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Therapist Reactions to Transgender Identity Exploration: Effects on the Therapeutic Relationship in an Analogue Study

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Transgender individuals seek mental health counseling for a variety of reasons (Bockting, Knudson, & Goldberg, 2006); however, their experiences in therapy are not always positive, and some experiences are quite negative (Rachlin, 2002). The present study utilizes an analogue research design and video vignettes to investigate how a therapist's response to transgender identity exploration affects participants' perceptions of the therapist and the therapeutic relationship. The study utilized a series of mock therapy video vignettes that vary the way that a therapist responds to the client including transition affirming, nonbinary affirming, and nonaffirming responses. Transgender participants were asked about their plan to transition or not transition and were then randomly assigned to watch 1 of 3 mock therapy clips. Participants then completed a series of questions about their perception of the therapist's expertness, likability, trustworthiness, the session smoothness and depth, and their own feelings of positivity and arousal. Results indicate that the nonaffirming video condition had a significant negative effect on the participant's perceptions of the therapist and the quality of the therapeutic relationship. No significant differences were found between the transition affirming and nonbinary affirming conditions. This study provides a more nuanced understanding of the ways in which transgender individuals experience various affirming and nonaffirming therapeutic approaches.

Public Significance Statement
Transgender and gender nonbinary people perceive a therapist and mock therapy session more negatively when the therapist is not affirming of a client's possible transgender identity. The study provides empirical evidence for the negative effects that conversion therapy efforts (with transgender and gender nonbinary people) can have on the therapeutic relationship.

Keywords: transgender, nonbinary, affirming, therapy, counseling

Transgender[1] individuals seek mental health counseling for a variety of reasons (Bockting et al., 2006). In addition to seeking services for general mental health and wellness, transgender individuals may also seek services for concerns related to gender identity. For some, this can include talking about the possibility and the process of transitioning medically (e.g., genital surgery, hormones, etc.) and/or socially (e.g., change of name, pronouns, style of dress, etc.), from their birth-assigned gender to some other gender identity, while others choose not to take steps that would feminize or masculinize their body or appearance. For those who do want to transition medically, the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) explain that mental health professionals evaluate, prepare, and refer clients for hormone therapy, chest surgery, or genital surgery (Coleman et al., 2012). Indeed, transgender people may have specific experiences with therapists because of their[2] transgender identity, including the need for a letter of support if they seek to transition medically, exploration of gender identity, minority stress concerns, or coping with stigma related to their transgender iden-

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[1] The word transgender is used as an umbrella term throughout the study to include people across the transgender spectrum who identify as part of a binary gender category (i.e., man and woman) as well as those who do not identify with binary gender categories (i.e., nonbinary, genderqueer, agender, bigender, etc.). This includes people who are interested in transitioning socially or medically as well as those who are not interested in transitioning or interested specific parts of a transition.

[2] The singular "they" and "their" are used throughout as a gender-neutral alternative to the pronouns he or she.

tity. In other cases, their desire to seek therapy may be unrelated to their gender identity, or tangentially related. Thus, transgender individuals may access counseling services for a number reasons, including both gender-related and nongender-related concerns.

However, transgender individuals' experiences of therapy are not always positive, and some individuals have quite negative experiences (Rachlin, 2002; Shipherd, Green, & Abramovitz, 2010). Transgender clients have identified numerous factors that are unhelpful in therapy, including having to teach therapists about transgender issues and clinicians not knowing the difference between sexual orientation and gender identity (Benson, 2013). Additionally, there are concerns about being misunderstood and stereotyped because of the lack of education that therapists receive about transgender issues (Benson, 2013). Indeed, few therapists receive training regarding transgender issues and most are not well equipped to work with transgender clients (Benson, 2013). Without research, training, and guidance regarding the complexity of experiences transgender people have in therapy, therapists are left with their assumptions, biases, stereotypes, and best guesses about how to work effectively with transgender clients. Given the vulnerability of this population, it is critical that clinicians have the training and guidance needed to provide transgender-affirming services, especially with a community that is often stigmatized, marginalized, and misunderstood (Shipherd et al., 2010).

