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Samuel Lurie
Exploring the Impacts of Disclosure
for Transgender and Gender
Non-conforming Therapists

ABSTRACT

Transgender and gender non-conforming (TGNC) people face numerous challenges and disparities as members of a marginalized and stigmatized group (Grant, et al., 2011). With the increased visibility of the transgender and gender non-conforming community, there are also more TGNC people becoming professionally trained therapists, and there is a lack of guidance on navigating this particular experience. Four focus groups were conducted in the northeastern part of the United States with 19 total participants who are all Master's level or above mental health clinicians who identify as TGNC. The purpose of this qualitative exploratory study was to examine the experiences of transgender and gender non-conforming (TGNC) therapists related to disclosure about their gender identity and how it impacts both the therapeutic relationship and the practitioner's own sense of efficacy, safety and well-being. Findings were divided into three main domains of: the therapeutic relationship; supervision and workplace; and self-care and community. All three sub-sections revealed issues of burdens, stresses and challenges related to disclosure, as well as ways in which being out or visible have been beneficial and strengthening for the clinical relationship and internal resources for the individual. Relational Cultural Theory (RCT) (Jordan, 2011) provides a theoretical lens with which to clinically address these challenges in the context of social and cultural oppression for empowerment. This project addresses a current gap in the literature on this emerging, timely topic and provides guidance for training and supervision in the field of clinical social work and counseling.

**EXPLORING THE IMPACTS OF DISCLOSURE FOR TRANSGENDER
AND GENDER NON-CONFORMING THERAPISTS**

A project based upon an independent investigation,
submitted in partial fulfillment of the requirements
for the degree of Master of Social Work.

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2014

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CHAPTER I

Introduction

Transgender and gender non-conforming people face numerous challenges and disparities as members of a marginalized and stigmatized group (Grant et al., 2011). Over the past decade, there has been a surge in research on the needs of transgender people that has focused on their experiences as patients or recipients of services, due in large part to the increase in visibility of this marginalized population and the recognition that there are severe disparities in health care access, delivery and outcomes (Benson, 2013; Bess & Stabb, 2009; Grant et al., 2011; Lambda Legal, 2010).

At the same time, more transgender people are becoming visible in professional training programs for mental health providers, or mental health professionals already in the field are identifying as transgender and pursuing gender-related changes such as transition and name changes. Both of these aspects of increased visibility are increasing the number of transgender and gender non-conforming (TGNC) identified practitioners as well as the likelihood that aspects of the transition process of clinicians will be visible to clients and colleagues. This visibility poses unique questions on disclosure in the clinical relationship. The purpose of this qualitative exploratory study is to examine the experiences of TGNC therapists related to disclosure about their gender identity and how this disclosure impacts the therapeutic relationship, and the practitioner's own sense of efficacy, safety and wellbeing. This exploration aims to address a current gap in the literature on this emerging, timely topic.

Expected Contributions to the Field

While there is a small body of literature on the experiences of gay and lesbian clinicians' disclosure about sexual orientation, there is little published literature exploring the experience of TGNC therapists and how they navigate and experience issues of disclosure of their gender identity. This research project will benefit TGNC-identified mental health practitioners and their colleagues or supervisors who might be looking for guidance on these issues by helping to identify some common barriers, normalize what can be an isolating process, and provide some useful approaches that have helped others. This study can also benefit professional training programs that serve up-and-coming clinicians by offering insight and guidance about how these issues might arise in field placement that can contribute to recommendations for improving training experiences. The Council on Social Work Education (Martin, Messinger, Kull & Holmes, 2009) and the American Psychological Association (American Psychological Association, Task Force on Gender Identity and Gender Variance, 2009) both identified need for increased support for transgender-identified students in professional training programs along with increased workplace support for TGNC-identified clinicians and this study can add to the emerging literature that offers formative guidance on the development of best practices. Finally, this study can benefit clients of TGNC-identified clinicians by helping their clinicians feel more confident in their work and therapeutic choices as they focus on client concerns in therapy.

On a personal level, the information gained from this study will help me, the researcher, understand these issues more complexly, deepening my own social work education and training. As a member of the target population, that is a transgender-identified clinician, this research will address issues I face in my own clinical work on a daily basis. As I embark on this project, I am in a parallel process as I personally examine the impacts of disclosure on my own sense of

efficacy, safety and well-being: how am I figuring out issues of disclosure with clients, concerns of discovery, fears or confusion in how I am being perceived and how my lived experience is either visible or invisible in those perceptions? And what, for me, are the benefits and costs of being known versus stealth in my work? As an older MSW student, one with a professional background in transgender health and now making a career shift as a mental health clinician, I need the answers to these questions, but I am aware that I cannot answer them alone. I need to explore this in community, and to invite and witness more experienced professionals to share their experience, which is why I am conducting a study using expert focus groups. I will be using theories of reflexive research (Tang, 2006), heuristic inquiry (West, 2001) and participatory action research (Singh, Richmond, & Burnes, 2013) to help guide me in this exploration, to do so ethically and respectfully. Each of these theoretical approaches recognizes the researcher's subjective lens as a critical part of the research process that needs to be acknowledged when doing research with marginalized groups. Clinical social work is a field that is defined by listening without judgment, and it is a gift to take the time and space to self-reflect, to gain insight through examination of our subjective experience. By exploring and learning together, we will help shape a necessary and particular aspect of providing services, one that is conscious of our lived experience and ways in which our own experience informs and impacts both the care we provide and our own sense of well-being while doing transformative, healing, work.

Terminology

To clarify key terms used in this project, *gender identity* refers to a person's deeply held sense of their gender as boy or girl, man or woman which may be different from the gender they were assigned at birth (Benson, 2012; Lev, 2004). *Transgender*, or *trans*, refers to those who have a gender identity that is different from that assigned at birth (Lambda Legal, 2010), who

challenge gender norms, and who may seek social, legal or medical interventions to live more fully in their chosen gender (Lev, 2004). *Gender non-conforming* (Lambda Legal, 2010) is a more general term for those who challenge traditional gender norms. The acronym TGNC for “Transgender or Gender Non-conforming” is used in current literature and will be used in this paper (Grant et al., 2011; Lambda Legal, 2010). *Transition* indicates the process of moving from living in one’s assigned gender to their chosen, or aligned, gender, and this process involves medical, legal and social interventions (Lev, 2004). These interventions can include name and pronoun change, changes in dress and appearance, and pursuing medical intervention such as cross-sex hormone therapy (Deutsch, 2011). It is a process that takes time—generally at least a year—and is visible to those around the person transitioning. Some transgender people also seek surgical interventions such as chest reconstruction surgery, breast augmentation, facial feminization surgery or genital reconstruction surgery, although access to surgery is often difficult and not covered by health insurance making it so often out of reach for many who desire it (Lev, 2004). Often the goal of transitioning is to *pass*, that is, be seen and affirmed in the world by those around you in your chosen gender, but this is not necessarily possible for many people regardless of how long ago they may have transitioned. *Stealth* is a term used within trans community to indicate a more thorough level of passing, accompanied by the conscious choice of not being out as trans, and often accompanied with *passing privilege* (Blumer & Barbvachano, 2008). *Cis*, or *cisgender* refers to people whose identity is congruent with the gender they were assigned at birth (Hansbury, 2011; Serano, 2007) and will be used interchangeably with *non-trans* in this paper. The cis/trans nomenclature is taken from scientific terminology, trans, meaning “on the other side” and “cis” being “on the same side.” (Hansbury, 2011, p. 210). It is important to keep in mind that much of this terminology is continuously evolving, and used

differently even within transgender communities at different times. This overview of terms provides a common language that aligns with the time, place, and purpose of this project, and that is generally used by participants.

In psychotherapy, *disclosure* is a fairly broad concept that relates to what is revealed to the client about the therapist (Zur, 2009) and *inevitable disclosure* refers to information that clients discover “inevitably” such as a therapist’s pregnancy (McWilliams, 2004). *Dual relationships* is another consideration especially present in small communities, where the therapist and client may have relationships in social contexts as well as clinical, and *boundary crossing*, when therapists might have “appropriate, clinically driven self-disclosures that are carried out for the clinical benefit of the client” (Zur, 2007, p. 151).

Primary research question

In an effort to examine the issues that TGNC-identified clinicians face regarding disclosure, the central question for this exploratory, qualitative study is as follows: What are experiences of transgender and gender non-conforming (TGNC) therapists related to disclosure about their gender identity and how does this disclosure impact the therapeutic relationship and the practitioner’s own sense of efficacy, safety and well-being?

This is an unexplored area of research, the findings of which can benefit a whole new generation of therapists and have the potential to impact the content of professional training, the capacity for self-care of clinicians, and the quality of clinical services for a range of clients.

CHAPTER II

Literature Review

This literature review examines previous studies and other writing related to self-disclosure in clinical relationships. Of particular interest is scholarship examining the challenge transgender and gender non-conforming (TGNC) providers face with clients knowing, observing or finding out about a clinician's gender identity. Studies examining disclosure of lesbian, gay or queer identity will also be explored, as there is both a grouping of gender-nonconforming experience under the "LGBT" umbrella and a conflation of these experiences as the same. Gay, lesbian or queer experience has been discussed in the literature far longer than TGNC experience, and there is a long history of homophobia and oppression of gay and lesbian therapists from within the profession (Bjork, 2004; Blechner, 1996; Guthrie, 2006). Because gender-variance has long been present in gay and lesbian cultures, there are relevant stories and cases that apply to the experience of TGNC clinicians, but it is also important to clarify distinctions between sexual orientation and gender identity that play out in the lives of clinicians and in their clinical work.

This literature review will be organized by first looking at perspectives of therapist self-disclosure as a tool in therapy and then move on to empirical literature that explores self-disclosure for lesbian and gay clinicians and the legacy of homophobia and heterosexism. The review then narrows further to the relationship that TGNC people have had to mental health treatment and finally, a review of the very limited literature on TGNC clinicians themselves.

Nearly all the research that explores clinician self-disclosure in the clinical relationship focuses on the impact on the client (Audet, 2011; Gibson, 2012; Henratty & Levitt, 2012). This project will address the impact of self-disclosure and gender on the clinical relationship, but specifically from the perspective of TGNC clinicians by exploring the costs and benefits of disclosure from the therapist's point of view. Further, in the work that does explore the impact on the therapist, there is generally an assumption of choice, that the therapist is always making a choice about disclosure, rather than disclosure being beyond the therapist's control (Guthrie, 2006; Henratty & Levitt, 2012; Jaffe & Diamond, 2011). While there is certainly rich material in examining what goes into this choice (Greenspan, 1986; Reed, Miller, Nnawulezi & Valenti, 2012; Siebold, 2001), this level of intentionality and even pre-planning is not always an option as people may be out or outed through things such as their appearance, internet searches, publications, or community knowledge.

Self-disclosure as a therapeutic tool

Much of the discussion on therapist self-disclosure within the field of psychotherapy identifies its controversial yet evolving role as a therapeutic intervention, from the earliest psychoanalytical perspective of Freud, where the therapist is to be a "blank slate," to more relational approaches that acknowledge disclosure as not only inevitable, but at times beneficial (Carew, 2009; Maroda, 2009; Ziv-Beiman, 2013). Therapist self-disclosure is a fairly broad concept that relates to what is revealed to the client about the therapist. Self-disclosure can include professional information such as associations, training and degrees, to information about personal experience or identity, including race, spiritual beliefs, sexual orientation, parenting or reproductive issues, disability and more. Self-disclosure can also be described as transparency, when seen more broadly as any information available to clients, including nonverbal or

unintentional disclosure (Zur, Williams, Lehavot & Knapp, 2009, p. 22). And finally, another important area of disclosure widely discussed in the literature is what the therapist chooses to share with the client regarding “feelings, reactions or responses” to that client (Maroda, 2009, p. 28).

Different theoretical approaches influence how clinicians view disclosure. Ziv-Beiman’s meta-study (2013) on self-disclosure and therapists' theoretical approaches found "the greatest willingness to disclose among humanistic therapists and the lowest among psychodynamic therapists" (2013, p. 64). Humanistic theory posits that self-disclosure "allows the client to feel more equal to the therapist and to acknowledge that all human beings suffer from weaknesses and unresolved issues” (Ziv-Beiman, 2013, p. 61). An existential approach sees disclosure as a core technique with the "therapist conceived of as a guide, coach and model” (Ziv-Beiman, 2013, p. 61). Feminist therapists believe it is important to address power in the therapeutic relationship (Greenspan, 1986; Hanson, 2005), in part through the therapist’s honest sharing of feelings they might be having in the clinical encounter, and that "knowledge of the therapist's background and orientation is essential for the patient to give full informed consent" (Jaffe & Diamond, 2011, p. 161). Cognitive or behaviorally oriented therapists believe self-disclosure can challenge irrational thinking and model corrective behavior (Jaffe & Diamond, 2011), and a multi-cultural orientation acknowledges the value of disclosure with clients from different cultures to prove the therapist’s trustworthiness (Knox & Hill, 2003). When discussed with an intersubjective therapeutic lens, anything a therapist might share regarding feelings they themselves are having are part of therapist self-disclosure (Siebold, 2011) and, when done effectively, do deepen the therapeutic relationship and level of work done by the client (Bjork, 2004; Gibson, 2012; Silverman 2001). This is also true of relational cultural theory (RCT), which encourages

empathy and authenticity to foster connection but also with an awareness of social and cultural oppression (Duffey & Somody, 2011; Jordan, 2011).

All of the articles explored for this review take a nuanced view on disclosure as a therapeutic tool. They acknowledge there is a range of theoretical beliefs about disclosure and also recognize that there are many different levels of disclosure, while some are inevitable and benign, others are more involved or even risky. There is also a common theme that avoiding all disclosure is impossible; in fact, it has become widely accepted as an effective therapeutic tool (Burke & Tansey, 1991; Knox & Hill, 2003; Maroda, 2010; Ziv-Beiman, 2013; Zur, 2007). Some research has found that more experienced therapists are more likely to disclose regardless of theoretical orientation (Carew, 2005) and some believe that failure to disclose can even be detrimental to clients (Duffey & Somody, 2011; Greenspan, 1986; Hanson, 2005).

The research on self-disclosure also explores a therapist's motivation to disclose, and according to ethics of the major counseling professional groups, the American Psychological Association, the American Counseling Association and the National Association of Social Work, the most important issue is always "is it in the client's best interest?" (Jaffe & Diamond, 2011, p. 162). Considerations for whether or not therapist self-disclosure is in their client's best interest may be: when an issue is not resolved for the therapist (Audet, 2011; Burke & Tansey, 1991; Knox & Hill, 2003; Siebold, 2011); if knowing the information might create a sense of competition from the client (Henratty & Levitt, 2010); if it is seen as an intrusion or to fill an unconscious need of the therapist's (Siebold, 2011); or when the client would feel a need to take care of the therapist (Cole & Drescher, 2006; Gerstein, 2009; Silverman, 2001). Indeed, most of the studies that explore disclosure in the clinical relationship focus on the impact disclosure has on the client and how the client perceives the therapeutic relationship (Audet, 2011; Gibson,

2012; Henratty & Levitt, 2010), which still leaves a gap concerning the impact disclosure has on the therapist.

