE

2400 3rd Ave. Suite 200, Seattle, WA 98121-1814 | 206-441-5352 | www.antiochseattle.edu

Research Study Participants Needed!

We are seeking subject matter experts in the following fields:

- Clinical training
- Transgender counseling
- Transgender Identity

Description of Project

This project proposes an objective instrument for assessing a mental health clinician or clinical trainee's ability to discriminate between helpful and unhelpful responses commonly made in the initial clinical encounters with transgender clients. Development of the instrument is grounded in a combination of theoretical and empirical literature on the topic, as synthesized with the personal and professional experiences of the primary researcher as a transgender person and emerging clinician. Insights generated from this investigation may serve to validate this proposed instrument. The ultimate goal is to create new ways of safeguarding this population from clinicians who may cause harm.

To learn more or to volunteer to participate in this study, contact the principal investigator, Ianto West, a Psy.D. student from Antioch University Seattle at iwest@antioch.edu.

Participants

Clinical training experts will consist of mental health supervisors and clinical training directors with an interest in transgender identity. Supervisors who have worked with transgender-inexperienced or hostile trainees are greatly sought.

Transgender counseling experts will consist of mental health clinicians who have worked with a wide variety of transgender clients. Minimum of six years in clinical practice preferred.

Transgender identity experts will consist of transgender individuals such as nonbinary individuals, transgender women, and transgender men. Must be 18 years of age or older.

This research is conducted under the direction of Dana Waters, Psy.D., ABPP (phone number); dwaters@antioch.edu). If further information is needed regarding Antioch University Seattle IRB approval, contact (contact information).

Appendix B:

Informed Consent

Informed Consent

This project proposes an objective instrument for assessing a mental health clinician or clinical trainee's ability to discriminate between helpful and unhelpful responses commonly made in the initial clinical encounters with transgender clients. Development of the instrument is grounded in a combination of theoretical and empirical literature on the topic, as synthesized with the personal and professional experiences of the primary researcher as a transgender person and emerging clinician. Insights generated from this investigation may serve to validate this proposed instrument. The ultimate goal is to create new ways of safeguarding this population from clinicians who may cause harm.

If you decide to participate, you will be interviewed briefly over the phone to see if you will be a good fit for this project. If so, you will be sent a packet containing the proposed test with instructions for your review. The test itself is 26 pages (not including introduction and instructions) and is expected to take 1 – 5 hours to complete. You are permitted to take breaks and return at any time. It is asked that you return the packet within two weeks.

Discomfort and risks:

The review requested is lengthy and fairly detailed. In addition, the "unhelpful" prompts described were written based on actual statements made by clinicians. As such, some participants may find the topic or content disturbing.

Benefits expected:

This project is intended to contribute to a growing body of work concerning the provision of healthcare to transgender individuals. As training and evaluation methods improve, the provision of healthcare to this marginalized population is also expected to improve.

Alternatives:

Participants may engage in other forms of action or education concerned with the provision of healthcare for transgender individuals such as panels, workshops, training seminars, etc.

The packet will also ask broad demographic questions about your professional practice & education. Only non-identifying information from these items will be shared.

You are free to withdraw consent and to discontinue participation in the project or activity at any time.

Questions or comments should be directed to the primary researcher: Ianto West at iwest@antioch.edu or the Dissertation Chair, Dana Waters, Psy.D., ABPP at dwaters@antioch.edu

_____ _____

Name date

Appendix C:

Phone Interview for Selecting Subject Matter Experts

Phone Interview for Selecting Subject Matter Experts	
Questions	**Answer**
Clinical training Experts	
What is your field?	
What types of clinicians or trainees do you supervise?	
Can you describe your experience with transgender identity? Transgender issues?	
Have you ever supervised a clinician or trainee who had difficulty with a transgender client?	
Have you ever supervised a clinician or trainee who you were worried might struggle with a transgender client?	
Have you ever supervised a clinician or trainee who was openly hostile towards transgender clients?	
This proposed test contains some statements made by real clinicians that you may find upsetting. How will you know if the study is too distressing to continue? What will you do if this happens?	
Transgender Counseling Experts	
What is your field? How long have you been practicing?	
What types of clients do you typically work with?	
What types of transgender clients have you worked with?	
Do you have any other experience related to transgender issues or identity?	
This proposed test contains some statements made by real clinicians that you may find upsetting. How will you know if the study is too distressing to continue? What will you do if this happens?	
Transgender Identity Experts	
How would you describe your gender identity?	
Would you say that you are familiar with other transgender identities? How so?	
Broadly, how do you feel about the field of mental health?	
If you could make any changes to the field of mental health, what would they be?	
This proposed test contains some statements made by real clinicians that you may find upsetting. How will you know if the study is too distressing to continue? What will you do if this happens?	
This proposed test contains some statements made by real clinicians that you may find upsetting. How will you know if the study is too distressing to continue? What will you do if this happens?	

Appendix D:

Proposed Items to be Reviewed by Subject Matter Experts

Thank you for agreeing to participate in this study. In this packet you will find a brief description of the test, the proposed rationale, and the proposed test itself. The packet has been designed to provide room for feedback in written form, which can be either typed or handwritten should you prefer. For each item you will be asked to describe (a) how you would score the item, (b) whether the item corresponds with previously established themes, and (c) if you have any other comments.

Please take your time. Breaks are recommended. It is encouraged that you complete your review in two weeks. You can choose to withdraw your participation at any time.

You may be invited to give additional feedback at a later date.