Some guidance does exist to help clinicians provide an affirming therapeutic approach that helps transgender clients in the process of transitioning from their birth-assigned gender identity toward their current gender identity (ALGBTIC, 2010; APA, 2015; Coleman et al., 2012). Indeed, various resources exist that help guide clinicians in their work with transgender clients who want to transition. The World Professional Association for Transgender Health (WPATH), American Psychological Association (APA), and the American Counseling Association (ACA) provide guidelines and standards of care for mental health professionals working with transgender individuals (ALGBTIC, 2010; APA, 2015; Coleman et al., 2012). These standards are meant to provide therapists with guidelines to help aid in the delivery of appropriate services for transgender clients, especially for those who want to medically transition. Although the empirical literature regarding transgender mental health services is still quite limited, there are some recommendations and "best practices" throughout the literature based on both clinical experiences and some research.

As useful as guidance for transition may be, transgender individuals do not always want a medical transition that includes hormonal or surgical procedures (Factor & Rothblum, 2008b). Some individuals may not identify with binary gender categories of man and woman, and instead identify somewhere in between or outside of a binary understanding of gender. Further, some transgender individuals are not interested in transitioning socially, hormonally, or surgically, while others may be interested in some combination of a social or medical transition (i.e., transitioning socially but not interested in transitioning medically, or choosing only some aspects of a social or medical transition[highlight]) ([/highlight]Factor & Rothblum, 2008b). Although guidelines and recommendations aid clinicians in supporting transgender individuals, the approach tends to focus on assisting clients through the identity development process toward an expected transition process (Riley, Wong, & Sitharthan, 2011). The movement toward transgender affirming therapy has been beneficial to client's seeking services, and yet, these models of understanding and working with transgender clients may not be well-suited for those who identify as nonbinary or do not want to transition medically. Given the heterogeneity of the transgender community and the dominant narrative toward binary identity and transitioning, the recommendations may fall short when guiding clinicians to provide overall affirming therapy to all transgender clients, especially for those who do not fit the dominant paradigm (i.e., genderqueer, gender nonbinary, genderfluid individuals). Transgender individuals are diverse in their desire for hormones and surgery and it is important that therapists understand the process of transitioning, for those who are interested, but also the various paths to relieving gender discomfort or dysphoria for those who may not be interested in transitioning socially or medically.

Searching for empirical literature about affirming therapy approaches with transgender clients often yields scant results. Given the lack of research regarding best practices for counseling transgender clients and a reliance on a transition-affirming model, it is unclear how accurate or adequate the competencies and standards of care are for working with transgender individuals who are diverse in their plan to transition or not to transition. Similar to the critique of the multicultural counseling competence (MCC) movement's lack of empirical evidence to identify, validate, and then measure multicultural competence (Atkinson & Israel, 2003), the guidelines for counseling practices with transgender clients have encountered a similar dilemma given the dearth of research guiding the development of these competencies. Additional research regarding transgender individuals and their interactions with therapists can provide a more inclusive and nuanced understanding of transgender people's experiences in therapy. Although guidelines and recommendations exist and provide clinicians with some direction in their work with transgender clients, research regarding the development of affirming therapeutic relationships with transgender clients is still lacking. Various scholars have indicated the need for additional research that focuses on mental health services with transgender individuals, specifically for those who identify as genderqueer, gender nonconforming, nonbinary, or do not want to transition (Lennon & Mistler, 2010; Riley et al., 2011). Without such research, there is no way of knowing if the recommendations that are currently available are guiding therapists toward an affirming therapeutic approach for all transgender clients, especially those who do not fit the dominant paradigm. This is particularly important throughout the process of developing, nurturing, and repairing the therapeutic relationship.

It is unclear how a therapist's response to a client's transgender identity may affect the client's perception of the therapist, comfort in therapy, willingness to engage in therapy, and the overall quality of the therapeutic relationship. Arguably, one important factor in therapy is the therapeutic relationship (Lambert & Barley, 2001). The Task Force on Evidence-Based Therapy Relationships reviewed several meta-analytic studies regarding therapeutic relationships and released several suggestions for research and practice. The task force explains that treatment guidelines should address therapist's behaviors that facilitate the therapeutic relationship explicitly (Norcross & Wampold, 2011). Further, the therapeutic relationship should be tailored to specific clients such that the client characteristics and diagnoses are taken into account to enhance the relationship and the effectiveness of therapy (Norcross & Wampold, 2011).

The proposed study seeks to address both recommendations with transgender clients by focusing on the interaction between the specific therapists' approaches and the client characteristics (plan to transition/have transitioned or no plan to transition) that may affect how the participants perceive the therapist and the session. The therapists' approaches included explaining the process of transitioning to the client with no details for other options (transition-affirming), affirming the client's exploration of their gender identity and fluidity without assuming the client is interested in transitioning (nonbinary affirming), or not affirming not affirming of the client's possible transgender identity during the session (nonaffirming).