Personal accounts often prove the most intriguing and beneficial in exploring the individual experience therapists have with counter-transference and disclosure. Two particularly useful texts on this subject are Bloomgarden and Menutti's *Psychotherapist Revealed: Therapists Speak About Self-disclosure in Therapy* (2009) and Gerson's *The Therapist as a Person: Life Crises, Life Experiences, and Their Effects on Treatment* (1996). In these collections, clinicians grapple with a myriad of personal factors that influence their countertransferential experiences including the impact of their own lived experiences with grief (Cole, 2006; Warshaw, 1996), death or birth of a child (Basescu, 1996; Chasen, 1996; Comstock, 2009; Gerson 1996; Jaffe & Diamond 2011; Silverman 2001), decision to *not* have children (Leibowitz, 1996), marriage, divorce (Gerstein, 2009; Schlachet, 1996; Rucker 1996), effects of sexual trauma (Stevens, 1996), age and ageism (Strauss, 1996), health; disability, body size and eating disorders (Burka, 1996; Cole, 2002; Geller, 1996; Gerstein, 2009; Ruskay Rabinor 2009), and even "the impact of negative experiences as a patient on my work as a therapist" (Elkind, 1996, p. 159). These explorations from mental health professionals offer honest, thoughtful accounts of how personal experience impacts their work, and using their theoretical orientations helps explain how they personally made sense of these experiences and their impact on both their work with clients and their own identities.

Despite the wealth of literature exploring disclosure and personal influences on countertransference, the experience of transgender therapists with self-disclosure remains an unexplored area of research and discourse in the growing field of transgender care. The vast majority of transgender-focused studies focus on the patient or client experience when the client

is TGNC and how to better meet those client needs (Benson, 2013; Bess & Stabb, 2009; Bockting, Knudson & Goldberg, 2006; Collazo, Austin & Craig, 2013; Fraser, 2009; Lev, 2004; Lev, 2009; Lurie, 2005; Mascis, 2011; Singh & Burnes, 2010). The few studies that address self-disclosure from the clinicians' perspective in lesbian, gay, bisexual and transgender (LGBT) communities examine from a lens of therapists' sexual orientation, not gender identity (Guthrie, 2006; Heins 2012; Kessler & Waehler, 2005; Kronner 2013; Moore & Jenkins 2012; Moyer, 2012). As is often the case, even though these authors use the LGBT acronym, their work does not differentiate the T in LGBT.

Lesbian, Gay and Queer (LGQ), but not Transgender

Studies and literature that explore issues of therapist disclosure with the lesbian, gay, and queer (LGQ) communities (Bjork, 2004; Guthrie, 2006; Heins 2012; Kessler & Waehler, 2005; Kronner 2013; Moore & Jenkins 2012; Moyer, 2012; Satterly, 2004; Silverman, 2001) are relevant to this project, in part because there has long been a conflation between sexual orientation and gender identity. Some writers specify that they are writing about lesbians (Bjork, 2004, Silverman, 2001) or gay men (Blechner, 1996; Guthrie, 2006, Satterly, 2004); and these writers are also clear that they are reflecting on their own experience as therapists navigating disclosure with clients. None are specifically about the bisexual experience, which is another complicated identity rarely extricated from the LGBT umbrella (Embaye, 2006). These personal reflections are powerful, especially since they depict living through historical periods in the United States fraught with levels of shame, isolation, and blatant discrimination that thankfully are considerably less present today in LGQ communities. Cole and Drescher (2006) explain that “historically, the psychoanalytic position was that all therapists were heterosexuals. If they were not, they had to pretend to be. Gay therapists had to hide their true sexual identities or risk

professional ostracism and disgrace” (p. 3). This legacy of homophobia, stigma, and being pathologized created a determined counter-movement among some lesbian and gay therapists to “come out, both publicly and to their patients” (Cole & Drescher, 2006, p. 3) to help normalize a non-heterosexual experience.

Bjork (2004) is a psychiatrist who graduated from medical school in 1965 and did her psychiatric residency during a period when homosexuality was deeply pathologized, recalling “as I sat through those lectures, I still vividly recall my fear that I was a defective and incomplete person for being a lesbian” (p. 96). Bjork then lived through the huge cultural transformation of lesbian-feminism of the 1970s and ‘80s in New York City, and committed herself to challenging the dominant assumption that “all therapists are heterosexual.” (p. 98). She, like many of the writers in this review, uses case studies to describe choices and consequences of disclosure, identifying in each of them aspects of her own struggle with internalized homophobia and the need to offer “mirroring and idealizing functions” to members of sexual minorities who rarely see themselves among professionals. Bjork also describes coming out to a heterosexual client who had made an anti-gay slur and this disclosure led to the client making a link to his own childhood shame as the child of immigrants that was a turning point in his therapy: “My disclosure of my sexual orientation helped bridge the stigma surrounding his own shame of his ethnic origins and allowed him to resolve it” (p. 102). Not atypically, Bjork makes a connection between taking a personal risk and appreciating that it led to a therapeutic benefit for the client.

Blechner (1996) also was closeted throughout his training, and identifies internalized homophobia as having him doubt his self-worth and severely limiting what he spoke about with colleagues and clients counterbalanced with the newfound freedom of being out professionally. Silverman (2001) is a lesbian who writes honestly and complexly about being pregnant,

something that always brings the personal life of the therapist into the treatment room, and ways in which she recoiled at assumptions of her being heterosexual, and of feeling dishonest by her own silence and inability to correct those assumptions. Ultimately, Silverman found that working through her countertransference and internalized homophobia was work that also helped clients: “It is now clear to me that when I am more open and risk taking with my patients, they are more open and risk taking with me” (p. 60).

Guthrie (2006) writes as a gay therapist who specifically prefers to *not* disclose to clients, and he reflects that in doing so, he processes a number of painful internal issues related to secrecy and shame. By not disclosing “I felt like a phony, a charlatan, a flim-flam man. By being able to “pass” for straight, I first had an initial sense of pleasure, but it soon was replaced with feelings of guilt and shame at what I realized was my own homophobia” (p. 70). Cole and Drescher (2006) also talk about the sense of internalized shame that is stirred up for a clinician by “refusing to answer a simple question” (p. 3) when that question relates to sexual orientation.

Along with the theme of internalized homophobia and the intrapsychic shame that arises in counter-transference or reflection, there was also a sense of liberation and empowerment that stems from disclosure, and from clients themselves witnessing and moving through their own issues through hearing about lived experience or perspective of the clinician (Cole, 2006; Cole & Drescher, 2006; Moore & Jenkins, 2012). External and internal pressure to serve as a role model for gay and lesbian clients is likewise present and can create a sense of obligation, where “external pressure to come out may result from the real need of the client to use the therapist as a role model for successful integration of a gay/lesbian identity” (Kranzberg, 1998, p. 25). This role modeling can, in fact, support client identity development, but is not without risk.

The unintended and often unacknowledged result of a decision to serve as a role model *and* a therapist is a persistent and pesky fact of life for gay and lesbian therapists: the overlapping of relationships and dual roles. ... I believe gay and lesbian therapists need to acknowledge that choosing to act as a role model as well as a therapist involves an overlapping relationship with the attendant ethical complexities and potential for harm to clients when the roles are in conflict (Kranzberg, 1998, p. 26).

Part of this “acting responsibly” also involves self-care, and being conscious of one’s personal values and limits in terms of disclosure and boundary setting. Kranzberg (1998) reminds readers of the risk of over-identification and danger of assuming similarities, that “lesbian and gay therapists can miss important therapeutic opportunities if they assume that being gay carries the same meaning for the client as it does for the therapist” (p. 28). Privacy and personal safety are also concerns and several of these writers (Gibson, 2010; Kranzberg, 1998; Satterly 2012; Moore & Jenkins, 2012) remind readers of what Gibson (2010) calls the “unidirectionality of confidentiality” (p. 293), that is, whatever a therapist discloses to a client, the client is free to tell anyone else, and so “disclosing to one person can mean disclosing to a whole community” (Moore & Jenkins, p. 313). Yet another aspect of being out on the job is the relatively new existence of LGBT-focused counseling and residential treatment programs, where, in some cases, staff are pressured to declare their sexual orientation and “being out about one’s sexual orientation is seen as a job qualification rather than a revelation” (Gibson, 2012, p. 292).

Homophobia and heterosexism—the myriad levels of lived discrimination, shame, and isolation—are still very much part of the gay and lesbian experience, and it is important that these writers have honestly and complexly explored these issues in their work. Many of the

authors in this review recognize that there are ways in which they work with clients that stem directly from their own experiences related to oppression and stigma, and they are also aware that they must still maintain awareness around safety and boundary-setting, even if they are changing the parameters of the discussion, by being more open and relational than in traditional psychotherapy, in ways that serve the client. While these articles focus on gay and lesbian experiences, there are also many ways in which homophobia and transphobia are linked and the experiences and findings of these studies are applicable to TGNC clinicians, especially related to cultural oppression, professional discrimination, risks of coming out at all stages of identity development, and concerns related to transference, over-identification and tension between personal and professional life in small communities. But sexual orientation is a different disclosure than gender identity, and using the umbrella acronym of LGBT is misleading and limits usefulness and generalizability of those explorations.

For the most part, none of the articles on lesbian and gay therapists mention transgender or gender-nonconforming experiences specifically. For articles prior to the late-1990s, this can speak to cultural shifts in language and identity groups—while there have always been gender non-conforming people within lesbian and gay communities, there has not been as visible a named, self-identified TGNC community until the mid-1990s—but this absence in more recent literature is a failure that speaks to a more post-modern queer identity that subsumes TGNC experiences into a “queer” or “sexual minority” configuration (Heins, 2012; Hodges, 2011; Moore & Jenkins, 2012; Moyer, 2012). Moyer (2012) at least mentions this limitation. In her interviews with queer-identified therapists, there was a female cisgendered partner of a transman who questioned her own “queer” credentials since she is now seen as someone in a heterosexual relationship, and another who identified as a queer transgender man. The author admits she was

unable to extricate these experiences more deeply, but concludes that her study led to “increased questions about how therapists who have transitioned genders or are gender non-binary deal with disclosure of gender identity” (Moyer, 2012, p. 100). She literally invites this current study by quoting the transman informant as saying, “I would love a follow up to your study with someone looking exclusively at trans-identified clinicians” (Moyer, 2012, p. 101).

This next section of the literature review will look at some specific areas of need related to TGNC access to physical and mental health care, and how all TGNC people, including clinicians, are impacted by barriers to care and cultural and political shifts around treatment. Finally, the literature review will examine the very limited material on TGNC clinicians.

TGNC people and access to health care and counseling

Over the past 15 years, there has been a surge of research on identifying and meeting the needs of TGNC people as patients of physical and mental health care (Bauer, et al., 2009; Benson, 2013; Bess & Stabb, 2009; Bockting & Kirk, 2001; Collazo, Austin & Craig, 2013; Grant, et al, 2011; Kenagy, 2002; Lambda Legal, 2010; Lurie, 2005; Sperber, Landers, & Lawrence, 2005; Riley, E., Wong, T., & Sitharthan, G., 2011; Singh & Burne, 2010; Xavier, et al., 2013). These studies represent an acknowledgement of the alarming disparities in health care access and outcomes that are experienced by TGNC people. Such disparities are the result of multiple layers of oppression, including heteronormativity and homophobia, racism, poverty, homelessness, high rates of incarceration, lack of health insurance and discrimination by providers. These disparities first came to light in the mid-1990s, as extremely high rates of HIV were identified among transgender people, particularly transgender women of color. Yet there were no targeted prevention intervention efforts and data collection efforts had no category to effectively count transgender people (Bockting & Kirk, 2001; Kenagy, 2002). Grant et al. (2011)

conducted the largest quantitative study to date of transgender people in the United States, with over 6,400 valid respondents from all 50 states, Washington DC, Puerto Rico, Guam and the Virgin Islands. The survey showed significant barriers to care “whether seeking preventive medicine, routine and emergency care, or transgender-related services,” (Grant et al., 2011, p. 76). The survey found that 28% of respondents faced harassment in a medical setting, 48% postponed care because they could not afford it, and 19% faced outright refusal of care. In a profound reflection of disparities in mental health and well-being, a staggering 41% of respondents had attempted suicide, compared to 1.6% of the general population (Grant, et al, 2011).

Several examinations of health care discrimination utilized focus groups as their method for their exploratory, qualitative studies (Bauer et al., 2009; Kenagy, 2002; Sperber, Landers & Lawrence, 2005; and Xavier, et al., 2013). These studies also all found: high rates of poverty; structural oppression and social stigma that impacted access to care for TGNC people, resulting in higher rates of HIV; higher rates of suicidality; and overall risk and vulnerability that includes violence and trauma (Mascis, 2011; Singh, Hays, & Watson 2011). These studies also identified access to mental health services as limited, fraught with tension due to provider lack of knowledge and outright hostility, and a sense of frustration and insult that transgender experience is itself considered a mental illness.

Standards of Care, DSM and pathologizing TGNC people

It is the diagnosing and pathologizing of TGNC people’s experience as a mental disorder that has been at the root of the complicated relationship with mental health providers (Bockting, Knudson, & Goldberg, 2006; Lev, 2005). Until 2012, transgender people seeking to access transition-related care—hormone therapy, chest reconstruction or breast augmentation surgery,

or genital surgery—have needed to have letters from one or more mental health professionals affirming that the patient has Gender Identity Disorder and is an appropriate candidate for these treatments. The World Professional Association for Transgender Health (WPATH) standards of care (SOC) (Coleman et al., 2012) are guidelines that have been used to control who can have access to transition-related care by laying out requirements for length of therapy, topics covered, and essentially, approval for those wanting to pursue medical treatment for transition (Lev, 2004). This process has been termed the “gatekeeper role” by therapists and community members alike, and has often pitted clients against their own therapists, raising ethical questions and creating a sense of distrust between TGNC clients and mental health providers (Benson, 2013; Bess & Stabb, 2009; Lev, 2004; Lev, 2013; Singh & Burnes, 2010). The most recent version of the WPATH SOC, Version seven, (Coleman et al., 2012) no longer requires a therapist letter for hormone therapy; however, multiple letters are still required to receive surgery. Another result of linking therapy with transition-related care has been the exclusion of TGNC people from accessing therapy for reasons other than for seeking letters for medical transition (Benson, 2013, p. 21).

Use of an “informed consent” approach by primary care providers allows for access to cross-gender hormone treatment for gender transition without therapist letters. This approach, which was first popularized in the 1990s by the Tom Waddell Health Center in San Francisco, a clinic focused on serving homeless people, has since become a more common model in community health (Deutsch, 2011). This is a harm reduction model, that recognizes gatekeeping and insurance barriers can create more harm for many people, especially those from more marginalized groups who have no access to formal treatment and obtain hormones and other treatments through underground markets that could lead to increased risk for other health

problems (Tom Waddell Health Center Transgender Team, 2006). As Deutsch (2011) acknowledges, many providers and community clinics are using the informed consent model with positive results for patients seeking transition-related care or general care for transgender bodies. Not requiring letters from therapists for the provision of care can substantially shift the relationship that TGNC people have with their mental health providers, easing or even eliminating the traditional gatekeeper role.