If you have any questions, please reach out to the primary investigator Ianto West at iwest@antioch.edu or the dissertation chair Dana Waters, Psy.D. at dwaters@antioch.edu

Thank you,

Ianto West

Antioch University Seattle

About the Proposed Test

Purpose of The Proposed Test

The purpose of the proposed test is to identify clinical trainees in the field of mental health who are unprepared to begin supervised clinical work with transgender clients, as measured by their ability to avoid making unhelpful statements with transgender clients in their initial conversation.

Intended Population to be Tested (The Examinees)

The intended population for this test include trainees in mental health fields such as psychology, social work, marriage and family therapy, and counseling. Examinees are assumed to have completed classes in psychology and other social sciences in the U.S., most likely in English. Examinees have also likely had exposure to common aspects of mental health work, such as intakes, case formulation, and counseling. Most examinees are expected to have had minimal formal exposure to transgender issues, but may have had exposure to some gay and lesbian issues.

Intended Audience (The Test Administrators)

The intended audience of the test (who will act as test administrators) include clinical training supervisors, directors of clinical training. The results of testing are to be sent directly to test administrators, not to the examinees, as research suggests self-led testing for this topic is ineffective. Test administrators may use the results to make training decisions, such as whether or not to pair clinicians with transgender clients.

Format Description

The format involves several brief clinical scenarios with lists of possible responses a clinician might use to continue conversation with transgender client. The format is similar to a vignette. Examinees are asked to determine which responses are likely to be helpful, and which responses are likely to be unhelpful. Items were constructed with well-intentioned but unknowingly unaware clinicians in mind. In addition to the mini-vignette, there is also a brief multiple-choice terminology section.

The format was designed in such a way as to realistically resemble initial clinical conversations with transgender clients. Test items were written to be readable to examinees with little to no exposure to transgender terminology, except when accurate use of transgender terminology is the ability being tested.

Since the intended population to be tested is assumed to have taken exams previously, several unscored ambiguous items are included to avoid simple elimination of unhelpful items based on their contrast with helpful items.

Proposed Scoring

At this stage, examinee performance is intended to be evaluated in a binary fashion, based on the ability to avoid statements associated with harm during initial encounters with transgender clients. Either clinicians are ready to conduct respectful clinical conversations with transgender clients, or they are not. Cut off scores will be established at a later date. Responses that are very harmful (such as those associated with Discomfort/Disapproval of Transgender Experience, Assumption of Sexual Pathology or Abnormality, and the Denial of Bodily Privacy) may be

weighted more heavily. While unhelpful statements are also considered harmful, they are labelled as “unhelpful” to avoid provoking defensiveness in examinees.

Rationale

Prior research has linked several themes of unhelpful responses, common to initial clinical conversations with transgender clients, with both premature termination and psychological harm. As such, clinicians who have difficulty avoiding these statements are expected to also be at greater risk of harming transgender clients. What has not yet been established is whether the ability to avoid these unhelpful responses on a test will correspond with the ability to avoid these statements in person. This problem will be accounted for via empirical analysis at the conclusion of this dissertation. The rationale for the proposed test is primarily theoretical, pending further empirical validation.

The unhelpful statements used in this iteration reflect actual statements made by clinicians, as available in the literature on this topic, or as observed by the primary researcher directly. Unhelpfulness as a response style is based on research by D. Johnson (2014), as synthesized with the personal and professional experiences of the primary researcher as a transgender emerging clinician. This stage of analysis will examine whether the proposed items correlate with these themes as intended.

Unhelpful Themes

Some types of unhelpful responses with transgender clients have been established (Nadal et al., 2012; D. Johnson, 2014). Described as microaggressions, these types of responses have been associated with premature termination and psychological harm if left unaddressed by the therapist. The table on the next page briefly summarizes these themes, and provides a shorthand that can be used in your feedback.

Themes of Unhelpful Responses		
D. Johnson Theme	Shorthand	Description
Physical Threat or Harassment	Haras	Clinicians who physically threaten or verbally harass transgender clients. May be overt or subtle.
Denial of Bodily Privacy	Priv	Clinicians may invade the bodily privacy of transgender clients by asking persistent or invasive questions about their bodies when it is irrelevant. A common example can be found in abrupt questions about genital surgeries. Invasion can also arise whenever transgender disclosure is compulsory, such as when an old name or gender marker must be used for identification.
Denial of Existence of Transphobia	Denial E	Clinicians who deny the existence of transphobia. They may imply transgender clients are to blame for mistreatment, or may imply that they are wrong to feel hurt by others.
Denial of Individual Transphobia	Denial I	Clinicians may support that transphobia exists, but they are not personally transphobic. They may deny having cisgender privilege, or may deny that transgender people are harmed by their privilege, or that they are wrong to feel hurt by them.
Discomfort/Disapproval of Transgender Experience	DD	Clinicians may send the message that they disapprove or are otherwise uncomfortable with their client being transgender. This can occur through nonverbal communication or through other actions, such as abrupt changes in care after disclosure.
Omitting Gender Matters from Therapeutic Conversations	Omit	Clinicians may avoid or omit transgender issues from therapeutic conversations. For example, they may redirect conversation when gender comes up.
Assumption of Sexual Pathology or Abnormality	Sex P	Clinicians may send the message that they assume the client is sexually perverse, or has a sexual abnormality or pathology.
Exotification	Exo	Clinicians may also dehumanize transgender clients by treating them as objects of intellectual or sexual curiosity. For example, they may gawk or act entitled to sexual details. Transgender identity may also be treated as an interesting but frivolous pursuit.
Use of Transphobic and/or Incorrectly Gendered Terminology	Term	Clinicians may use outdated terminology or slurs. They may also use the wrong pronoun or name. This should be assumed to be harmful even when inadvertent.
Expecting Clients to Provide Education	Edu	Clinicians may place an inappropriate burden on transgender clients to educate them, often by asking them to speak on behalf of their community (as opposed to asking for clarifications or individual experience). Can also be a form of disguised provocation.
Assumption of Universal Transgender Experience	Univ	Clinicians may send the message that there is a preferred way to be transgender, and that other ways are suspect or unhealthy. Clinicians may not be aware that they have stereotypical expectations.
Endorsement of Gendernormative and Binary Culture or Behaviors	Gender BN	Clinicians may send the message that it is more normal, acceptable, and/or healthy to be cisgender and/or gender conforming.
Expecting Binary Transition Norms	Binary TN	Clinicians may send the message that they assume all transgender people have a binary identity and will use a combination of medical transition and binary-conforming presentation to achieve this. Clinicians may pressure clients to have surgery as quickly as possible or to behave in other ways that conform with stereotypical expectations. Clinicians may try to dissuade transgender clients from professing nonbinary identities, or from gender nonconformity. Originally a sub-theme of Gender BN, similar to Univ.