Method

This study used a video vignette analogue research design, which was meant to mimic the conditions of a therapy session (Heppner, Wampold, & Kivlighan, 2007), and was modeled after a study that focused on therapist responses to client's disclosure of their sexual orientation (Walther, 2010). In the present study, the videos of the therapeutic encounter used for the various conditions were very similar, except for several brief portions that were edited to include one of following three response conditions: transition affirming, nonbinary affirming, or a nonaffirming therapist response. The participant's plan to transition or not transition was also measured and served as the second independent variable: plan to transition/in the process of transitioning/have already transitioned or no plan to transition. The goal of the present study was to understand how slight variations in the therapeutic encounter may affect the participant's perceptions of the therapist and how their own desire to transition or not to transition may affect this perception across the following dependent measures: therapist attractiveness, therapist trustworthiness, therapist expertise, session depth, session smoothness, participant's positivity, and participant's arousal.

Participants

Participants included 409 individuals who self-identified as being on the transgender-spectrum (i.e., transgender, transsexual, genderqueer, nonbinary, androgynous, etc.), were over the age of 18, and lived in the United States at the time of the study. Participants ranged in age from 18 to 74 ($M = 29.5$, $SD = 10.3$). Participants reported their current gender identity as genderqueer (39%; $n = 158$), transgender man (20%, $n = 80$), transgender woman (17%; $n = 71$), woman (6%; $n = 26$), man (4%; $n = 18$), "something else" (13%, $n = 52$), or intersex (1%; $n = 4$). Participants reported their sex assigned at birth as female (63%; $n = 260$), male (36%; $n = 146$), or intersex (1%; $n = 3$).

When asked about sexual orientation, participants identified as pansexual (24%; $n = 97$), bisexual (23%; $n = 95$), lesbian (13%; $n = 52$), heterosexual (12%; $n = 49$), gay (10%; $n = 39$), and/or "other" (24%; $n = 98$). In terms of race and ethnicity, participants identified as European American/White (78%; $n = 319$), African American/Black (8%; $n = 32$), Latino(a)/Hispanic (7%; $n = 27$), Asian American (5%; $n = 19$), American Indian/Alaska Native (5%; $n = 19$), Middle Eastern (2%; $n = 6$), Native Hawaiian or Pacific Islander (1%; $n = 3$), or "other" (5%; $n = 21$). Self-reported socioeconomic status was poor (19%; $n = 78$), working class (26%, $n = 106$), lower-middle class (19%; $n = 79$), and middle class (23%, $n = 92$), while fewer identified as upper-middle class (7%; $n = 30$), and upper class (1%; $n = 3$). In terms of education level, most reported some college, but no degree (37%, $n = 147$) or a bachelor's degree (24%, $n = 96$), while fewer reported they had some graduate school experience or completed a graduate or professional degree (16% $n = 64$). In terms of geographic location, there were similar numbers of urban (38%; $n = 156$) and suburban (41%; $n = 166$) participants, and fewer rural participants (15%; $n = 60$). When asked about the political climate where they live, nearly half reported that it was somewhat or mostly liberal (43%; $n = 177$), one third reported somewhat or mostly conservative (32%; $n = 131$), and 19% reported a moderate political climate ($n = 78$).

Participants were also asked about their interest in transitioning medically (i.e., hormones, top surgery, bottom surgery, etc.). Over one third of participants indicated that they were not interested in transitioning medically (38%; $n = 155$), while approximately one third were interested in transitioning medically (34%; $n = 138$). Fewer were already in the process (19%; $n = 76$), or had already transitioned (10%; $n = 40$).

Participants were asked about their past experiences in therapy, if applicable. Most participants (80%) indicated that they had been to see a counselor or a therapist at some point in their lives ($n = 325$), and 19% reported no current or previous therapy experience ($n = 76$). Of those who had received therapy, one third reported that they had a mostly positive experience in therapy (33%; $n = 136$), another third reported mixed positive and negative experiences (29%, $n = 118$), and fewer reported neutral experiences (9%; $n = 37$) or mostly negative experiences (7%; $n = 30$). Participants were also asked about their reasons for seeking therapy, including topics unrelated to gender identity (39%; $n = 158$), both gender-related and unrelated topics (38%, $n = 155$), gender-specific concerns (23%; $n = 92$), or wanting a letter for hormones or surgery (17%; $n = 71$). Most reported that they received individual therapy (76%; $n = 309$), approximately a quarter reported experiences in group therapy (24%; $n = 99$), and few reported having experiences with couple's therapy (8%; $n = 34$). Participants were also asked how many different therapists they had seen, and approximately half reported having one to three different therapists (48%; $n = 198$), 17% reported seeing four to six different therapists ($n = 70$), and others reported seeing seven or more (9%, $n = 37$).