Another shift in the treatment of TGNC people from the medical model is the newest edition of *The Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM–5; American Psychiatric Association, 2013) that replaced Gender Identity Disorder with Gender Dysphoria. Gender specialists have long criticized the diagnosis Gender Identity Disorder as labeling normal human variation as “disordered” (Bockting, Knudson & Goldberg, 2006; Lev, 2005; Lev, 2013). The move to the new language of “gender dysphoria” was partially a result of a movement to reform the DSM gender categories away from individual pathology. As Lev (2013) writes on the change,

The shift in diagnostic nomenclature initiates a potential shift in clinical conceptualization from gender nonconformity as ‘other,’ ‘mentally ill,’ or ‘disordered’ to understanding that gender, as a biological fact and as a social construct, can be variable, diverse, and changeable and existing without the specter of pathology (p. 289).

The DSM change places more of an emphasis on the person’s discomfort with gender non-congruence, that is their social gender and gender identity do not match the gender they were assigned at birth, but the term “dysphoria” is not without continued controversy. As Lev (2013) writes, “the story of Gender Identity Disorder, and the new diagnosis of Gender

Dysphoria is a narrative of an oppressed people and their liberation struggle, amid the psychobabble of gender conformity, mental illness, and medicalization of human diversity” (p.290).

Research that explores disclosure among TGNC people more generally reveals many layers of oppression, including violence, poverty, homelessness, lack of access to health care, high rates of incarceration, and suicide attempts. This is not disclosure from a place of power such as a therapist’s disclosure, but rather often from much more vulnerable experience: youth displaced from homes; students pressured to leave schools; spouses losing families; employees losing jobs; and the most fundamental, visibility or discovery that results in violence or death. It is through this lens that much of the literature on TGNC people recognizes the vulnerability, discrimination, and oppression faced by gender non-conforming people. None of these studies take into account that TGNC people may be providers themselves and this next section will look at the literature specifically addressing TGNC people who are themselves mental health clinicians.

TGNC Clinicians

The literature focusing on transgender-identified therapists is quite nascent; the articles that address this topic specifically incorporate personal experience and case examples from the authors. A number of articles appeared in a special issue of *Journal of Gay & Lesbian Mental Health* that were originally presented at the Transgender Clinical Symposium, held in New York City in 2010. Perhaps because these articles are adaptations of live presentations, they feel quite personal. Nealy’s *Man in the Mirror* (2011) is a transcript of the keynote address he delivered at the symposium. It is an important piece as the author names his personal journey of gender

transition while mid-career as a professional therapist, and he notes there is little in the clinical literature on this issue, that, "there is no road map for this" (p. 174).

Also in the special issue is a modified transcript from a panel of TGNC providers, speaking on "providing to one's own community," offering a thoughtful dialog among five clinicians from various positions both professionally and in terms of their public or evolving personal gender identity (Shelton, Winterkorn, Gay & Sabatino, 2011). The providers speak to a number of aspects of working for and being part of a marginalized community, identifying the impact on their personal lives as well as various professional challenges. They also discuss the importance of recognizing the wide variation of experiences within the TGNC community and of naming their own privilege—being educated, employed professionals—within it. The article clearly identifies the need for more training for providers and for further exploration of this issue. (Shelton et al., 2011).

Case study presentations often untangle some of the personal issues of the writer while offering a slightly more academic approach. Hansbury (2011), a psychotherapist, psychoanalytic candidate, and specialist in transgender issues in therapy, offers a composite clinical example of a number of trans patients and notes "to my knowledge, [this] is the first paper to address the unique trans-trans dyad in the clinical situation" (p. 210). Hansbury offers that because he is "publicly out" (p. 212) many of his trans clients seek him out because they are "looking for an experience of twinship and mirroring" (p. 212). Mathy (2006) uses cases to illustrate thoughtful disclosure of her sexual orientation (lesbian); her gender identity (raised male and living as female); and her racial identity as Native American (an identity that is not necessarily visible.) She also describes a case where she intentionally chose to *not* disclose anything about her identity with a client who espoused views she saw as homophobic, sexist and racist, assessing

that these views were formed as part of his religious background and she saw it as “an issue of cultural competence” (p. 115) to not disclose to the client. Patton (2009) is a TGNC therapist whose gender non-conformity is not necessarily visible, who describes working with a young passing transgender client, and the chapter offers an honest assessment of many differences between the therapist and their client—race, class, age, and different gender identities on the TGNC spectrum. This honest reflection on differences of class, race, access to education and health care and a range of lived experience along the transgender spectrum is also evident in the “Providing to one’s own community” panel (Shelton, et al., 2011). Just like a number of the authors above who focused on gay and lesbian disclosure, these authors also cite similar motivations, i.e. being a role model, having a sense of “obligation of visibility” and being able to provide mirroring as trans clinicians—all of which impact decisions regarding disclosure. But there is no single transgender community or experience, and a number of the speakers clearly identify that their lives are still quite different than their clients. Said one member of the panel:

The community I work with is primarily composed of poor, transwomen of color. I identify as transgender on the male spectrum, white and middle class. Issues faced by trans individuals can be the same, e.g. fear, isolation, lack of resources and understanding, but often play out in very different ways. Even though the community I work with lives in New York City (as do I), being an African-American transwoman living in East New York raises very different safety issues than does being a white transman living in Chelsea” (Shelton, et al., p. 214).

Along with the panel addressing themes of difference among client and therapist, even when they share a particular identity experience, was the aspect of disclosure being desired by the client.

Often people assume that if you and your client are trans, you have a shared experience, but that is not necessarily the case. When I sought a therapist, I wanted someone who was trans because I thought she would know things about my experience. I did not want to know about *her* trans-experience, and I think if she informed me of it, I would have felt like she was making false comparisons. I would have felt put upon” (Shelton, et al., p. 215).

But the careful consideration of disclosure and the deciding question of “is it in the client’s interest” certainly serve as the line in the sand around TGNC disclosure as well:

Self-disclosure is only ever appropriate if it is in the service of the client. Our clients’ uncertainty of their therapist’s ability to understand their experiences is rich material for exploration. A reason for specifically considering the work of differently gender-identified therapists with transgender clients is that the sociopolitical context of transgender identities affects our work and our decision making, especially from a social-justice perspective (Shelton, et al., p. 215).

Blumer and Barbvachano (2008) offer cases to describe how they manage disclosure and visibility. The authors self identify as a passing female-to-male transgender graduate student and his graduate supervisor, who describes her gender identity as “androgynous” (p. 49). Their article uses “feminist therapeutic tools” (p. 46) to explore dynamics of power and transparency both in the supervisor/supervisee relationship and in the therapeutic dyad, especially as it pertains to a passing female-to-male therapist. But their approach seems to idealize the transmale therapist in a way that feels overgeneralizing and even naïve. In discussing gender preference of clients the authors imply that female-to-male (FTM) transmen do in fact have lived experience as female that allows them to be better suited to work with cisgender women, particularly those with sexual

trauma histories. Blumer and Barbvachano also imply that because an FTM therapist embodies a lived experience as recipient of sexism and an embodied, visible, perceived experience as a man, they can somehow repair a client's view of men:

There have been several situations in which I believed that it would have been advantageous for my prospective clients to have been informed of my background—for instance, when the clients were female and reported that they ‘did not think a man could possibly understand [them]’ or when clients expressed desire to see only female clinicians. In these instances, it was obvious that these clients assumed that because I appeared to be a biological male, I had always been a biological male, and therefore could have had no experiences similar to what most biological women experience. I am reasonably sure that had they known about my background this would have changed their ideas about my gender and sex, as well as their decision to see a female therapist (p. 50).

This assessment seems overly simplistic and not in line with the longer history of reflection and research regarding disclosure among lesbian and gay therapists, nor does it reflect the comments from the panel of TGNC-therapists and their view around being considerably more mindful about the choices related to disclosure and keeping the therapy experience centered on the client. However, Blumer and Barbvachano (2008) do acknowledge there is virtually no literature on this topic, writing “this work is important because it gives us an opportunity to contribute to a body of literature that is non-existent,” (p. 49) and they want to help provide guidance for others. They miss an opportunity, however, to offer guidance related to supervision, which continues to be absent in the literature.

Exploring the decisions, choices, and impact on the therapist's sense of self and authenticity is necessary, and an important part of this proposed study. It will be important to explore how TGNC-identified therapists bring unique perspectives to the therapy room, whether they are out as TGNC or not.

Rationale for current study

This exploration of the literature draws linkages between research that has been conducted over the past few decades regarding therapist self-disclosure and psychotherapeutic approaches, and notices that there is an increased openness to the use of self-disclosure as a therapeutic tool. It also reviews specific issues raised among lesbians and gay men, and people with other complicated experiences that may not be visible, such as related to parenting, grief or disability. Despite this related literature, there is extremely little research on the experience of transgender and gender non-conforming clinicians working with either transgender or non-transgender populations. This study will address this gap in the literature by exploring these unique experiences in an empirical study, making room for the voices of TGNC therapists to inform and shape shared knowledge in the profession.

As more TGNC people are joining the ranks of professional mental health clinicians, the need for information and guidance on this issue is timely and growing. The Council on Social Work Education (Martin, Messinger, Kull & Holmes, 2009) and the American Psychological Association (American Psychological Association, Task Force on Gender Identity and Gender Variance, 2009) have both issued guidelines for supporting TGNC students in educational training programs, but without specific information on how to help them navigate disclosure in the field or therapeutic relationship itself.

This brief exploration of the literature shows this important emerging issue has begun to be voiced, but not yet examined through a rigorous empirical study. All the practitioners whose writing is cited in this review are struggling to be thoughtful and honest, yet they are only telling their own singular experiences, indicating a need for more exploratory work with a broader pool of participants. Given that there are so few articles on this concern, and it has been identified as an emerging issue in the growing field of transgender health, this study is timely and necessary, and its findings should be able to address a gap in the literature, broaden counseling and social work education, and contribute to the skills of the growing group of TGNC-identified mental health professionals.

CHAPTER III

Methodology

Research Purpose and Question

The purpose of this qualitative exploratory study is to examine the experiences of transgender and gender non-conforming (TGNC) therapists related to disclosure about their gender identity and how this disclosure impacts both the therapeutic relationship and the practitioner's own sense of efficacy, safety and well-being. There is little literature exploring the experience of TGNC therapists and what does exist is more personal or anecdotal in nature rather than empirical (Blumer & Barbvachano, 2008; Hansbury, 2011; Mathy, 2006; Nealy, 2011; Shelton, et al, 2011). With the increased visibility of the transgender and gender non-conforming community, there are also more TGNC people becoming professionally trained therapists. There is a lack of guidance for navigating this particular experience of disclosure about personal gender-related information that may impact the therapeutic relationship or relationship in the workplace. A qualitative approach was chosen for its strength in exploring new, under-examined phenomenon and for its capacity to shed light on such experience using personal narratives for meaning making (Drisko, 1997; Engel & Schutt, 2013; Singh & Shelton, 2011). This study incorporated focus groups of TGNC clinicians in the northeastern part of the United States to explore this question.

Research Method and Design

This exploratory qualitative study utilized a focus group method of data collection with transgender or gender non-conforming-identified (TGNC) providers in both Massachusetts and New York. Four focus groups were conducted during the winter of 2014 with a total of 19 participants who work in rural, suburban and urban areas. The use of focus groups allowed for a purposive sampling of participants based on their expertise as master's level or above TGNC-identified mental health clinicians. Focus groups were chosen as the research method for their ability to create a group environment of participants with similar experiences in order to “analyze little known phenomena...in a short amount of time” (Acocella, 2012, p. 1126). More importantly, focus groups of experts with similar experiences, especially in such a specialized yet under-studied group, can create an atmosphere for support through a group reflective experience that can co-construct learning and meaning (Belzile & Öberg, 2012; Trochim, 2006). The interaction among focus group participants, and the opportunity to “talk to one another” (Acocella, 2012, p. 1129), are benefits of this method that can contribute to the richness of the data. This method and approach was an efficient, respectful and dynamic way to involve a significant number of perspectives. Focus groups also allow for the researcher to name their own social location in relationship to the material and participants. Precedent for the benefit of the researcher locating oneself is found in the writings of Singh and Shelton (2011), who explain that providing basic researcher reflexivity, naming the researcher's social location, is a way of establishing “credibility and trustworthiness” for the research (p. 220). In this case, the researcher is a member of the transgender community, a female-to-male (FTM) transgender man who transitioned in my mid-thirties, who is white, middle-class, middle-aged, and a U. S. citizen with a professional background in public health. Naming the researcher location, or in the case of

the group, as a transgender person with long history in activism on transgender health seemed a benefit as it quickly created trust for participants.

This study was approved by the Human Subjects Review Committee of the Smith College School for Social Work on November 25, 2013 (Appendix B). In accordance with federal guidelines, all data used for the project will be stored on a password-protected computer for three years after completion of the study and then destroyed unless it is still being used for further research.

Sample

Nineteen people participated in this study. Purposive sampling was used with participants required to have the following characteristics: 1) Over the age of 18 and able to communicate fluently in English; 2) master's level mental health clinicians (MSW; MFT; MA, MS) or above, (such as PhD level psychologists); 3) currently practicing or have practiced with clients in any mental health setting, including private practice, inpatient or outpatient programs, community mental health, home visits, community outreach, advocacy and other settings; 4) currently or previously identify as TGNC and have worked therapeutically with clients while having this identity, and; 5) willing to be identified as TGNC to peers in a focus group setting. Exclusion criteria were: 1) Those who were not at least master's level clinicians; 2) those who did not self-identify as TGNC; 3) those who had not worked directly with clients while having a TGNC identity; and 4) those who were not willing to be identified with peers in the group setting.

With the requirement of an advanced clinical degree for participation, this was a highly educated group. Of the sample, 60% (N=12) had an MSW; 25% (N=5) had a PhD and 15% (N=3) had an MA. They ranged in age from 28 to 63 with an average age of 43 years old. Years in practice ranged from 1.5 to 31 with an average of 9.1 years. The racial diversity was 74%

(N=14) white or Caucasian; 11% (N=2) Black or African-American; 5% Asian; 5% Mixed and 5% Other. Because this study is specifically about people with non-dominant gender identity and expression, the gender question was not premised on a typical binary definition based on sex assigned at birth, i.e. male or female. Rather, participants were simply asked to write their gender identity on a blank line. The gender identity breakdown was 69% (N=13) as FTM/Transman or male-identified; 26% (N=5) MTF/Transwoman or female-identified, and 5% (N=1) as gender non-conforming female. Transition status was also reported, with 79% (N=15) having transitioned, 11% (N=2) considered themselves in the process; 5% (N=1) planning to in the future, and 5% (N=1) not planning on transitioning. The range of time since transition based on subjective reporting by participants was zero to 22 years with an average of 10 years.