For Your Feedback **Avoiding Unhelpful Responses with Transgender Clients: REVIEW 1**	
Test items / Prompts	**Feedback**
Imagine you are working with a new client who tells you that they are transgender. You are surprised that they describe themselves this way, but eager to show them that you care. Describe the helpfulness of these follow-up questions: *Examinees will be presented with the forced-choice option of "helpful" or "unhelpful" for each of the following items*	
What surgeries have you had?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Were you born as a man or as a woman?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about

	this item?
Do you like to cross-dress?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Why would you want to do that?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Is there a different name you'd like to be called by?	(a) How would you score this item?

	(b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
What pronouns would you like me to use to describe you?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Why are you telling me this?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about

	this item?
Are you gay?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Would you like me to use a different name in your records?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
I am sorry, I am unable to help you. I am going to have to end the session now.	(a) How would you score this item?

	(b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Other _____ *Not scored. Used to prevent answering by process of elimination (test-wiseness). Answers to open-ended portion may be provided to test-administrators, qualitatively judged on a case-by-case basis.*	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
The conversation appears to be going well. You feel like you are starting to understand the client, but you still need to gather more information about their history. Describe the appropriateness of the following questions: *Examinees will be presented with the forced-choice option of "helpful" or "unhelpful" for each of the following items*	
Why do you want to change to the other gender?	(a) How would you score this item?

	(b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Have you taken any steps to transition?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
What steps have you taken so far to transition?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?

Are you sure you want to change your gender?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Where do you think these feelings come from? *Ambiguous - Not scored. Used to prevent answering by process of elimination (test-wiseness)*	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
When did this first come up for you?	(a) How would you score this item? (b) Does this item relate to any of D.

	Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Why do you feel the need to tell me this?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Do you have any other unusual urges?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?

Have you told anyone else before?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Have you had the surgery yet?	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Other _____ *Not scored. Used to prevent answering by process of elimination (test-wiseness). Answers to open-ended portion may be provided to test-administrators, qualitatively judged on a case-by-case basis.*	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why?

	(c) Do you have any other comments about this item?
After sharing so much of themselves, you notice the client seems a bit more withdrawn. You want to make it clear that you are there to support them. Describe the helpfulness of the following reassuring statements: *Examinees will be presented with the forced-choice option of "helpful" or "unhelpful" for each of the following items*	
You can relax here, my clinic works with gay people all the time.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
You have to understand this is really hard for me.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why?

	(c) Do you have any other comments about this item?
I have had some training on this issue, but everyone is different.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
You can relax with me, I love drag.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?

Your gender is your choice. *Ambiguous - Not scored. Used to prevent answering by process of elimination (test wiseness)*	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
I'm sorry, your lifestyle is difficult for me to understand	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
We work with clients with many different kinds of sexual problems.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why?

	(c) Do you have any other comments about this item?
You should try not to take things so seriously.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
You can talk to me, hardly anything shocks me anymore.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Before we finish, I'd love a chance to get feedback on how this visit went for you. But	(a) How would you score this item?

you should know that it's also not your job to have to educate me.	(b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
It is the same as any other diagnosis.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
I am not an expert in that, but I would be happy to help you with other problems. *Subtle – Not Scored. Used to prevent answering by process of elimination (test wiseness)*	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?

Feel free to let me know if something I say doesn't come out right. I have had some training, but there's always room for improvement.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
You deserve respect no matter your sexual preferences.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
I would be happy to help you feel more like a real man (or woman, if applicable).	(a) How would you score this item?

	(b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Other_____ *Not scored. Used to prevent answering by process of elimination (test wiseness). Answers to open-ended portion may be provided to test-administrators, qualitatively judged on a case-by-case basis.*	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
The conversation has gotten back on track, and the client decides to open up to you a bit more. They tell you that they have been feeling very frustrated that the people in their life still use their old name. This seems to be something that has been bothering them. Describe the helpfulness of the following approaches: *Examinees will be presented with the forced-choice option of "helpful" or "unhelpful" for each of the following items*	
Explore strategies for appearing more convincing to other people	(a) How would you score this item?

	(b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Change the subject.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Reflect, "it sounds frustrating that it's still happening."	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?