Measures

Counselor Rating Form-Short (CRF-S; Corrigan & Schmidt, 1983). The CRF-S is a 12-item measure that was included to assess participant's perceptions of the therapist on a 7-point Likert scale. The three dimensions and corresponding items include: attractiveness (friendly, likable, sociable, warm), expertness (experienced, expert, prepared, skillful), and trustworthiness (honest, reliable, sincere, trustworthy). In a validity study of the CRF-S, the reliability for the attractiveness subscale ranged from $\propto = .89$ to $\propto = .93$, the expertness subscale ranged from $\propto = .85$ to $\propto = .94$, and the trustworthiness subscale ranged from $\propto = .82$ to $\propto = .91$ (Corrigan & Schmidt, 1983). Cronbach's alpha for the CRF-S composite score and subscales with the current sample were high (composite CRF-S $\propto = .98$. CRF-S attractiveness

subscale ∝ = .96, CRF-S expertness subscale ∝ = .97, and trustworthiness subscale ∝ = .96).

Session Evaluation Questionnaire (SEQ; Stiles, 1980). The SEQ was included to assess participant's perceptions of the session across the video conditions. The SEQ measures depth, smoothness, positivity, and arousal of a therapeutic encounter using a 7-point semantic differential scale. Stiles (1980) explains that the SEQ is meant to measure the impact of the session rather than the long-term outcome of therapy or the benefit to the client by gathering (a) ratings of the actual session itself and (b) the participant's feelings after the session. In the original study, reliabilities were reported for the client's rating of session depth (∝ = .87), session smoothness (∝ = .93), positivity (∝ = .89), and arousal (∝ = .78; Stiles, 1980). With the current sample, the reliabilities were high for most subscales, session depth (∝ = .90), SEQ smoothness (∝ = .88), SEQ positivity (∝ = .82), though SEQ arousal was lower (∝ = .66).

Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970). The ATSPPH is a 29-item scale that assesses a participant's willingness to seeking psychologist support across four dimensions: recognition of the need for help, ability to tolerate stigma, interpersonal openness, and confidence in therapists on a 4-point Likert scale (0–3). In the original study, the internal reliability of the ATSPPHS ranged from ∝ = .83 to ∝ = .86. Test–retest reliability over days, weeks, and 2 months all indicated high reliability ratings, with all ∝ > .7, and most ∝ > .8 (Fisher & Turner, 1970). The reliability of this scale in the current sample was high (∝ = .85).

Procedure

Participants were recruited via Amazon Mechanical Turk (MTurk), listservs, e-mail lists, social media, and community centers that support transgender individuals. Participants were directed to an online survey where they were shown the informed consent and were asked to participate. Participants then answered a series of prevideo questions. For example, participants were asked if they live in the United States and if they were at least 18 years of age. Participants who reported that they did not live in the United States or were younger than 18 years old were thanked for their time and removed from the study.

In order to ensure relatively equal distribution of participants who want to transition and do not want to transition across the three video conditions, participants were asked about their interest in transitionally medically (i.e., hormones, top surgery, genital surgery) and were divided into two categories. Those who indicated that they were interested in transitioning, were in the process of transitioning, or had already transitioned were grouped into one category and those who indicated no interest in transitioning medically were placed into a separate category. These two groups of participants were then each randomly assigned to view one of three video conditions. After viewing the video, the participants were asked to complete a series of questionnaires including the Counselor Rating Form-Short (CRF-S; Corrigan & Schmidt, 1983), Session Evaluation Questionnaire (SEQ; Stiles, 1980), and the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970). At the end of the study, all participants were thanked for their time and given resources for mental health counseling services. All participants were offered an opportunity win a $50 gift card incentive. MTurk participants additionally earned $0.50 for completing the study.