In terms of work environment, participants worked in: private practice (N=5); community mental health (N=5); social service agency (N=5); hospital (N=2); and college or school health (N=2). Just over half, (N=10) work specifically (though not exclusively) with LGBT populations, both youth and adults. Participants were from seven states (some listed more than one): Massachusetts (N=11), New York (N=5), and one each from Michigan, New Jersey, Rhode Island, Vermont, Washington. They described their regions as urban (57%); suburban (19%); rural (10%); and mixed (14%).

Planning and Recruitment

Prior to sending out a call for participants, all logistical details such as location, date and times of the groups were confirmed so potential participants could respond only if they could attend one of the planned groups. Sites were chosen that were central to the recruitment region, accessible by public transportation, and held in what would be private locations. In an effort to gather a more gender-diverse sample that would extend beyond the researcher's networks, one

recruitment strategy was to submit proposals to several regional transgender conferences to conduct a focus group as part of conference programming. Both proposals were accepted, one in New England and one in New York, but the second one would have been too late for this project's timeline. Once the first focus group was accepted for the conference, the other three focus groups were scheduled. Another consideration for diversity in the sample was to hold the groups in different regions so that they would draw people from urban, suburban and rural areas.

After the logistics were in place and sites confirmed, the process of recruiting participants began. The call for participants was distributed through professional networks that included electronic mail listservs with the World Professional Association on Transgender Health (WPATH) and gender specialists in New England and New York. The recruitment letter (Appendix E) was approved by the Human Subjects Review committee to be distributed to the above listed groups and to leadership members in these groups. The recruitment letter was also distributed through social networking sites such as Facebook and LinkedIn and used to invite participants through direct invitation and snowball sampling.

A total of 29 people responded who met criteria and could attend the focus groups. Participants were screened for eligibility through initial email or phone contacts, and then sent a confirmation email with directions to the site, information on contacting the researcher, and an electronic copy of the informed consent (Appendix C). The informed consent outlined the study purpose and goals, explained that participation was voluntary with the option to withdraw at any time prior to the group, gave an assessment of risks and benefits of participation and emphasized confidentiality for participants as well as asking that they disguise any case material discussed. Participants were told they would sign and receive a hard copy of the informed consent on site. They were also sent a second email reminder a week before the event, encouraging them to

contact the researcher if their plans changed and they were unable to attend for any reason. Seven participants contacted the researcher by phone or email to say they would not attend, and another five people were no shows without contacting the researcher. Winter weather, flu season and normal competing demands of life were some factors named, but several participants had also expressed concern about the confidentiality of the groups themselves and wavered about participating due to a discomfort with needing to be out to fellow participants.

Data Collection Methods

Four focus groups were conducted with four to six participants per group. The groups were between 80 to 110 minutes in length. Upon arrival at the focus group site, participants were given a hard copy of the informed consent (Appendix C) to sign and a demographic form (Appendix A) asking questions such as age, gender, race, work environment, and type of degree. They were also given a unique identifier code to link their demographic form without having their name listed on any documents to maintain confidentiality. Food was available and orientation to the space provided as necessary. A large-print version of the research question was read aloud and posted on the wall to help establish focus, and verbal agreements for confidentiality were made before turning on the recording devices. The focus groups were all audio-recorded using two separate recording devices as an insurance against any mechanical failures. The researcher transcribed each group, and the combination of transcribing, listening to the recording multiple times, and coding, assured a deepening of the thematic discovery in the early stages of analysis.

Additionally, three of the four groups had an observer other than the researcher. A fellow social work student was recruited from the local area, and served as an assistant by helping with logistics, note taking and observation of group dynamics. These observers also signed a

confidentiality agreement (Appendix F) and their notes on group interaction were part of the field notes used for analysis.

Interview and facilitation

A focus group method for data gathering allows for a semi-structured group discussion among individuals with a shared experience. As such, the exact questions asked fluctuate based on the flow and direction of the discussion. Participants were given an overview of the agenda (Appendix D) and the group followed a general outline with open-ended questions clustered in categories that included gender identity and practice; workplace experiences; supervision (either as supervisor or supervisee); and overall sense of well-being. The researcher, who has experience conducting focus groups for various public health projects, facilitated each of the groups.

Data Analysis

The analysis involved an immersion in the data through listening, transcribing, coding and exploring for emerging themes. The discussion and themes are unearthed using a combination of concepts that combine several approaches to research analysis. Both reflexive and heuristic approaches acknowledge the location of the researcher in interpreting data and recognize that there is an intersubjective component to how any data is first understood and then written and shared (Mauthner & Doucet, 2003; West, 2006). A phenomenological approach was also incorporated in framing and analyzing the data. As Singh and Shelton (2011) explain, a qualitative, phenomenological approach is appropriate when seeking to understand an experience where there is little scholarly work to draw upon (2011, p. 218). While qualitative research cannot be used to show causality, the data was scoured to find links and themes. The researcher maintained field notes and a research journal throughout the recruitment, data collection and analysis phases to gather initial reflections and emerging themes. Data from the focus group,

collected through MP3 audio-recordings, were transcribed verbatim by the researcher. This same researcher then used open coding to begin the analysis process and examination of the material using a thematic analysis and content analysis to identify categories, themes and connections. The analysis was focused on the research question, that is, specific ways that disclosure of their gender identity impacts the participants in their therapeutic work, workplace and general sense of personal well-being.

Ethics and Safeguards

There have been some important ethical considerations throughout this process. TGNC-identified people have been subjected to oppression, discrimination and marginalization in both their personal and professional lives. Even if participants were all professional clinicians, they have also lived experience as being pathologized, vulnerable and targeted. Allowing room to honor that lived experience and not trigger or re-enact feeling of powerlessness were an important aspect of the research. Tang (2006) reminds us, “feminist ethnography has alerted us that research processes are laden with power differentials and subjectivities. Self-reflexivity is a way of minimizing the power imbalance,” (p. 14). Singh and Shelton (2011) explain that another way to name researcher reflexivity is “researcher-in-relation” (p. 222) and naming this relationship is essential to establish “trustworthiness,” an element in qualitative research that establishes credibility. One way to quickly build safety in the room was for the researcher to disclose being a member of the TGNC community at the onset of the focus group. Taking into account that the researcher is a member of the transgender community and is known for working specifically in transgender health care, it was also important to make sure that the participants were not all friends of the researcher. Although a number of individuals did say that they participated because they knew or wanted to support the researcher, they were professional

acquaintances, most of whom were unknown to the researcher. Two potential participants did not ultimately take part because, upon discussion, it was agreed they were too close to the researcher. It is also possible that my being known in the community created a bias *against* the project. For example, potential participants may have been deterred from participating if they knew me from a different context, thought this represented a dual role, or just did not feel comfortable working with me as a facilitator and researcher.

Participants also, by and large, did not know each other, or only knew each other casually, which was also a benefit for the flow of the group discussions. Several participants were reluctant to participate because of their own confidentiality concerns, and this made the researcher especially aware of being careful to mask any identifying information or characteristics of all participants. One additional safeguard for confidentiality in this project is the choice to avoid any code or identifier in attributing quotes to particular participants, because even with a code, the combination of quotes may be identifying.

Limitations

Limitations of the study lie in the limited time frame to complete the project, limited diversity in the sample with respect to race and gender, and having only one researcher review the data. Limitations of the focus group methodology are that the groups only met once, the personalities of the facilitator and other participants can play a role in the willingness of some participants to share, and there was limited time for probing or deepening of conversation. Participants self-selected to take part and the groups were only held in the northeastern part of the United States, limiting its findings regionally. It is not expected that findings from a qualitative study will be generalizable, but this exploratory undertaking with 19 informants can

provide an early road map in an area that will have both professional and personal meaning and implications.

CHAPTER IV

Findings

Introduction

In creating a road map for understanding, the research question was explored through the use of participant voices to elicit reflection on their experiences and concerns. The research question for this project was: What are experiences of transgender and gender non-conforming (TGNC) therapists related to disclosure about their gender identity and how does this disclosure impact the therapeutic relationship and the practitioner's own sense of efficacy, safety and well-being? Four focus groups were conducted in the northeastern part of the United States with a total of 19 participants, all of whom are TGNC-identified master's level or above mental health clinicians. Focus groups were chosen to enable a group with shared experience to reflect with their peers and colleagues on that experience and to create a space for discussion, exploration and collective meaning making (Acocella, 2012, Belzile & Öberg, 2012, Trochim, 2006). The focus group agenda (Appendix D) was broken into three main domains to address the research question. These domains were: 1) disclosure of gender identity or TGNC history in relationship to practice with clients, which addresses *efficacy*; 2) supervision and workplace experiences, which address *safety*; 3) community and strategies for self-care, which address *well-being*. This chapter will look at results from each of these domains, focusing on the impacts that were most compelling and specific for TGNC therapists.

I: Efficacy: Impact of disclosure on therapeutic relationship

The first series of focus group questions explored the experiences of disclosure to clients about the therapists' gender identity. Types of disclosure included participants being known or out as TGNC; being outed by others; choosing whether or not to disclose (if they have passing privilege); and using disclosure as a therapeutic tool to provide role modeling, or to model vulnerability, for clients. The three main themes for this section are: a) being visible; b) shared experience as a TGNC person; and c) role modeling for effectiveness.

Being visible. Visibility, or lack of visibility, creates a particular burden or fear for TGNC therapists in ways that differ from other therapists. Focus group members had a range of experience with TGNC clients finding out or knowing about their gender identity if it was not apparent. Passing privilege indicates the experience of TGNC-identified people who have transitioned and whose gender history is not easily identifiable based on their appearance. The privilege includes having a choice related to disclosure of their transgender history and 14 of the 19 participants described having passing privilege. Participants assessed that while all therapists do think about transference and counter-transference, there is a particular weight to appearance and disclosure for TGNC therapists. "It's something I struggle with with every client, and it's a struggle that cis therapists don't have. I sometimes feel like I just disclosed because maybe I felt pressure to, for myself. I don't have an easy answer but I'm always aware of the struggle."

Not having control over who knows. Participants in all four groups talked about grappling with feelings of fear and worry about not having control over who knows about their gender history, "about half my clients know I'm trans, but I don't know which half." They identified that this is an ongoing personal stressor, as is not knowing how it might affect a relationship with a client or others.

I have had the experience of being outed without my consent, clients coming in and saying they looked me up, [on the internet], but I wanted it to be more in my control who knows what. I'm not unrealistic in my expectations, I know the information's out there, but I don't want it as easily accessible to people.

For participants who are in early transition, or are visibly gender variant, concerns arose related to changes in their outward appearance:

I have enough visibility that people know me and it's not realistic to be stealth... I don't intend to wear a sign on my head that says 'I'm a trans woman come talk to me' but there will be lots and lots and lots of people who know.

Several mentioned how quickly information spreads among clients, and how there is no way to control for gossip in the community: "People talk! They talk. I can always say I'm never surprised what I hear."

Being invisible with LGQ clients. More than half of clinicians interviewed work specifically, though not exclusively, with LGQ clients and several expressed a concern with not being recognized as being queer. None of the participants identified solely as heterosexual on the demographics form. Participants identified as lesbian (11%), gay (10%), bi (21%), or queer (47%); with one participant writing "trans-hetero?" with a question mark, and another writing "bi, but mostly straight." Participants struggled with giving up a level of visibility through passing and carrying a burden around not being able to make a connection with clients based on being visible as queer.

I think where [not being visible] came up for me was sitting with queer clients and not having them recognize me as queer but then my having a lot of knowledge about the queer community. I'm always in my head thinking 'am I

going to say something to them or not say something to them’? Do they think I’m just a straight guy who knows a *whole* lot about the queer community, how are they reading me, are they reading me as gay and that’s why I know a lot?”

Another participant echoed this, and in both cases, participants were expressing a concern with their own internal process of wondering if disclosure would be for the client’s benefit or might add a complication: “I’m more unclear about whether to come out to my non-trans but queer clients. It could make them feel more comfortable or it could make it about me, so I’m not really sure.”

Fear of rupture or clinical break. Participants were concerned about the possibility of being considered deceitful by clients if they did not disclose and how this worry impacted their sense of efficacy. This was stronger for participants with passing privilege, that is, their TGNC status is not immediately obvious by their appearance and a part of their concern was in having a clinical rupture or losing ground should a client find out.

I had a client who’s gay who had a lot of issues around masculinity and how he was expressing masculinity and at one point he said something like ‘it’s really cool to see you as a male you’re so sensitive and able to express emotion but you’re still masculine and manly. I wish I could be like that.’ And I had this fear reaction, like oh man, if he Google’s me and finds out—all those feelings like I’m deceiving, all that internalized transphobia, really came up. And also [I had] this thought I better never tell him, I better not disclose.

Another described a similar worry should a client find out and it detract from therapeutic success:

I'm literally in there comparing hand size, you know, my feet, what's it like for us both to ride on the train, both being 5 foot 6, you know, men, and I've got this whole other thing riding along in the back of my head all the time, this awareness inside me that's always ticking away, what about if he knew [I was trans], would it eliminate all the benefits we got.

Relief: Confidence increased and stress lessened with time. Along with reports of stress, fear and concern about being discovered by clients, participants reflected on ways in which these concerns, and the way in which they impact their sense of efficacy, shifted over time. This was a result of becoming more comfortable, in part by having more experience and feeling more settled professionally.

I think it got a lot easier for me as a trans provider once I stopped caring who knew and who didn't know. I'm still very sensitive about when I disclose and when I don't... I just stopped worrying about it so much and it took a big weight off my shoulders.

Another participant reported similarly that things changed over time and how experience has made him feel more confident in his ability to navigate the complexity in therapeutic work with clients:

I think I just feel more comfortable now, just being a clinician for a longer period, and not letting that [concern about disclosure] cloud my thoughts and not care as much. I guess I feel more confident than I did before.

Visibility summary. To summarize the sub-section on visibility, focus group members had a range of experience with clients finding out or knowing about their gender identity and reflected on ways in which they have managed the impacts on them personally and clinically.

They reported a desire to be visible with LGQ clients; a concern about clinical rupture upon discovery; and reported a greater sense of comfort or confidence related to disclosure over time. The following section will discuss impacts from working specifically with other TGNC clients.

Shared experience of being TGNC with TGNC clients. Many of the participants do specifically work with TGNC clients and this seemed to be a more likely dyad in which participants would use disclosure intentionally for the clinical relationship. Some participants are sought out for being TGNC, some see disclosing as part of what is expected in doing work with other TGNC people, and some feel like it is always important to “be whatever they need me to be” and be careful with assumptions about the details of shared experience. This sub-section of the efficacy category will focus on the TGNC-TGNC dyad and will be divided into two main themes: a) managing trans-transference; and, b) discomfort with the gatekeeper role.