Encourage them to transition further or faster	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Encourage them to be patient *Subtle and ambiguous. Not scored. Used to prevent answering by process of elimination (test wiseness)*	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Ask why they feel the need to be seen as the victim	(a) How would you score this item?

	(b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Refer them to someone else and politely ask them to leave the office.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Ask them if this is related to having had (or not had) surgery.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?

Ask what they have been doing to cope.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Explain why others may have difficulty using their chosen name	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Explore whether they are committed to transitioning *Subtle. Not scored. Used to prevent answering by process of elimination (test wiseness)*	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why?

	(c) Do you have any other comments about this item?
Other_____ *Not scored. Used to prevent answering by process of elimination (test-wiseness). Answers to open-ended portion may be provided to test-administrators, qualitatively judged on a case-by-case basis.*	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
When is it generally helpful to ask about a transgender person's genitals?	
If they have not told me yet and it's not in their file.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?

If I cannot tell by appearance.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
If I am unsure which pronouns to use.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Never *Ambiguous. Not scored. Used to prevent answering by process of elimination (test wiseness)*	(a) How would you score this item? (b) Does this item relate to any of D.

	Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
After I have asked them if it is ok to ask and they consent.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Before making recommendations for preventative screenings or other physical interventions.	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
<u>This next section takes a look at your</u>	

ability to pick up on terms commonly used in transgender communities. *Multiple-choice, possible to select more than one*	
A client tells you that they do not identify as male or female, but as something in-between. This client most likely is _____?	(a) How would you score this item?
Either a transgender man or a transgender woman	(b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why?
Questioning their gender	
Confused about their gender	
Intersex	
Nonbinary, genderqueer, or other	
Both transgender and gay or bisexual	(c) Do you have any other comments about this item?
In denial about being gay or bisexual	
Other_____ *Not scored. Used to prevent answering by process of elimination (test wiseness). Answers to open-ended portion may be provided to test-administrators, qualitatively judged on a case-by-case basis.*	
Someone who describes themselves as a transgender man was most likely	(a) How would you score this item?
Assigned female or intersex at birth	
Assigned male or intersex at birth	
Assigned intersex at birth	(b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why?
None of the above	
Any of the above	(c) Do you have any other comments about this item?
Someone who describes themselves as MTF was probably	(a) How would you score this item?
Assigned female or intersex at birth	
Assigned male or intersex at birth	

Assigned intersex at birth None of the above Any of the above	(b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Someone who describes themselves as genderqueer was probably Assigned female or intersex at birth Assigned male or intersex at birth Assigned intersex at birth None of the above Any of the above	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?
Transgender men who describe themselves as straight are most likely attracted to Men Women Men and women Other transgender people Any of the above	(a) How would you score this item? (b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why? (c) Do you have any other comments about this item?

Transgender women who describe themselves as lesbian are most likely attracted to	(a) How would you score this item?
Men	
Women	(b) Does this item relate to any of D. Johnson's themes? If so, which ones? Why?
Men and women	
Other transgender people	
None of the above	
Any of the above	(c) Do you have any other comments about this item?
End of the proposed test Additional questions for your feedback below	
Where any items difficult to read or understand?	
Did any item descriptions contain elements that could be considered *unhelpful*?	
Do you have any concerns about the vignette section?	
Do you have any concerns about items in the terminology section?	
Do you have any other concerns about the proposed scoring?	

Given your proposed answers to the test, at what score would you consider a potential trainee *unready* to work with transgender clients, even with supervision?
Do you have any concerns about the implications or potential uses of this test?
Do you have any other comments or suggestions?

Appendix E:

Summary of Flagged Items

Emphatic Comment Item Lines (3 or More Emphatic Comments)

Item Line	Content
23	Have you had the surgery yet?
34	You can talk to me, hardly anything shocks me anymore.
40	I would be happy to help you feel more like a real man (or woman, if applicable).
43	Explore strategies for appearing more convincing to other people
46	Encourage them to transition further or faster.

Unexpected Scoring

Item Lines Scored By At Least One Participant With Good Feedback Contrary To Expectations

Item Line	Content	Feedback summary
15	Have you taken any steps to transition?	*"Have you"* presupposes that transitioning is the goal.
16	What steps have you taken so far to transition?	Similar feedback to 15, presupposes transition is a goal.
19	When did this first come up for you?	Suggestive of an "origin story" (P3). Only appropriate within a WPATH context, and complicated then too.
22	Have you told anyone else before?	Shaming tone, presupposes someone is newly transitioning.
28	I have had some training on this issue, but everyone is different.	Phrase "this issue" flagged as problematic phrasing. Suggests being transgender is an issue.
35	Before we finish, I'd love a chance to get feedback on how this visit went for you. But you should know that it's also not your job to have to educate me.	Could constitute a backhanded request for reassurance or education. Overall gestalt of the item described as "awkward" (P4, P9).
37	I am not an expert in that, but I would be happy to help you with other problems.	Though some indicated it would be helpful, unhelpful endorsements were clearer and had no preconditions (such as providing adequate referral).
38	Feel free to let me know if something I say doesn't come out right. I have had some training, but there's always room for improvement.	Some saw as a helpful invitation for feedback, but it also makes a "big deal" of the clinician's education (P4).
59	Never (in response to "When is it generally helpful to ask about a transgender person's genitals?")	Only appropriate in some contexts and, even in those contexts, there are other options. P3 pointed out that this information can be shared by describing what groups of people generally seek.
60	After I have asked them if it is ok to ask and they consent.	Power imbalance complicates ability to consent. Overlaps with feedback about Item line 59.