Video Condition

Three mock therapy videos were created with actors playing the role of therapist and client. For each condition, the same mock therapy session video was used with only slight variations in the delivery of the manipulation. In the first condition (transition affirming), the therapist explained the process of transitioning to the client with no details for other options. This condition represents an affirming therapeutic practice that assumes that most or all transgender clients want to transition and supports the client this process. This is a common expectation and practice, though there is increased awareness that not all transgender people want to transition (see Coleman et al., 2012). In the second condition (nonbinary affirming), the therapist affirms the client's exploration of their gender identity and gender fluidity without assuming the client is interested in transitioning. This condition represents an affirming therapeutic practice that does not assume that most or all transgender clients want to transition, while supporting clients who may identify as nonbinary. In the third condition (nonaffirming), the therapist is not affirming of the client's transgender identity during the session. In this condition, the therapist tries to help the client identify with their sex assigned at birth. For example, in the nonaffirming video condition the therapist states ". . . it sounds like you're really pretty confused about your manhood . . . Just so you know, I have worked with people who don't feel normal and helped them get in touch with their masculinity again." The therapist discusses the client's gender exploration as a "*phase"* and reports that she could help the client be *"normal"* and less confused by changing the client's behaviors to match more masculine men and to be the person they were "*born"* to be. This condition represents therapists who are not attempting to be affirming of a person's possible transgender identity, but may try to be generally warm, supportive, or "helpful" by suggesting the person identify more with their birth assigned gender. The final videos were approximately six to seven minutes in length.

Results

A two-factor, between-subjects multivariate analysis of variance (MANOVA) was conducted, in which the therapy video condition (transition-affirming, nonbinary affirming, and nonaffirming) and plan to transition (plan to transition or no plan to transition) served as the two independent variables. The Counselor Rating Form (Corrigan & Schmidt, 1983) and the Session Evaluation Questionnaire subscales of session depth, session smoothness, and participant's positivity (Stiles, 1980) served as the dependent variables. The SEQ arousal was not included in this MANOVA analysis because of the lack of a moderate correlation with other dependent measures (see Table 1). It was hypothesized that participants would rate the transition affirming and the nonbinary affirming videos more favorably than the nonaffirming video across all dependent variables.

Results for this MANOVA indicate that the there was a statistically significant difference in the perception of the therapist and session based on the video condition viewed with a medium to large effect size, $F(8, 404) = 9.55$, $p < .0001$; Wilk's $\Lambda = 0.71$,

Table 1
Correlations Between Counselor Rating Form and Session Evaluation Questionnaire

Variables	1	2	3	4	5	6	7	8
1. CRF Attractiveness	—							
2. CRF Expertness	.79**	—						
3. CRF Trustworthiness	.82**	.89**	—					
4. CRF Composite	.92**	.95**	.96**	—				
5. SEQ Depth	.67**	.76**	.73**	.76**	—			
6. SEQ Smoothness	.62**	.64**	.62**	.66**	.57**	—		
7. SEQ Positivity	.63**	.67**	.68**	.70**	.64**	.66**	—	
8. SEQ Arousal	−.08	−.11	−.15**	−.13	−.80	−.14**	−.09	—

** $p < .01$.

partial $\eta^2 = .159$. The test of between subject effects indicated that the therapy video watched had statistically significant effects on CRF composite, $F(2, 205) = 34.28$; $p < .0005$; partial $\eta^2 = .25$; SEQ session depth $F(2, 205) = 21.73$; $p < .0005$; partial $\eta^2 = .18$; SEQ session smoothness ($F(2, 205) = 26.56$; $p < .0005$; partial $\eta^2 = .21$; and SEQ participant's positivity $F(2, 205) = 28.06$; $p < .0005$; partial $\eta^2 = .22$, all with large effect sizes.

Tukey's HSD post hoc tests indicate that there was a significant difference between the transition affirming video condition and the nonaffirming video condition across all dependent variables (CRF composite, $p < .0005$; SEQ session depth, $p < .0005$; SEQ session smoothness, $p < .0005$; and SEQ participant's positivity, $p < .0005$). There was also a significant difference between the nonbinary affirming video condition and the nonaffirming videos (CRF composite, $p = .0005$; SEQ session depth, $p = .0005$; SEQ session smoothness, $p = .0005$; and SEQ participant's positivity, $p = .0005$). Tukey's post hoc test indicated that there were no significant differences between the two affirming conditions (transition affirming and nonbinary affirming) and all the dependent variables (CRF composite, $p = .661$; SEQ session depth, $p = .921$; SEQ session smoothness, $p = .937$; and SEQ participant's positivity, $p = .915$). These findings support the hypothesis that there is a main effect of therapeutic focus on the dependent variables.