Managing trans-transference. Participants spoke of the complexities of having their own gender exploration experiences, often fraught with difficulties, mistreatment and discrimination from providers, and how this impacted their work with clients. They also described different expectations or projections that TGNC clients might have in working with them. A term used for this in the focus groups was “trans-transference” (J. Xavier, personal communication, October 6, 2013) i.e. what it means to be a TGNC clinician working with TGNC clients and navigating the transference and counter-transference in the therapy room. This concept brought up some of the most animated exchanges in the groups. One participant spoke of the importance of naming difference with clients:

Most of the time I’m sort of disentangling their projections, that my experience was different than their experience, and I don’t have this instant understanding of their lives that my clients might suppose. In particular clients who were from very

different backgrounds, maybe much younger, transitioned in their early teens, maybe undocumented immigrants, maybe women of color, their histories are so different, so I want to tease out those differences, it seems more important than the actual gender identity component.

One therapist who works with children reflected on the ways in which there is so much more cultural visibility and possibility for young trans people now, counter-transference can include a sense of regret for him:

Sometimes I can get jealous in my private thoughts. I've been surprised that I'm not sort of angry, resentful or bitter because, goddamn it, when I said that [I was trans] in 1960 nobody listened to me. I feel like I should have a lot of anger and bitterness about this, because I wasted a lot of time, but I'm happy that I can just be happy for them. You know, 'you changed your name on your cubby, that's great!'

This ability to "be seen however the client needs to see me" is important, but so were the experiences of disclosure that were providing mirroring and affirmation at a core level. Several reported disclosure as an aspect of role modeling that could be literally life-saving:

There was one young FTM I saw [who had an abuse history.]-I took him seriously, I helped him transition and I was twice his age and able to be that transferential trans dad. ... A big part of the relationship was I could show him 'I don't have to kill myself, I can grow up and I can go have a life.'

Another participant reflected a similar experience, first with helping a client individuate from the transference, but then also knowing that he was modeling a core aspect of survival:

I'm mentoring someone who is pretty young and I find myself catching myself. I don't know if I want to tell him 'that's how I did it', or 'this is how it could be done', because it's going to be so different for him, especially as someone 15-16 [years old]. It's just such a different world and such a different life. I keep telling him I'm here as a person with a similar experience, but I can't tell you how to do it, or if you do it this way it will magically be better, but I can say that it's ok and I'm still here living and breathing.

To synthesize this section on the TGNC-TGNC dyad, there were three main elements, that of "disentangling projections" and establishing differences; experiences of counter-transference that could include envy; and a satisfaction in being able to provide life-affirming role modeling.

Discomfort with gatekeeper role. "I don't want to stand in the way." As discussed in the literature review, the WPATH Standards of Care have historically required working with a mental health clinician for a specific period of time (three to six months) and acquiring a letter before starting cross-gender hormones for gender transition. The new standards of care (Coleman, et al., 2011) are much more flexible regarding this letter, but historically the letter has been a significant part of the process for accessing transition-related care for TGNC people and is still a significant component of accessing this care, especially for any gender-related surgery. Many of the participants could reflect on their own experience of trying to get a letter as clients and expressed complicated feelings about moving into the position as the professional expected to write this letter.

Because I know that I faced a lot of barriers from professionals in my transition and I don't want to stand in the way of someone's autonomy and self-

determination, but you don't just want to be a letter writing factory, or not have it be a thoughtful process. But I think to myself, well, if they got this far then they've had a thoughtful process, so should I just give them their letter and if they want to do therapy great and if they don't, good luck.

Another participant has yet to write letters and feels anxious about it: "I haven't been in a position to do the letter thing yet, and I'm kind of terrified actually. Because I remember it [getting his own letter] being very traumatic for me, so I think that would be challenging to handle."

One participant explained that they had made a decision to not write a letter because having that power in the evaluation process was so uncomfortable:

I wasn't so sure I was in the right frame of mind to be providing that service at the time, because I was very much like, I don't want to stand in anybody's way nor do I just want to be writing letters. I decided just not to do it anymore so I just backed out of it altogether.

Another participant reflected on writing the letter itself as being a positive therapeutic process and impacting a sense of efficacy, with their intervention informed by having had a negative experience personally as the recipient of services.

I had a terrible time getting my letter, and had a really negative experience with a therapist, so I feel pretty strongly about not wanting to stand in the way of people who want letters but also wanting to be responsible as a professional. I've had some really great experiences with clients, co-writing the letter, making the letter a really collaborative, affirming process.

Finally, while the particular dyad of working with other TGNC clients supplied clinicians with insight and compassion for clients, it sometimes left them feeling pressured as well:

It can be helpful to disclose to help the client to, to say, 'listen I've been there, done that'...that's helpful. But sometimes I get the opposite, like 'you should know where I'm coming from so you should speed this along, you shouldn't be this gatekeeper, you should just give me this letter'. It puts you in a tough position, because I don't want to be the gatekeeper with you proving whether or not you're trans.

Discomfort with the gatekeeper role was a recurring theme in the focus groups, even if there was a range of ways in which individuals have managed that discomfort.

The following findings on role modeling are the last sections on efficacy and the therapeutic relationship.

Role modeling for effectiveness. Participants discussed the positive impact of role modeling on their sense of efficacy with a range of different clients, not only TGNC clients. They described role modeling as being helpful to normalize and make visible a range of TGNC experiences and they reflected on times in which they could use their TGNC experience as a way to model vulnerability that was efficacious therapeutically.

Role modeling for family members. Several participants talked about disclosing to family members of trans clients in an effort to offer being a role model and help families envision a future for the TGNC family member. A participant who works with youth said:

The trans people that I work with, it's been about getting their families on board and I've had success with that. I feel effective. I like that I'm in this role because they take me seriously as the professional in this situation. I think it's helpful for

them [family members] to see a trans adult who somewhat has their crap together and has a life, so they can see a future for their kids, that this isn't the end of the world.

Another participant who practices in a small rural community, also described the positive impact this disclosure had on his sense of efficacy:

I've had a really positive experience with parents whose kids are transitioning. They've expressed to me, 'I've never met anyone who's actually trans, it's really helpful to see you as someone who is functioning in the world.'

Another therapist identified understanding the value of this kind of disclosure but that it is often a dilemma about when and how:

Sometimes I can see they're [families] struggling with something and I want to figure out a way to disclose...to show them some vulnerability, to show them I'm a trans person and I'm living a strong successful life, quote unquote. I'm not always sure I do that right. I'm always struggling where and when.

Modeling vulnerability leads to breakthroughs. The final part of this section on efficacy will reflect on participant comments about disclosure to non-TGNC clients for the purpose of modeling vulnerability. This was sometimes sought out by the client, as one participant explained "a client asked to see me specifically because she thought I'd be more understanding to her causes because of my issue." It appears that modeling something through being TGNC seemed to resonate in the clinical situation and helped the clinician feel more effective through taking the risk of sharing something, either personal information or relational reflection:

I have one guy who I'm seeing who has a really hard time dating and he has a hearing impairment and he's really scared that someone's going to judge him for

the hearing impairment so I was trying to model vulnerability for him about like, how sometimes putting yourself out there and being vulnerable is going to help you make a connection. I used myself, my transness, and my nervousness, like I'm nervous right now, my hands are sweaty, and I want to share something with you to see how it will effect our relationship and then I came out to him and it's been great, a) our relationship's really stronger and b) I think I'm trying to get him to understand how it can work for him to come out about his own thing.

Several participants reflected on the “deepening” that can occur through being vulnerable, by bringing “more of me into the room.”

I think the authenticity thing, specifically about being able to come out to clients, on more than one occasion it's been a real shifting point for the relationship to feel more real and more genuine, for the quality of the work to really deepen. And I don't know what it is about that disclosure, if it's really about more of me in the room that feels like I'm taking a risk with vulnerability, but there's been a few recently where things have just opened up. It deepens it.

Finally, one participant said that he rarely discloses proactively, but he will if asked, and this too has led to beneficial results in therapy and a sense of success for him.

I've made the decision that while I don't intentionally out myself, if someone asks me directly, I'll never lie about it. And so I have had people say, are you trans, and I say yeah. And in those instances, I have found it really something that builds the relationship, a very positive experience.

Summary of efficacy section. In exploring disclosure and a sense of efficacy in the clinical relationship, participants reflected on struggles they have regarding visibility of multiple

aspects of their identity; projections from clients regarding their experience and managing those projections; ways in which they feel pressured to disclose; and ways in which their own experiences with being pathologized in the mental health system impact the kind of care they provide. They discussed that some of the stress they feel about disclosure changes over time and they become more relaxed about it as they grow more confident. They also discussed that they are more mindful of ways in which they can role model vulnerability to benefit the therapeutic relationship. One of the most significant findings of this section was about the TGNC-TGNC clinical dyad, and ways in which the provider feels uncomfortable and pressured at times, and is also willing to navigate discussions about similarities that offer mirroring and idealizing functions.

II: Safety: Impact of disclosure on supervision and workplace

The questions on supervision and workplace reflected the impacts that disclosure, either chosen or not chosen, have with clinical supervision, during a job search, or when working within an agency or institution. Participants identified working in social service agencies, community mental health, college health, hospitals, schools, and private practice. Themes that emerged included feeling a stress and unmet need regarding clinical supervision; enduring enormous tension and fear when applying for jobs because of required background checks that would reveal gender history without their choice or control; and feeling stuck at a job because it would be too difficult to move, where these stressors would come up again.

Stress and unmet need in clinical supervision. Discussing aspects of clinical supervision brought out a lot of interaction and energy in the focus groups. People in each group talked about having inadequate supervision that did not meet their needs regardless of their TGNC experience. In particular, participants in more urban settings referred to supervision as “a

luxury” that “just seems to fade” due to stretched resources across the profession. While lack of adequate supervision might be a somewhat common concern in the field more generally, themes unique to TGNC supervisees emerged, especially related to a burden of having to educate supervisors and feeling invalidated by them when addressing gender or TGNC-related concerns. Participants in all groups talked about avoiding topics related to gender with their supervisors or looking elsewhere for clinical supervision because they experienced their supervisors as “clueless,” “unhelpful,” or “invalidating.”

Supervisor’s lack of knowledge. A number of participants explained that they have had to do a lot of educating with supervisors to increase the supervisors’ awareness and knowledge about TGNC issues, and that this work has felt like a burden that has not evolved into more trusting working relationships that would allow for greater discussion of TGNC therapist concerns.

One participant explained supervisors’ basic need for education, and how it impacts his ability to do work he needs to do in clinical supervision:

I’ve had supervision where they needed so much information to be able to get to the issue, that it was exhausting. I felt like I couldn’t get to the place where I could discuss what I needed to because they didn’t have the background information [related to gender].

Another participant reflected that she is able to talk about some issues with her supervisor, but still feels a burden of having to teach and train him:

I do get regular supervision by somebody who is a very experienced clinician who knows nothing about trans issues, he knows a little about LGB issues, nice guy. But if it’s about my trans clients, I’m often informing him, I have to explain terms

or explain the transition process, or cultural competency issues, I kinda get decent supervision from him in general, he's not transphobic, he's just clueless.

This lack of knowledge is not only frustrating, but felt damaging to some TGNC clinicians. Participants revealed that because of supervisors' lack of information, they have also endured certain types of scrutiny, a sense of being mistrusted, and basic indignities.

I was alone with my supervisor for the first time after having come out, the first question I got in supervision was 'so what was your name before?' And I was like, 'I don't know how to say this but that is not an appropriate question'. I felt like I had no other option than to call out my supervisor. And unfortunately it really shut down the conversation and she hasn't talked to me about it since then. So I need to figure out how to do supervision with my supervisor.

Another participant agreed that he has had to deal with intrusive questions noting he had to say "that's too personal," adding "I don't think it should impact the relationship with the supervisor, but it does." Several participants talked about having fear around challenging their supervisor, and about an overall sense of discomfort and worry about job security should they do so, "like maybe it would create for them a sense that maybe it wasn't a good idea to hire me." These concerns were not just theoretical. One participant revealed being involved with legal action related to supervisor mistreatment that is directly related to being a transgender person, an enormously stressful impact of the supervisor's response to the clinician's disclosure.

Feeling isolated and invalidated. For those who felt positive about their clinical supervision more generally, there was frustration with being able to broach gender-related concerns in an otherwise fruitful relationship. One participant who works in private practice with a significant TGNC clientele, acknowledged this as a weak area with her supervisor:

I've raised counter-transference issues that I think may be going on because of my [gender] presentation and that is the only time where [my supervisor] didn't quite get what I was talking about. ... As bright as she is and as savvy as she is, there was something she wasn't getting and it was the only time I ever felt like that, like she was saying 'I think you're making more of this than is really going on.' So I felt this little bit invalidated, even though it took a lot of guts for me to raise whatever was going on.

Another participant said his supervisors back off from talking openly with him when he brings in issues related to TGNC clients, as if he already has the expertise and would know anything on that topic that would come up.

I've had supervisors not want to touch the trans stuff. Not because they're not supportive, but they don't want to offend me or they feel under-informed themselves to they'll defer to me to an extent that it is not helpful. 'No actually, this isn't about trans stuff, I just want some clinical feedback', and they're like, 'well, you've got this figured out, this is your thing, trans stuff'.

It was common for participants to use informal networks for support, but in general, even when working in a position where there is clinical supervision, participants talked about not bringing this issue to supervision, and not having formal places to turn to reflect on issues with clients. One participant reflected on this sense of isolation: "I feel like other than some friends of mine who are also trans and providers, and we can sometimes talk about this, but other than that, who the heck can I talk to about it? I sometimes feel like I'm hanging out there without too many people to talk to."

Job search and security in the workplace. As participants reflected on jobs, job choice and ways in which they have grown—or felt stifled—in their positions, they discussed the many ways they lack choice regarding disclosure in a workplace. This concern was not with clients, but with co-workers and a sense of distrust that sometimes came from colleagues:

It wasn't the clients that were having a hard time, it was the staff and they made my life miserable for a while. Because they knew I was trans they suddenly thought that I was perhaps going to be harmful to clients or that I wasn't psychologically stable enough to be treating some clients.

The same kind of scrutiny and worry that participants identified with supervision was also evident in looking for jobs. Several participants also mentioned this happening as they interviewed for field placements while in graduate school.

Background checks. In three of the groups, participants talked about the issue of being forced to come out in the hiring process because of required criminal background checks, now a norm in any school- or agency-based clinical work. This theme reflected a sense of feeling pressured and at risk in what is already a vulnerable process.

One of the places I applied was the VA, and they have an application where you have to put male or female on there, there's no blank anything, and then you also have to be registered for the draft, so I had to go through this whole special thing for them, that I'm transgender, I'm male, and not registered for the draft because I'm female, this whole long spiel.

Others talked about not knowing for sure how this information impacted the job search, but speculating that it played a role. A participant explained that she had over a hundred interviews and never got a position:

When I was looking for work I ran into a lot of problems, because they do the query, and it'd come back in my old name, and as soon as the query came back I was out. I couldn't keep it a secret and I must have gone on 150 interviews, unsuccessfully, and you don't get that many interviews if your resume looks bad. I assumed it had to be the trans thing.

The combination of having to explain themselves early in the application process, taking risks to be more open, and having such personal information be part of the interview process—“it felt very awkward that all these HR and admin people were having these conversations about my body and my appearance before I even got there”—were all stressors related to disclosure in the job search process. As one participant lamented, fittingly for many, “I wonder, what places or opportunities might I have had if people didn't know, or if this wasn't a letter I had to send along with my other application materials, you know?”