Items with Mixed Feedback, Not Including Terminology Section

Item Line	Item text	Feedback Summary
15	Have you taken any steps to transition?	"Have you" presupposes that this is something someone would do, or is a goal.
19	When did this first come up for you?	Suggestive of an "origin story" or "moment of reckoning" brought up independently by three participants.
22	Have you told anyone else before?	Shaming tone, presupposes someone is newly transitioning.
28	I have had some training on this issue, but everyone is different.	Phrase "this issue" read as othering
37	I am not an expert in that, but I would be happy to help you with other problems.	Though some indicated it would be helpful, unhelpful endorsements were clear. Helpful endorsements added that it would only be helpful if followed up with referrals, which goes beyond the prompt.
38	Feel free to let me know if something I say doesn't come out right. I have had some training, but there's always room for improvement.	Strong opinions on both sides.
59	Never (in response to "When is it generally helpful to ask about a transgender person's genitals?")	Several skipped. Generally viewed as inappropriate unless part of a WPATH conversation, or if the clinician is their surgeon.
60	After I have asked them if it is ok to ask and they consent.	Helpful endorsers also expressed some discomfort, others pointed to power imbalance complicating consent. Overlaps with feedback about 1.5.59.

Mostly Unanimous Items, Excluding Terminology

6	Is there a different name you'd like to be called by?
7	What pronouns would you like me to use to describe you?
10	Would you like to use a different name in your records?
16	What steps have you taken so far to transition?
18	Where do you think these feelings come from?
30	Your gender is your choice.
35	Before we finish, I'd love a chance to get feedback on how this visit went for you. But you should know that it's also not your job to have to educate me.
43	Explore strategies for appearing more convincing to other people
48	Ask why they feel the need to be seen as the victim.
49	Refer them to someone else and politely ask them to leave the office.
52	Explain why others may have difficulty using their chosen name.
53	Explore whether they are committed to transitioning.
61	Before making recommendations for preventative screenings or other physical interventions.

Appendix F:

Revised Item Packet

Thanks again for your participation in this study.

I would like to share a little bit about the preliminary results. So far, it looks like there was broad agreement about the scoring for many of the items, especially items intended to be "unhelpful." Some items intended to be helpful have instead been marked "ambiguous" and will not be scored. However, some items intended to be "helpful" will need revision. Your feedback has been helpful in identifying these items.

In this second round, you are invited to give feedback on these items selected for revision.

There are 10 items total. It is expected to take about 10 – 15 minutes to review.

If you do wish to provide feedback, please return the packet in one week. If you do not wish to participate in this round, please disregard this email.

If you have any questions, please reach out to the primary investigator Ianto West at iwest@antioch.edu or the dissertation chair Dana Waters, Psy.D. at dwaters@antioch.edu.

Thank you,

Ianto West

Antioch University Seattle

Avoiding Unhelpful Responses with Transgender Clients: ITEM REVIEW 2	
Imagine you are working with a new client who tells you that they are transgender. You are surprised that they describe themselves this way but eager to show them that you care. Describe the helpfulness of these follow-up questions:	
Original: Is there a different name you'd like to be called by?	Revised: What name would you like me to use when we meet?
Your feedback on the revision:	
Original: What pronouns would you like me to use to describe you?	Revised: What pronouns would you like me to use for you?
Your feedback on the revision:	

The conversation appears to be going well. You feel like you are starting to understand the client, but you still need to gather more information about their history. Describe the appropriateness of the following questions:	
Original: What steps have you taken so far to transition?	Revised: What has it been like so far?
Your feedback on the revision:	
Original: When did this first come up for you?	Revised: How did this first come up for you?
Your feedback on the revision:	
Original: Have you told anyone else before?	Revised: Are there others in your life who know?
Your feedback on the revision:	

<table>
<tr><td colspan="2">After sharing so much of themselves, you notice the client seems a bit more withdrawn. You want to make it clear that you are there to support them. Describe the helpfulness of the following reassuring statements:</td></tr>
<tr><td>Original:
I have had some training on this issue, but everyone is different.</td><td>Revised:
I have had some training on gender diversity, but I’d like to know what it is like for you.</td></tr>
<tr><td colspan="2">Your feedback on the revision:</td></tr>
<tr><td>Original:
Before we finish, I’d love a chance to get feedback on how this visit went for you. But you should know that it’s also not your job to have to educate me.</td><td>Revised:
How did this conversation go for you?</td></tr>
<tr><td colspan="2">Your feedback on the revision:</td></tr>
</table>

When is it generally helpful to ask about a transgender person's genitals? (Select all that apply)	
Original: If they have not told me yet and it's not in their file. *Proposed score: Unhelpful* If I cannot tell by appearance. *Proposed score: Unhelpful* If I am unsure which pronouns to use. *Proposed score: Unhelpful* Never *Proposed score: Ambiguous – Not scored* After I have asked them if it is ok to ask and they consent. *Proposed score: Helpful* Before making recommendations for preventative screenings or other physical interventions. *Proposed score: Helpful*	Revision: If they have not told me yet and it's not in their file. *Proposed score: Unhelpful* If I cannot tell by appearance. *Proposed score: Unhelpful* If I am unsure which pronouns to use. *Proposed score: Unhelpful* Never *Proposed score: Ambiguous – Not scored* After I have asked them if it is ok to ask and they consent. *Proposed score: Ambiguous – Not scored* If it is unclear and a client is directly asking about their options for genital dysphoria *Proposed score: Helpful*
Your feedback on the revision:	