Lack of mobility in a job. Partially due to the stressors described above, it was difficult for many to consider changing jobs. Several described having proven themselves, or having worked through difficulties with co-workers or supervisors and even worked to get more trans-inclusive policies in their agency, and not wanting to consider moving. One participant described it as “feeling trapped.”

There are times when I feel am I stuck here because it wouldn't be safe for me to go somewhere else, I would lose health care or benefits, so it has become not only a choice because I want to work in that organization, but also a choice about safety and long term well-being, ...that I've got to know that my health insurance and my employer will take care of me. And they have worked for it, they have

gone to bat for their trans employees, and I don't want to start over again without that. So I do feel almost trapped in the position.

Another participant who has moved up the ranks at an LGBT agency into a leadership position, says that she feels she has hit a glass ceiling as a transwoman doing policy work, and that her broader expertise beyond trans issues goes unrecognized.

I still feel like my job prospects are minimal. Like other people in my position would earn more, have more job opportunities, would have worked in different places, and that's just sort of the way it is. That's an aspect of structural oppression that I personally can't control. Say if I was a gay man in this world, would I still be in this job? I doubt it, I doubt it very seriously. I'd probably be working as the executive director of some organization.

Six participants identified working in private practice, and spoke of the freedom it offers in terms of being able to control the work environment in more satisfying ways. Several others identified having the goal of moving in to private practice in the future. Private practice was described as providing a sense of freedom in terms of focusing on specific kinds of work and scheduling, but participants also spoke to a sense of isolation. Participants identified being involved in peer supervision groups as an important way to have support and to lessen isolation.

Summary of safety section. Participants reported multiple layers of tension and worry regarding job searches and opportunities for professional growth or mobility. Supervision was an area where they experienced unmet need, especially related to supervisor lack of knowledge or competency around TGNC-related issues and concerns. Several reported that they stayed in positions that were difficult financially but which offered some other supports, especially trans-competence. Several discussed how being in private practice provided a sense of freedom, but

also identified a potential for isolation. Participants identified being involved in peer supervision groups as an important way to have support and to lessen isolation.

III: Well-being: Impact of disclosure on self-care and community

This third section of the Findings chapter addresses the impact of disclosure on the TGNC therapist's sense of well-being. Well-being in this case was operationalized as aspects of the clinician's personal healing work, self-care, and connection to community. Questions were asked related to how aspects of being out, known or visible as TGNC play a role in this well-being. This area seemed to share the most in common with therapists more generally, "these are the same struggles as my cis, non-queer colleagues, who are just struggling with feeling overwhelmed and trying to find balance," so the focus here, as in the rest of the findings, was to intentionally narrow in on the things that seemed most specific and compelling for TGNC therapists and the impacts of their being known, out, or visible as TGNC.

The two main themes to be addressed in this section are: a) collision of roles in getting their own needs met; and b) community connections for networking and activism.

Collision of roles in getting their own needs met. A concept that came up in numerous ways was limited options for participants' own personal healing or transition-related needs due to dual roles. As they have sought out support groups, community gatherings, or their own therapy, they reported ways in which they experience their position as therapists—and being known, out or visible as TGNC—as colliding with their being able to comfortably participate or find providers themselves.

Own therapy. Several participants addressed their own ongoing therapy as a resource for self-care, but also mentioned challenges in finding a therapist to meet their own needs. Several participants echoed the idea that it was difficult to find quality therapists, who were trans-aware,

who they could afford, and who they did not already know through personal or professional networks.

If you go into this profession, you start to realize there are a lot of bad therapists out there. I don't see a therapist now because I think I'm kind of happy. But if I did want to see a therapist I'd want to see people who I can't see, because they're my friends! And they're really eff-ing good! And that's who I'd want to see.

The combination of few competent therapists in a community and having a particular level of awareness around being a therapist seemed to impact their choices.

I wouldn't be afloat without a therapist. [But I couldn't afford it] and I tried an institute and realized I didn't want to be someone's learning how to do this. I didn't want to be sitting in a room with someone who was totally afraid they might offend you because you're trans and they don't know what to say. So after being on the wait list for a year and a half I finally got a really good therapist and that has been really helpful.

These examples not only show ways in which any therapist has to navigate dual roles, but specifically some of the tensions and challenges that are present for TGNC therapists in particular. One participant said that this was exacerbated by lack of choices: "it's especially difficult because there aren't many providers who are competent in trans issues."

Support groups and gatherings. Isolation is something that participants have faced in their personal lives and attending support groups or events is a way to break that isolation. Yet this too creates a collision of roles in the community. One participant talked about balancing the two roles of therapist and participant: "It took me a long time to start seeing trans clients because I wanted to make sure that every time I showed up to a support group I wouldn't see clients."

Several people spoke to having to plan very carefully and even probe with clients to try to avoid seeing clients at events they want to attend for their own purposes. One talked about traveling significant distance with the hope of having this privacy:

I've gone to [a trans community conference in Chicago] for four years. The first time I went, I left the hotel room, I walked down the hall, and one of my clients was there. It was unbelievable. They didn't recognize me, but this was in Chicago! Now I take a fairly systematic approach with my clients to see whether or not they are going to be attending [other events]. The reality is that I am now in the community in a different way. I've run into former clients, and they don't recognize me. It feels very odd. As I transition, I certainly want to be part of this community, but I don't know what that's going to look like as a *therapist*.

Participants reflected on ways in which they navigate the dual roles, and ways in which this challenge is something they cannot avoid altogether but need to learn how to adapt to and learn how to balance in ways that are comfortable for them.

Retracted social life. Participants in both small towns and large cities reflected on ways that their personal networks and social circles need to be smaller and have “retracted to a very small circle” to either avoid or manage disclosure. One participant explained: “I wish I had understood the implications of working in such a small community and the impact that would have in terms of limiting options.” These options referred to friendships, attending events and even comfort walking around town. This sense of “small community” was not limited to geographical small towns, but was also present in cities, as LGBT communities may still be relatively small. The smallness of community necessitates concerns about maintaining privacy, building new friendships and impacts their own sense of emotional safety.

There are ways in which it's felt partly necessary and partly appropriate that I've backed a little bit away from some of the things I used to do. ... As a provider I feel less safe, less appropriate to be doing that.

One participant reflected that the cost of this small circle included isolation and an inability to trust and build new relationships.

There are lots of things I do professionally and don't do personally that I know I'd probably benefit from. My community's grown smaller. And I think my ability to trust has become more narrow, and I think that impacts me personally.

Navigating dual roles impacted the participants in numerous ways, limiting choices and options in terms of their own involvement with therapeutic or social supports. Some of them have figured out ways to make things work for them, through negotiating or planning, but there was a burden in having to manage a collision of roles and concern about disclosure in getting their own needs met.

Community connections. A number of participants play or have played leadership roles in their communities, especially around building TGNC community, such as organizing networking events, co-hosting of a monthly community pot-luck, managing an online listserv, and facilitating support groups. This was an aspect of internal strengthening that was crucial to sustainability and balance, and having these leadership roles may help with managing the risks of disclosure.

Feeling refreshed and hopeful through networking. Participants identified networking with colleagues, peers and friends as a core strategy for well-being. One described the importance of his peer network:

What's helped me the most is talking with other trans guys who have a similar sense of identity in being mostly stealth and talking about what it's like. I have a good core group of friends who have a similar experience and we can talk about what does it mean if we are out or not out, what does it mean about transphobia, what does it mean about our manhood ...Just having a core of folks to live that with, has been really helpful.

In addition to networking with friends was networking with colleagues. One explained that it was important to see other TGNC clinicians at different stages of having navigated transition and their professional lives.

I lack your perspective. I don't know what it's like to be fully transitioned. I don't know what it's like to see that things get better. It's good to see that hopefully, over time the craziness dies down.

Another person who started a regional gender specialist email listserv, said, "It's been a really nice way to feel like I'm not so alone, I can just throw out an email on any topic and somebody answers."

The importance of working with TGNC peers and colleagues was reflected in how people felt about participating in the focus groups themselves. This was important, as one of the reasons the focus group method was chosen was to provide a networking opportunity for participants.

I'm always quite refreshed when I see there are other people in other places doing this. There's the whole cliché you're not alone, but it does feel less isolating. It helps me feel less raw.

One of the focus groups was held at a conference and a participant said she had traveled to the conference for the sole purpose of participating in the focus group:

This focus group is the only reason I'm at this conference. I wasn't gonna come, But when I saw you were doing this, I said, 'I gotta come. I gotta come and see if there are any others and how many others there are!'

And another participant, who said he had really deliberated over attending the focus group due to the requirement that participants had to be willing to identify to each other as TGNC-identified clinicians:

There is a healing aspect, to be able to sit in the room with people and say, 'oh yeah, wow,' about all the things we deal with. There is something very healing, very soothing, something balm-like, that goes along with that experience that is worth it, to me, to go sit in a room where I'll be identified just by the fact that I'm sitting in that room. And I wouldn't typically do that. I want that shared kind of experience to communicate with other people around, that I don't get anywhere else.

This reflection highlighted the emotional costs related to disclosure, particularly the complications of not wanting to be out or known and the personal impact that can have in creating a sense of isolation.

Meaning through activism. Participants in all focus groups identified political activism as a way they have been able to make connections for strength and balance. Many said they have found purpose, meaning and connection through their activist histories, even if they are less active now. Others identified conducting educational trainings as a way that helped them feel empowered. For some, there was an important message about being aware of the possibility of burnout, that if you are involved and out as TGNC, many things might be expected of you.

I wish I had more confidence in terms of making the choice to say no sometimes. To know that I don't have to do everything, I don't have to be on all the time. I can choose not to go to this gathering or that thing, and it will be ok. It's huge to intentionally give myself a break.

And finally, one spoke about activism and political connection as being a core element to sustainability as a therapist.

There's a conversation about self care that revolves around the individual and doing self care at that level is extremely important, it's about survival, but I also think there's a level of self-care that is at the political level. Tying our individual work to a larger political framework to create meaning and longevity. I'm interested in that we create, long-term capacity through connecting to larger contexts and to me that is self-care.

Summary of well-being section. To summarize the section on the impact of disclosure on well-being, participants shared that in some ways this category had the most in common with non-TGNC therapists, such as seeking a work-life balance in the face of stressors. But in narrowing the findings to TGNC therapists and disclosure, this section discussed the two main themes. The first, collision of roles in getting their own needs met, addressed challenges in seeking out their own therapeutic resources and feeling the tension of dual roles. The second theme, community connections for support and activism, identified the need for networking and finding ways to balance individual and political levels of self-care and activism.

Summary of findings

The findings chapter was divided into three main sections to match the domains of the research question. The first section, efficacy and the therapeutic relationship, included: fear and

worry related to visibility and possible ruptures upon discovery; managing a shared experience in the TGNC-TGNC dyad and having a discomfort with the gatekeeper role in that dyad; and providing role modeling functions for all clients. The second section, safety, explored disclosure as it related to clinical supervision and workplace issues. Findings of the safety section included: feeling invalidated and isolated in supervision that made it difficult to get needs met; and stress related to job search and lack of job mobility, largely due to being discovered and then scrutinized for being TGNC. In the third area, well-being, findings were related to: collision of roles while trying to get personal needs met, and the critical importance of community connections. All three findings sub-sections reveal issues of burdens, stresses and challenges related to disclosure, as well as ways in which being out or visible have been beneficial and strengthening for the clinical relationship and internal resources for the individual.

CHAPTER V

Discussion

This chapter will explore the findings of this study in the context of current literature and previous research on disclosure among therapists related to LGBQ identity and TGNC issues. There will be a discussion around the strengths and limitations particular to this study, as well as a discussion of the relevant implications for clinical social work practice and education, and suggestions for future research.

This project was designed to explore the experiences of transgender and gender nonconforming (TGNC) therapists and ways in which disclosure of their gender identity impacted their clinical work and their own sense of efficacy, safety and well-being. This study's purpose was to bring forward these voices to address a gap in the literature, as there have been no studies to date examining this experience and, by doing so, provide helpful information for other TGNC clinicians, for their colleagues, and for professional training programs. The project also served a more personal goal, providing an opportunity for me, the researcher, to learn more about conducting an empirical study and to explore these issues for my own professional development.

Four focus groups were conducted in the northeastern region of the United States with 19 participants from seven states. This was a seasoned, experienced group of clinicians, with an average age of 43 and average number of 9.6 years in practice as therapists. The findings from

this study are an early step in untangling a relatively newer experience for therapists, that of being TGNC-identified and practicing as a mental health clinician.

Findings and Literature

There were three main findings areas, based on the research question's three main sub-questions. Key findings for the first area, efficacy and the therapeutic relationship, included: fear and worry related to visibility and possible ruptures upon discovery; managing a shared experience in the TGNC-TGNC dyad and having a discomfort with the gatekeeper role in that dyad; and providing role modeling functions for all clients. Key findings in the second area, safety, included: feeling invalidated and isolated in supervision; and stress related to background checks in a job search. In the third area, well-being, key findings were related to: collision of roles while trying to get personal needs met; and the critical importance of community connections.

As there was so little specifically in the literature on the TGNC-therapist's experience, the strategy to review literature on lesbian, gay and queer therapists proved relevant and useful. The expectation was that related literature would reflect aspects of the experience, but with a need to be mindful of ways in which the TGNC experience was subsumed in the lesbian, gay, and queer research. Another strategy was to examine literature that explored other aspects of therapist self-disclosure and lived experience such as Elkind's discussion relating "my negative experiences as a patient have had a powerful and positive impact on my clinical work" (1996; p. 173). It was also helpful to review literature related to TGNC people and the history of barriers to accessing health care and mental health services that provides context for the fraught relationship between TGNC people and mental health providers.

Several key findings were consistent with the related LGQ literature. In the earlier literature on lesbian and gay therapist disclosure, authors identified the “need to offer mirroring and idealizing functions” (Bjork, 2004) in matching dyads and discussed that modeling vulnerability could lead to breakthroughs with all kinds of clients (Bjork, 2004; Cole, 2006; Moore & Jenkins, 2012; Silverman, 2001). This was echoed by the participant in this study saying: “Being able to come out to clients, [has] been a real shifting point for the relationship to feel more real and more genuine for the quality of the work to really deepen.” This was relayed as a way of bringing authenticity to the relationship that in turn brings out increased trust, connection, willingness to be vulnerable, and, ultimately, growth.

Earlier writers spoke of a sense of shame, wanting to keep their sexual orientation secret, and internalized homophobia (Cole & Drescher, 2006; Guthrie, 2006). The results of the present study support this experience as participants voiced a struggle with shame and internalized transphobia. Participants also echoed what was in the literature by acknowledging that their disclosure could be a powerfully effective tool for role modeling and empowerment (Bjork, 2006; Cole & Drescher, 2006; Moore & Jenkins, 2012), but that there sometimes was an internal and external pressure to disclose (Kranzberg, 1998). Kranzberg also warned of a risk of assuming similarities based only on sexual orientation, and so clients and therapists might be tempted to believe they have more of a shared identity than they really have. This same concern was also voiced by focus group participants in this study: “Most of the time I’m sort of disentangling their projections; that my experience was different than their experience and I don’t have this instant understanding of their lives that my clients might suppose.”

The little literature specifically on TGNC therapists also addressed the risk of “assumption of sameness,” with the panel of TGNC providers (Shelton, et al. 2011) discussing

the importance tracking differences, and to always gauge disclosure on whether or not it is in the service of the client. This study's sample, made up of very experienced therapists, was articulate about being able to assess what might be in the service of the client. They also had enough experience to echo what was in the literature related to becoming more comfortable with disclosure over time in practice with clients (Carew, 2005; Greenspan, 1986).

Several aspects of the findings that were not consistent with the literature were more specifically related to TGNC therapist's unique experience, distinct from other groups of therapists. One of the most significant findings in this area was the discomfort that participants expressed regarding being in the "gatekeeper" role as therapist for TGNC clients. This does not seem surprising given the history of restricted access to transition-related care, the requirement for psychotherapy for a particular period of time to receive a "letter" approving care, the pathologizing and demeaning language used to describe people with non-conforming gender expressions or identities, and social and cultural discrimination towards TGNC people (Bockting, Knudson & Goldberg, 2006; Coleman, 2012; Fraser, 2012; Grant, et al., 2011; Lev, 2013; Whitehead, et al., 2012). However, the passion that was present in these discussions indicates an important area deserving closer examination. Participants expressed conflicted thoughts and feelings about being in the gatekeeper role, and several stated specifically that they were uncomfortable because of oppressive experiences they had themselves as recipients of care: "I faced a lot of barriers from professionals in my transition and I don't want to stand in the way of someone's autonomy and self-determination."

Participants also identified a number of useful solutions to foster what feels like a more ethical and balanced working relationship with clients who are interested in pursuing medical transition. One solution mentioned was the utilization of a consultation network to have a

colleague write the letter, “which means that the therapy does not have to be contaminated by the therapist standing in judgment.” Others spoke of providing more integrative care, “I don’t believe in the gatekeeper, [I tell clients] first go to the doctor, ask them if they’ll just give you what you want. As an advocate, because I have a lot of privilege, I’m happy to call your doctor and give them some feedback about what they’re doing.” This experience—a range of discomfort and solutions—should be harnessed in some way to help improve strategies for treatment and advocacy. The unique experience that clinicians in this study discussed, that of being both recipients and providers of transgender-related treatment, offers compelling insight to help reshape discussions of best practice in working with TGNC clients and their support systems in affirming ways.

Another particularly vibrant discussion area was related to participants voicing a desire to be visible as “queer”, which some felt they have lost as they gained passing privilege and are often perceived as heterosexual. Interestingly, none of the participants identified solely as heterosexual on the demographics form. As discussed in the findings chapter, they self-identified as lesbian (11%), gay (10%), bi (21%), or queer (47%); with one participant writing “trans-hetero?” with a question mark, and another writing “bi, but mostly straight.” Many attached significant importance to clients seeing them as part of the queer community, which they realized might be complicated by being perceived as having an opposite-gender partner: “I had a feeling like I wouldn’t be able to connect with a queer client if they were reading me as a heterosexual male.” Another participant explained that he was concerned about clients seeing him with his wife who is visibly pregnant, that these clients are invested in seeing him as a gay man, and “they’re trying to figure out how I can be queer and have a pregnant wife. I feel like I’m betraying them.” This finding also complicates the critique that the LGBT acronym conflates

different communities under one label by demonstrating that some TGNC providers actively want this connection. For some, being visible as queer helps to explain their gender non-conformity without having to be out as someone who has transitioned. It seems to provide a safer container for a wider range of gender expression, such as being a sensitive man or a woman wearing a tie, that may be easier for clients to comprehend or relate to.

Other findings from this study that were not addressed in the literature were those in the safety sub-section, related to supervision and job search stress. One article, written by a supervisor and supervisee (Blumer & Barbvachano, 2008), missed the opportunity to provide some guidance related to supervision and this is an obvious area for future research and best practice guidelines. In this current study, participants identified some possible solutions, including peer supervision and supervision groups that normalize TGNC experience (along with other marginalized experiences that are often pathologized, such as polyamory). One participant explained this normalization: “I can sit in group supervision and talk about a trans client who's in a poly daddy-girl relationship and it doesn't phase anybody, they're like, ok, let's talk about the problem. They're not focusing on that [expressions of alternative sexuality] as a problem.”

Also, while it was not an intentional focus of the literature review for this project, Bettinger (2010) does address the lack of research on LGBT issues in human resource development and the current study serves as a reminder to include specific TGNC concerns in any policy change implementation that addresses discrimination or barriers faced by LGBT people. The level of stress related to background checks in a job search was palpable, as these background checks result in discovery of participants' gender identity without their having control over the disclosure process at a particularly vulnerable time. This is an important impact to explore further, perhaps linking information on TGNC people more directly with concerns

related to employment discrimination and human resources best practices more generally related to TGNC employees.

In the findings area on well-being, which examined TGNC therapists' self-care and connection to community, the literature reflected the findings related to therapists identifying a retracted social circle, issues of navigating dual roles in a small community and the unidirectionality of confidentiality (Gibson, 2010; Kranzberg, 1998; Moore & Jenkins, 2012). In a number of ways, the discussions about self-care and well-being are the most consistent with more general therapist needs about balancing personal and professional life. Areas that were distinct reflected specific things that TGNC therapists might seek out, such as their own therapy and having difficulty finding trans-competent therapists who are not already their friends, and in having to avoid going to TGNC-related support groups or events because of concern of seeing clients.

Importantly, the findings on self-care and well-being also captured the connection that many of the participants have to political activism and to ways in which that activism fuels and sustains them in being able to do their professional and personal work. Participants identified several aspects of political and organizing work that provided connection, meaning and community. These included working towards macro policy and political changes, such as working with a coalition aimed at bolstering access to an informed consent model of care; to changing policies at the agency level, such as eliminating transgender exclusions in health care coverage; and to serving as board members or conducting trans-awareness trainings for agencies or groups. These kinds of activities reflected the desire to "tie our individual work to a larger political framework to create meaning and longevity" that was identified as sustaining and important for "self-care at political level."

Overall, the results of this study are both reflective of wider therapists' concerns related to disclosure described in the literature and more LGQ concerns, such as in managing projections, timing, and consideration of what will best serve the client. (Again, bisexual concerns remain generally absent from the literature.) Aspects that were unique to this sample and study were often related to the specific relationship that TGNC people have to the medical model and to transition-related services and care that are different from the more general LGQ communities, to aspects of their own transition, and to particular forms of discrimination that they face in their own lives. But, as there has long been a presence of gender non-conformity within LGQ communities, this group continues to be impacted by homophobia and heterosexism as well as by transphobia and gender-related discrimination and oppression and the intersectionality of race, sexuality, gender, and class.

Along with this intersectionality, it is important to discuss relative privilege, that among TGNC people, this sample has more privilege—having graduate degrees and professional employment experience—and this reflects race, gender and class privilege within the TGNC spectrum. One participant of color touched on the intersectionality of oppression and how it impacts his sense of self and well-being as a Black transman: “I always struggle with, am I good enough, like if I don't ever really get to the top, get the most advanced degree, then no one will think I'm credible or want to come to me...It's like a glass ceiling but also an internalized thing that is very much tied up with race and gender and class.”

Relational Cultural Theory (RCT) provides a theoretical lens with which to address this sense of self in the context of social and cultural oppression. As in any relational theory, RCT identifies the importance of connection and empathy, but with the added awareness of “the impact of forces of domination and oppression on marginalized and disempowered groups”

(Jordan, 2011, p. 358). RCT is also a systems and activist paradigm, seeking “to move beyond the individual construction of the consequences of disconnection to the societal ramifications of power imbalances and marginalization” (Jordan, 2011, p. 358), recognizing that social context shapes experience and that healing takes place by repairing individual connection and working towards social change. Pain that is experienced by an individual is validated as being a result of larger systems of oppression, not a personal weakness. The healing aspect of the work is in empathy, mirroring and “creating growth-fostering relationships” with the therapy room being only one place where this kind of relationship is practiced. Practitioners encourage the building of other relationships and interconnectedness, as a greater sense of self-worth is fostered, what Duffey and Somody call “power that empowers” (2011, p. 236). This empowerment can benefit both TGNC therapists and their clients by naming the pain that comes from being marginalized or devalued, allowing it to be heard, and reframing it with a greater sense of self-empathy and connection.

Strengths and Limitations

The choice of focus groups as the method for this study was good for collecting a large number of voices for an under-explored experience. Nineteen people participated, but many more people had expressed interest in taking part. The decision to have in-person group interviews helped to quickly create an atmosphere of trust and connection among participants. A limitation of having the focus groups was in its geographic parameters, as people from other parts of the country contacted me asking either for focus groups in their region or to participate over distance, such as with a web-cam or Skype. It is also possible that another format, such as using web technology or conference calling, could provide more privacy or even anonymity, which may help more people feel comfortable participating. The final sample of 19 was a fairly

diverse mix in terms of gender, race, and age but still had over-representation of female-to-male (or transmasculine) participants (69%) and white participants (74%). There was only one participant who identified as gender non-conforming with no desire to transition, and the study would have benefitted from more representation of this experience.

In terms of the focus group questions, which reflected the sub-questions of the main research question, participants were engaged and expressive with the material. But the interview instrument may have been too far ranging, resulting in a broader survey of questions without an opportunity to probe more deeply on any given question. Each group did get through all the questions however, and while it would be interesting to have more voices and a wider range of perspectives, saturation was reached with the four groups. The sampling strategies were purposive and non-probability, so they were not random and, as is the case for all qualitative studies, are not generalizable (Singh & Shelton, 2011; Trochim, 2006). In a qualitative study, reliability and validity can be addressed through the trustworthiness of the research (Golafshani, 2003). In this case, one aspect of strengthening the trustworthiness was through researcher reflexivity, identifying the researcher position in relationship to the research (Singh & Shelton, 2011). As noted in the methodology chapter, by identifying myself as a member of the TGNC community with the participants, I could establish credibility, but this identification could also have a limiting effect, making it less safe or appealing to participants for reasons such as knowing me from a different context, not being comfortable speaking openly with someone who might be known in the community, or believing this represented a dual role. Another limitation was having only one person, this researcher, analyze the data, as this was an individual investigative project. It is impossible to separate out my own bias, even if unconscious, that is reflected in what I chose to forefront and what I chose, however painfully, to leave out.

Implications for social work practice, policy and training

The findings from this study have numerous implications towards reducing stressors related to disclosure of gender identity for TGNC clinicians, and towards increasing positive outcomes in the therapist's clinical relationships, in supervision and the workplace, and in areas of advocacy, activism and self-care. All of these implications also address core social work values of building positive relationships, recognizing the impact of marginalization, and working towards social justice.

Therapeutic relationship and practice. Participants in this study identified issues of visibility, managing projections from clients, impact of their own experience as recipients of mental health services on provision of care, and role modeling for all clients as part of what is happening in the therapeutic space. Participants who had practiced for a longer period of time expressed an evolving sense of comfort related to disclosure, and this can be conveyed to emerging clinicians and their supervisors to help alleviate the inevitable anxiety that newer clinicians often bring to their work. Creating and sustaining networks for peer supervision appears to be a necessity, not an option, for TGNC clinicians to decrease isolation and continue to empower and strengthen their sense of their own work. Participants also expressed discomfort with the role of "gatekeeper" for TGNC clients. With changes in trans-related health care, such as greater access to services through informed consent models of care and a newer version of the WPATH Standards of Care, the letter requirement has shifted somewhat. It is still required for any surgical interventions, but not for initiating cross-gender hormone treatment (Coleman, et al. 2012). It certainly continues to be necessary for clinicians to be trained and supervised on what it means to have power in the clinical relationship and to be able to discuss ways in which their own lived experience influences their relationship to having that power. Clinical social workers

make other “gatekeeping” decisions in people’s lives all the time, where a specific diagnosis can lead (or not lead) to services or entitlements, such as disability insurance, housing options, job training programs or food stamps. Being able to identify how to manage this power ethically must be a part of training for all clinical social workers that is influenced by the findings of this study in a more narrow area.

Supervision, workplace and training. Findings from this study related to supervision and workplace stress can be helpful to create best practices through the Council on Social Work Education (Martin, Messinger, Kull & Holmes, 2009) and the American Psychological Association (American Psychological Association, Task Force on Gender Identity and Gender Variance, 2009), which have issued guidelines for supporting TGNC students in educational training programs, but still need specific information on how to help them navigate disclosure in the field or therapeutic relationship itself. Supervisors need training and guidance on being trans-affirming, not relying on their supervisees to train them on cultural understanding of gender and trans-related issues; on understanding that the lived discrimination along with experiences of being recipients of mental health services do impact TGNC therapists, creating counter-transference that is rich for supervision discussion; and to recognize that as clinical supervisors, they have transferable skills to assist TGNC supervisees as they would any other clinicians.

These findings can also be useful in strengthening workplace inclusion by identifying ways in which policies such as background checks can be destructive. Even when background checks are required, an agency can provide policy statements regarding confidentiality and privacy, helping all applicants have an understanding of who sees that kind of information, what it is used for, and providing directions for privately raising any personal concerns with human

resources administrative staff. The findings also found that affirming workplace policies such as trans-gender inclusive health care were important in attracting and retaining TGNC clinicians.

Advocacy and social work. Activism was meaningful for participants in a number of ways. It helped to create and sustain community, paved the way for other TGNC individuals by making workplaces and communities safer and more welcoming. The larger political perspective of fostering social change also speaks to core values of social work, informing support for client autonomy, recognizing discrimination and resilience in lived experience, and in commitment to advocacy with clients, agencies and policy.

Personal reflection

A major impetus for this project was related to my own experience as a transgender person with passing privilege who is becoming a mental health clinician. I have worked with clients where I would never consider disclosing my own trans identity and this study gives me guidance on ways to think about how to manage this in the future, with a range of clients, those directly dealing with gender issues and those who are not. More typically, I do disclose in training environments and, like many in this sample, a Google search would provide this personal information to anyone who looked. This project helped me see situations where disclosure could be useful; to not worry too much about what clients might find out and to see that they more likely want to have me serve different mirroring functions for them. This research also helped me recognize not only the importance, but absolute necessity, of establishing peer supervision early in my career. I take comfort in the buttressing effect of hearing these other stories, of the eagerness that colleagues have to make connection, and of knowing that I am not alone.

Future research

The purpose of this study was to add to the literature on TGNC-identified providers of services, and it would be valuable to research a wider range of TGNC-identified providers, not just therapists, but including those with advanced training, such as family practice physicians, psychiatrists, surgeons or endocrinologists; alternative practitioners; and those with less training, such as street outreach workers, support workers or case managers. Conducting further study that has a wider range of provider experience, including more people of color or TGNC people on the trans-feminine spectrum, can also help examine barriers to access to graduate level education and training experienced by those on the TGNC spectrum with less privilege.