Avoiding Unhelpful Responses with Transgender Clients: ITEM REVIEW 2 Summarized Feedback	
Original (Item Line 6) *Is there a different name you'd like to be called by?* *Revised:* ***What name would you like me to use when we meet?***	P4: This revision is a step in a positive direction because it does not assume/imply that the client may use a different name in other social settings and asks specifically about how the client would like to be called during the session. P7: I like the revised wording. CONCURRED
Original (Item Line 7) *What pronouns would you like me to use to describe you?* *Revised:* ***What pronouns would you like me to use for you?***	P4: The removal of "describe" makes the question sound much less pathological in it's approach. The first gives the impression that the provider plans to leave the meeting and immediately "describe the patient" in a consult meeting. P7: This is a nice change as well. CONCURRED
Original (Item Line 16) *What steps have you taken so far to transition?* *Revised:* ***What has it been like so far?***	P4: I would specify "what has (your transition) been like so far" or (actualizing your identity) or (client focused language) in order to ask a question that pertains to gender identity. P7: I think these are two different questions. If I want to know what steps they have taken, the revised question may not elicit this info and I would be left needing to ask more directly. This would take me back to the first question. The second question is a great question to ask, but again, I am not sure it would elicit the same information as the first question. LITTLE IMPROVEMENT – not offensive, but could be overly vague.
Original (Item Line 19) *When did this first come up for you?* *Revised:* ***How did this first come up for you?***	P4: Perfect- as long as the client is there with the intention of discussing gender identity. P7: I don't see one of these as any better or worse (helpful or unhelpful) then the other. In fact, like the last set of questions, I think these two are not the same question though unlike the last set, they may elicit the same or similar information. MIXED – may still be problematic (qualifier added), could also be overly vague
Original (Item Line 22) *Have you told anyone else before?* *Revised:* ***Are there others in your life who know?***	P4: This works better because the person may be stealth P7: The difference here is subtle and a preference for one over the other may vary from person to person. SOME IMPROVEMENT – subtle change
Original (Item Line 28) *I have had some training on this issue, but everyone is different.* *Revised:* ***I have had some training on gender diversity, but***	P4: Instead of "I'd like to know what it is like for you", maybe rephrase as "but I'd like to hear specifically about your experiences", because is "it" gender diversity? Coming out? Transition? P7: The revised version is certainly preferable. MIXED – qualifiers added, may still be vague

I'd like to know what it is like for you.	
Original (Item Line 35) *Before we finish, I'd love a chance to get feedback on how this visit went for you. But you should know that it's also not your job to have to educate me.* *Revised:* ***How did this conversation go for you?***	P4: Improvement, but "How do you feel like this conversation went for you?" may invite more open ended feedback than "fine" P7: The revised version is preferable. GOOD IMPROVEMENT – with additional suggestion
When is it generally helpful to ask about a transgender person's genitals? (Select all that apply) (Whole Item starts on Item Line 55)	
Original: After I have asked them if it is ok to ask and they consent. (Item Line 60) *Proposed score: ~~Helpful~~* Before making recommendations for preventative screenings or other physical interventions. (Item Line 61) *Proposed score: Helpful* *Revised:* After I have asked them if it is ok to ask and they consent. *Proposed score:* ***Ambiguous – Not scored*** **If it is unclear and a client is directly asking about their options for genital dysphoria** *Proposed score: Helpful*	P4: This is because the power dynamic makes the consent line blurry. A client may not feel empowered to say no if they assume a counselor is asking questions with therapeutic intent and not knowing their line of reasoning. If it is unclear and a client is directly asking about their options for genital dysphoria. Agreed, with client focused language E.g. "what make you feel ____ about your ____?" P7: I agree with the first revision (consent). For the last item, I think the original and revised statements are addressing two different situations and I think they may both be helpful. GOOD IMPROVEMENT – but one part may be vague

Appendix G:

Quantitative Analysis

Table 10

Code Legend with Times Endorsed

Code	**D. Johnson (2014) Microaggression Theme**	**Times Endorsed**
Binary TN	Binary Transition Norms	81
DD	Discomfort/Disapproval of Transgender Experience	114
Denial E	Denial of Existence of Transphobia	90
Denial I	Denial of Individual Transphobia	74
Edu	Expecting Clients to Provide Education	61
Exo	Exotification	73
Gender BN	Endorsement of Gendernormative and Binary Culture or Behaviors	92
Haras	Physical Threat or Harassment	33
Omit	Omitting Gender Matters from Therapeutic Conversations	50
Priv	Invasions of Bodily Privacy	71
Sex P	Assumption of Sexual Pathology or Abnormality	62
Term	Use fo Transphobic and/or Incorrectly Gendered Terminology	55
Univ	Assumption of Universal Transgender Experience	92