This study began to explore ways in which people with TGNC experience have skills and strengths that can benefit them in their roles as mental health clinicians and this question should be further studied. Finally, as this study was conducted during a time of rapid cultural change—increased visibility, establishment of non-discrimination laws and policies, insurance changes, new version of the WPATH Standards of Care and the DSM-5—a longitudinal study tracking the impacts of changes on health and wellness outcomes would be valuable.

Conclusion

This study is the first time a population of TGNC-identified mental health clinicians has been studied and it was clear that participants were hungry for the opportunity to express their ideas and experiences. This study is taking place at a moment of enormous cultural, political and social change for transgender and gender non-conforming people. For decades, the most basic access to medical care has often been denied or out of reach. Now, with changes in discrimination laws affecting health care coverage, more access to health care through the Affordable Care Act, an increase in providers of care, and the new, more flexible, WPATH

standards of care, access to medical and transition-related care has radically opened up. Discrimination will still exist, and TGNC people will still have fears and concerns about seeking health care, but this shift will alter access in profound ways. This has also meant a new visibility for transgender people as providers of care. The current president of WPATH is Jamison Green, a transgender man whose activism goes back 25 years, and his being in the leadership role of an organization that supports thousands of trans-affirming providers around the world is symbolic of shifts in power and access to care. Seemingly every week there is an announcement in my email inbox about legislative change, individual and collective victories for trans inclusion, from schools, to Medicare, to federal contractors. This month—May, 2014—saw the release of the encyclopedic *Trans Bodies Trans Selves: A Resource for the Transgender Community* (Erickson-Schroth, 2014) dubbed “by and for trans people” with dozens of entries by TGNC-identified medical and mental health professionals. The very week this thesis was submitted, *Time* magazine published a cover story “The Transgender Tipping Point: America’s New Civil Rights Frontier” featuring a picture of actress and activist Laverne Cox, an African-American transwoman (Steinmetz, 2014).

Along with this moment of cultural and social change is a growing visibility of TGNC-identified clinicians, and they will be contributing to this shift by bringing an awareness to power relationships between therapist and client, based in part on their own lived experience as recipients and seekers of affirming care. The findings of this study and their implications for training and supporting TGNC clinicians can help lead to a time when disclosure is less fraught with fear and worry and held with a sense that, when used skillfully, it can help strengthen therapeutic relationships and lead to diminishing intrapsychic shame, fostering growth, and strengthening community for both TGNC therapists *and* their clients.

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Appendix A: Demographics Questionnaire

Exploring The Experience Of Transgender And Gender Non-Conforming Therapists and the Impact of Disclosure on the Therapist's Sense of Efficacy and Well-being. MSW Thesis Project of Samuel Lurie

Demographics Questionnaire:

Type of professional degree: _____ Year earned _____

Number of years practicing as a clinician _____

Theoretical approaches or interventions that inform your work:

Population(s) that your work focuses on: _____

Issues that your work focuses on: _____

Environment in which you work (*i.e. Community Mental Health; private practice, etc.*):

Rural, Suburban, Urban, Other: _____ State: _____

Age: _____

Race(s): _____

Ethnicity(ies): _____

Sexual Orientation: _____

Gender Identity: _____

Additional Words you use to describe your gender identity:

Have you transitioned? ___ yes, ___ no; ___ not yet but plan to;
___ not planning to; ___ in process

If yes, how long ago? _____

Appendix B: Human Subjects Review Approval Letter



School for Social Work
Smith College
Northampton, Massachusetts 01063
T (413) 585-7950 F (413) 585-7994

November 25, 2013

Samuel Lurie

Dear Samuel,

You did a very nice job on your revisions. Your project is now approved by the Human Subjects Review Committee.

Please note the following requirements:

Consent Forms: All subjects should be given a copy of the consent form.

Maintaining Data: You must retain all data and other documents for at least three (3) years past completion of the research activity.

In addition, these requirements may also be applicable:

Amendments: If you wish to change any aspect of the study (such as design, procedures, consent forms or subject population), please submit these changes to the Committee.

Renewal: You are required to apply for renewal of approval every year for as long as the study is active.

Completion: You are required to notify the Chair of the Human Subjects Review Committee when your study is completed (data collection finished). This requirement is met by completion of the thesis project during the Third Summer.

Congratulations and our best wishes on your interesting study.

Sincerely,

A handwritten signature in black ink, appearing to read 'Elaine Kersten'.

Elaine Kersten, Ed.D.
Co-Chair, Human Subjects Review Committee

CC: Kristin Evans, Research Advisor

Appendix C: Informed Consent



Consent to Participate in a Research Study

Smith College • Northampton, MA

Title of Study: Exploring the Experience of Transgender and Gender Non-Conforming Therapists and the Impact of Disclosure on the Therapist's Sense of Efficacy and Well-being.

Investigator: Samuel Lurie, MEd and MSW Candidate; |, slurie@smith.edu

Dear Potential Participant:

Thank you for considering participating in this project. I am a second year MSW student focusing on clinical social work and also a member of the World Professional Association on Transgender Health (WPATH). The purpose of this study is to examine the experiences of transgender and gender non-conforming (TGNC) therapists related to disclosure about their gender identity and how it impacts both the therapeutic relationship and the practitioner's own sense of efficacy, safety and well-being. The findings of this study will address a current gap in the literature and professional education on this emerging, timely topic, as more TGNC people are joining the ranks of professional mental health clinicians and have unique experiences that have not yet been explored in empirical studies. The data collected from this study will be used to complete my Master's in Social Work (MSW) Thesis and the results of the study may also be used in publications and presentations. Please read this letter and ask any questions that you may have before agreeing to be in the study.

In order to participate in this study you must: (1) be at least 18 years old and able to communicate fluently in English; (2) be a master's level or above mental health clinician; (3) currently practice, or have practiced, with clients in any mental health setting, including private practice, inpatient or outpatient programs, community mental health, home visits, community outreach, advocacy and other settings; (4) currently or previously identify as Transgender or Gender Non-conforming (TGNC) and have worked therapeutically with clients while having this identity; (5) be willing to be part of an interactive focus group with peers that is audio-recorded. A focus group is an opportunity for people who share a particular experience to interactively respond to questions related to that experience. In this case, participants will discuss their experiences as TGNC therapists and reflect on issues related to disclosure with clients or colleagues.

If you agree to participate, you will be asked to complete a preliminary demographics questionnaire that should take no longer than 5-10 minutes to complete and attend a focus group that will last 1.5-2 hours. The focus group will be audio-recorded and, as the researcher, I will be the only person who listens to the recording as I transcribe it for analysis. Another social work student may attend to assist with logistics of the focus group and take notes and that person will sign a confidentiality agreement. At the completion of the study, I will be happy to provide access to the research findings and final thesis.

There may be some risks in participating in the study. First, it is possible you may experience discomfort when reflecting on your experiences as a TGNC person, both in your personal and professional life. Second, you may have discomfort expressing your thoughts about this topic in front of others; and third, you may be concerned that others may discuss comments outside of the group. To address these concerns, participants will be reminded at the beginning of each focus group of the purpose of the study, to share only what they feel comfortable with, to

maintain confidentiality about who attends and what is shared in the group, and not to mention specific names or characteristics of clients that may be recognizable to others.

There are likely a number of benefits of participation, including contributing to the profession's knowledge of the experience of TGNC clinicians; gaining new insight into your own work and experience as TGNC-identified therapists; and increasing professional networking and a sense of community by interacting with peers addressing a complicated professional issue that participants have in common. While there is no monetary compensation available for your participation, it is hoped the above benefits will provide real satisfaction. Snacks will also be provided at the focus groups.

Your confidentiality and safety are important, but because participation involves interaction with others that is recorded, it is not completely anonymous or confidential. **By agreeing to participate in this study, and by signing this consent form, I would ask that you also consent to keeping information shared by others, and the identity of other participants, strictly confidential.** Audio-recordings will be listened to privately by me and no actual names will be written into the transcripts. All identifying information of participants such as names, email addresses and the signed informed consent forms will be stored separately from the data and all data will be on a password protected computer. Data in professional publications or presentations will be presented in the aggregate without reference to identifying information. Data, audiotapes, notes and consent forms will be kept in a secure location for three years as stipulated by federal guidelines after which time they can be destroyed unless required for further research.

Your participation is completely voluntary. You are free to refuse to answer specific questions, to decline participation, or withdraw from the study at any time without any consequences. However, if you choose to withdraw after the focus group has begun or been completed, it is not possible to fully extricate your comments from the recording. If you want to withdraw, please notify me in writing by the date of the focus group. After that date, your information will be part of the final study.

Finally, if you have any questions or concerns, please feel free to contact me or the Chair of the Smith College School for Social Work Human Subjects Committee at (413) 585-7974. I am grateful for your consideration.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE DECIDED TO VOLUNTEER AS A RESEARCH PARTICIPANT FOR THIS STUDY, THAT YOU MEET THE GUIDELINES FOR BEING INCLUDED, THAT YOU HAVE HAD THE CHANCE TO ASK ANY QUESTIONS ABOUT YOUR PARTICIPATION, AND THAT YOU HAVE READ AND UNDERSTOOD THE INFORMATION PROVIDED ABOVE.

You will be given a signed and dated copy of this form to keep for your records

Name of Participant (print): _____

Signature of Participant: _____ Date: _____

Signature of Researcher: _____ Date: _____

Appendix D: Interview Questions and Agenda

Interview Questions and Agenda for Focus Groups:

(Note: This will be a semi-structured interview, and the questions will serve as prompts and categories, not an exact script.)

The general research question for this project is: **How does disclosure of gender identity for TGNC clinicians impact the therapeutic relationship and the practitioner's own sense of efficacy, safety and well-being?**

Opening:

Climate setting: Review of study purpose, confidentiality, signed Informed Consent Forms, to share only what they feel comfortable with, to maintain confidentiality about who attends and what is shared in the group, and not to mention specific names or characteristics of clients that may be recognizable to others. Also, be mindful of letting each person time to speak, (step up step back).

Language and terminology used.

- Introductions of participants: Position and how long in it? Pronoun.
- To start with a broad question:
- In thinking about the research question, how would you say your gender identity has played a role in your clinical work?
 - In what ways has this changed over time?
 - What factors have influenced your approach to disclosure?

Disclosure:

- If you did come out, are just *are* out, what kind of impact does being out have with the clinical relationship and work? Are there ways that has changed over time? Do you think people seek you out because you are TGNC? How does that feel?
- How about situations when you are not out to clients. Do you have any clients who do not know anything about your TGNC identity? Can you share anything about that experience for you?
- Have there been situations where you chose intentionally not to disclose to clients? (That is, you thought about it and didn't disclose.) If so, what influenced that decision?
- Do you think there have been any kinds of "trans transference?" that is, have clients behaved in any ways you noticed because they knew or thought you were TGNC? In what ways did it impact anything they said or did in therapy? In what ways have clients impacted your success of comfort?
- Have there been situations where you were outed to clients? What were some of the ramifications for you?

Agency and workplace:

- In what ways has the workplace impacted your success or comfort?
- Have you made any job choice decisions based on your TGNC identity or experience? Can you discuss that?

Supervision:

- In what ways has supervision influenced your success or comfort?
- Can you identify supervision that has been helpful? Supervision that has been less helpful?
- If you have supervised others, has your TGNC experience ever played a role in these discussions or experiences? What are some resources that have helped you with supervision?

Community and sense of well being:

- Because the LGB, Trans and queer communities are small, how has being a therapist in this community impacted you in terms of community involvement? (such as going to events, being involved with groups or organizations, etc.) How have you navigated this?
- What have been sources of support for you in terms of self-care?
- What has surprised you in terms of well being or self-care?

Closing questions: (Make sure I get to this with 15-20 minutes to go!)

As we begin to wrap up, I have a few general questions:

- Is there something you wish you had known about this issue when first dealing with it? If you had advice to give to others, what might that be?
- Is there anything else you would like to add?
- And finally, what was it like to participate in this group? Did you get something out of this experience?

Thank them, and follow up!

Contact me with any thoughts.

Reminder about confidentiality how to get results of final thesis.

Bolster and appreciation!

Appendix E: Recruitment Announcement

Exploring The Experience of Transgender and Gender Non-Conforming Therapists and the Impact of Disclosure MSW Thesis Project of Samuel Lurie

CALL FOR PARTICIPANTS: Trans*-identified Mental Health Clinicians and Disclosure Research Project

PLEASE DISTRIBUTE TO YOUR NETWORKS

Dec. 30, 2013

Dear Colleagues:

Happy New Year! I'm writing to ask for your assistance in spreading the word about my research project and help identify participants.

My name is Samuel Lurie and I am currently an MSW student at the Smith College School for Social Work in Northampton, Massachusetts. I am also a member of the World Professional Association on Transgender Health (WPATH) and have worked for many years training health care providers on transgender-related issues. I'm excited about this project, which will also be my thesis, and I'm asking for you to please spread the word or consider participating.

I will be exploring issues of disclosure in the clinical environment for Transgender and Gender-nonconforming (TGNC) mental health clinicians and how this disclosure—either chosen or not—has impacted TGNC-therapists in both professional and personal ways. This is an unexplored area of research, the findings of which can benefit a whole new generation of therapists, strengthen understanding among currently practicing clinicians, and potentially impact the content of professional training programs to better serve TGNC people. It is my hope to share the findings at community/professional conferences and work to possibly publish the findings.

I would love your participation if you: 1) Identify as a Transgender or Gender Non-Conforming clinician and have worked with clients while having this identity; 2) have a counseling-related master's degree or above (MSW, MA, MS, MFT, PhD, PsyD); and 3) are willing to meet with colleagues in a focus group setting to discuss these issues. Focus Groups allow for interactive real-time engagement between people who share expertise and experience. The focus groups will be 1.5-2 hours and will be audio-recorded for me to transcribe.

The Focus Group times/locations will be:

- 1) Sat. Jan. 25, 1-2:20pm, First Event, Peabody, MA, Boston Peabody Marriott Hotel, (will be held at Conference, <http://firstevent.org>)
- 2) Sun, Jan. 26, 12-2pm, Jamaica Plain, MA, at The Meeting Point, 3464 Washington Street.
- 3) Sat. Feb. 8, 12-2pm, New York, NY, at LGBT Community Center, 208 W. 13th Street.
- 4) Sun. Feb. 9, 12-2pm, Northampton, MA at Smith College Conference Room.

If you are or know of a TGNC-identified clinician who would like to participate in this study, and would possibly be able to attend , please contact me at least a week before the focus group you would like to attend, or ASAP, so I can sign you up. Potential participants will also be asked several screening questions and provided with directions and Informed Consent materials beforehand that will also outline confidentiality concerns. There is no compensation for participation, but snacks will be provided.

If you have any questions, please feel free to write or call me directly. Thank you again and I look forward to hearing from you or colleagues who you send my way!

Best,

A handwritten signature in black ink, appearing to read 'Sam Lurie', with a stylized flourish at the end.

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