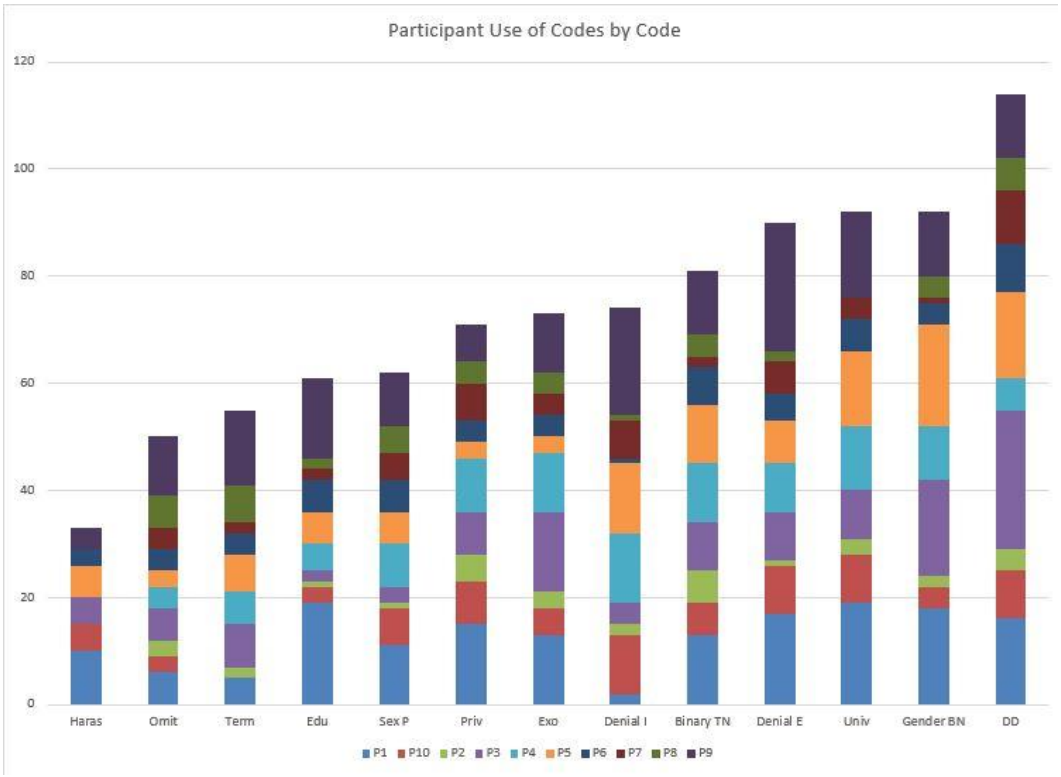

Figure 4. Participant Use of Codes by Code

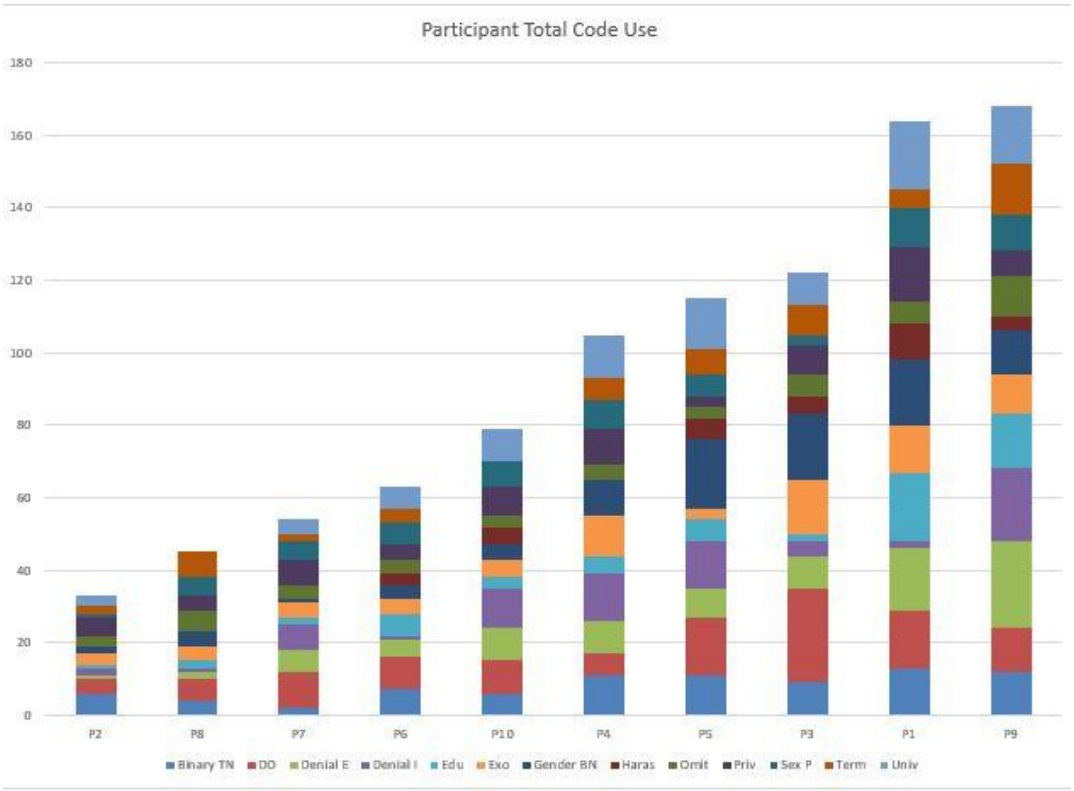

Figure 5. Participant Total Code Use

Appendix H:

Consolidated Iteration #3

Iteration #3

Item Line	*Text*	*Intended Score*
1	**Imagine you are working with a new client who tells you that they are transgender. You are surprised that they describe themselves this way, but eager to show them that you care. Describe the helpfulness of these follow-up questions:**	
2	What surgeries have you had?	Unhelpful
3	Were you born as a man or as a woman?	Unhelpful
4	Do you like to cross-dress?	Unhelpful
5	Why would you want to do that?	Unhelpful
6	What name would you like me to use when we meet?	Helpful
7	What pronouns would you like me to use for you?	Helpful
8	Why are you telling me this?	Unhelpful
9	Are you gay?	
10	Would you like to use a different name in your records?	Helpful
11	I am sorry, I am unable to help you. I am going to have to end the session now.	Unhelpful
12	Other _____	Unscored

13	**The conversation appears to be going well. You feel like you are starting to understand the client, but you still need to gather more information about their history. Describe the appropriateness of the following questions:**	
14	Why do you want to change to the other gender?	Unhelpful
~~15~~	~~Have you taken any steps to transition?~~ (removed from pool)	
16	What has it been like so far?	Helpful
17	Are you sure you want to change your gender?	Unhelpful
18	Where do you think these feelings come from?	Unhelpful
19	How did this first come up for you?	Helpful
20	Why do you feel the need to tell me this?	Unhelpful
21	Do you have any other unusual urges?	Unhelpful
22	Are there others in your life who know?	Helpful
23	Have you had the surgery yet?	Unhelpful
24	Other _____	Unscored

25	**After sharing so much of themselves, you notice the client seems a bit more withdrawn. You want to make it clear that you are there to support them. Describe the helpfulness of the following reassuring statements:**	
26	You can relax here, my clinic works with gay people all the time.	Unhelpful
27	You have to understand this is really hard for me.	Unhelpful
28	I have had some training on gender diversity, but I'd like to know what it is like for you.	Helpful
29	You can relax with me, I love drag.	Unhelpful
30	Your gender is your choice.	Unhelpful
31	I'm sorry, your lifestyle is difficult for me to understand.	Unhelpful
32	We work with clients with many different kinds of problems.	Unhelpful
33	You should not try to take things so seriously.	Unhelpful
34	You can talk to me, hardly anything shocks me anymore.	Unhelpful
35	How did this conversation go for you?	Helpful
36	It is the same as any other diagnosis.	Unhelpful
37	I am not an expert in that, but I would be happy to help you with other problems.	Unhelpful
38	Feel free to let me know if something I say doesn't come out right. I have had some training, but there's always room for improvement.	Unscored
39	You deserve respect no matter your sexual preferences.	Unhelpful
40	I would be happy to help you feel more like a real man (or woman, if applicable).	Unhelpful
41	Other _____	Unscored

42	**The conversation has gotten back on track, and the client decides to open up to you a bit more. They tell you that they have been feeling very frustrated that the people in their life still use their old name. This seems to be something that has been bothering them. Describe the helpfulness of the following approaches:**	
43	Explore strategies for appearing more convincing to other people	Unhelpful
44	Change the subject.	Unhelpful
45	Reflect, "it sounds frustrating that it's still happening."	Helpful
46	Encourage them to transition further or faster.	Unhelpful
47	Encourage them to be patient.	Unscored
48	Ask why they feel the need to be seen as the victim.	Unhelpful
49	Refer them to someone else and politely ask them to leave the office.	Unhelpful
50	Ask them if this is related to having had (or not had) surgery.	Unhelpful
51	Ask what they have been doing to cope.	Helpful
52	Explain why others may have difficulty using their chosen name.	Unhelpful
53	Explore whether they are committed to transitioning.	Unhelpful
54	Other _____	Unscored
55	**When is it generally helpful to ask about a transgender person's genitals?**	
56	If they have not told me yet and it's not in their file.	Unhelpful
57	If I cannot tell by appearance.	Unhelpful
58	If I am unsure which pronouns to use.	Unhelpful
59	Never	Unscored
60	After I have asked them if it is ok to ask and they consent.	Unscored
61	If it is unclear and a client is directly asking about their options for genital dysphoria.	Helpful

62	**<u>This next section takes a look at your ability to pick up on terms commonly used in transgender communities.</u>**	
63	**A client tells you that they do not identify as male or female, but as something in-between. This client most likely is _____?**	
64	A) Either a transgender man or a transgender woman	Incorrect
65	B) Questioning their gender	Incorrect
66	C) Confused about their gender	Incorrect
67	D) Intersex	Incorrect
68	E) Nonbinary, genderqueer, or other	Correct
69	F) Both transgender and gay or bisexual	Incorrect
70	G) In denial about being gay or bisexual	Incorrect
71	H) Other _____	Unscored
72	**Someone who describes themselves as a transgender man was most likely**	
73	Assigned female or intersex at birth	Correct
74	Assigned male or intersex at birth	Incorrect
75	Assigned intersex at birth	Incorrect
76	None of the above	Incorrect
77	Any of the above	Incorrect
78	**Someone who describes themselves as MTF was probably**	
79	Assigned female or intersex at birth	Incorrect
80	Assigned male or intersex at birth	Correct
81	Assigned intersex at birth	Incorrect
82	None of the above	Incorrect
83	Any of the above	Incorrect
84	**Someone who describes themselves as genderqueer was probably**	
85	Assigned female or intersex at birth	Incorrect
86	Assigned male or intersex at birth	Incorrect
87	Assigned intersex at birth	Incorrect
88	None of the above	Incorrect
89	Any of the above	Correct
90	**Transgender men who describe themselves as straight are most likely attracted to**	
91	Men	Incorrect
92	Women	Correct
93	Men and Women	Incorrect
94	Other transgender people	Incorrect
95	Any of the above	Incorrect
96	**Transgender women who describe themselves as lesbian are most likely attracted to**	
97	Men	Incorrect
98	Women	Correct
99	Men and Women	Incorrect
100	Other transgender people	Incorrect
101	None of the above	Incorrect
102	Any of the above	Incorrect