Additional analyses were conducted to understand the role of the video condition and plan to transition on participant's willingness to seek professional psychological help and the SEQ arousal subscale. A two-way analyses of variance (ANOVA) was conducted to test these two dependent measures that were not used in the main analysis, including the SEQ arousal subscale and the Attitudes Toward Seeking Professional Psychological Help (ATSPPH). Results indicate that there was a significant effect of video condition on SEQ arousal ($p = .023$), but no significant effect of plan to transition on SEQ arousal ($p = .479$). The ATSPPH was not statistically significant for video condition ($p = .33$) or plan to transition ($p = .58$). These finding suggest that the video condition does influence the participant's arousal, but their plan to transition or not to transition does not affect this reaction. It also shows that neither the video condition nor one's plan about transitioning effect their overall attitudes toward seeking professional psychological support.

A second hypothesis was tested to examine the possibility of an interaction effect between the video condition and the participants transition plan. It was hypothesized that participants who had transitioned, were in the process of transitioning, or wanted to transition would rate the transition affirming videos more favorably than the nonbinary affirming video and that those who had no plan to transition would rate the nonbinary affirming video more favorably than the transition affirming video.

This analysis utilized the interaction results from the previous MANOVA with the same therapeutic relationship variables: counselor ratings, session depth, session smoothness, and positivity. Results indicated that the there was no significant difference in the perception of the therapist and session based on the interaction between the video condition and the participants transition plan, $F(8, 404) = 1.097$, $p = .364$; Wilk's $\Lambda = 0.958$, partial $\eta^2 = .021$, with a small effect size.

Discussion

Main Findings

The findings from this study provide clear empirical evidence for the negative effects that a nonaffirming intervention had on transgender participants' perceptions of the session and therapist. Across all measures, the nonaffirming video condition was rated more negatively when compared with the transition affirming and nonbinary affirming conditions. These findings empirically support the various books, articles, recommendations, guidelines, and transgender advocates who voice the importance and need for affirming therapeutic approaches for transgender and gender questioning individuals. These results are important because they show how the therapeutic relationship might be strengthened or harmed when therapists use an affirming versus nonaffirming approach with clients who are questioning their gender identity. When the therapist is *not* affirming of the client's gender identity, the therapist is viewed as less trustworthy, less of an expert, and less likable. The perception of the session changes as well, with participants rating a nonaffirming session clip as less smooth, less deep, and less positive.

The therapeutic relationship is at the center of the therapeutic process (Lambert & Barley, 2001) and a strong working alliance and therapeutic relationship has been shown to be one of the strongest predictors for general positive adjustment, including positive affect, self-esteem, connectedness, and optimism (Nuetzel, Larsen, & Prizmic, 2007). Both therapists and clients perceive the therapeutic relationship to be one of the centrally important factors in the therapy outcomes (Thomas, 2006). Trust between the therapist and the client has been linked to the therapist having more unconditional positive regard toward the client (Peschken & Johnson, 1997). Similarly, clients who perceive that their therapist

shows empathy and unconditional positive regard tend to have more trust in their therapist (Peschken & Johnson, 1997). Thus, given that these therapeutic relationship factors are such a major component of therapy outcomes and the present study shows that a nonaffirming approach can be detrimental to participants' perceptions of the therapist and session, even in an analogue situation, it is imperative that therapists understand the factors that are affirming and not affirming in therapy with transgender clients. These results are especially important given research that finds that for those with less social support the therapeutic relationship is more important and helps clients improve faster (Leibert, Smith, & Agaskar, 2011). Transgender and gender nonbinary individuals often experience less social support (Budge, Adelson, & Howard, 2013; Factor & Rothblum, 2008a) and more stigma (Bockting, Miner, Romine, Hamilton, & Coleman, 2013), which may make the therapeutic relationship an even more important factor for this population. Further, this research may also be relevant to understanding some of the affirming and nonaffirming experiences that lesbian, gay, and bisexual clients may encounter in therapy. Though the content of the messages may differ, there may be similarities in the impact of affirming and nonaffirming experiences on the therapeutic relationship.

The results also displayed a small, but nonsignificant, trend in the data with respect to a possible interaction between the video condition and the participants plan to transition. The effect might be detected with a different manipulation, more participants, or a different method. Indeed, a more potent manipulation might be one that helps the participant feel as if they are in the position of being the client and are experiencing the session themselves. Further exploration may be especially important because the measures used in this study are most often used to measure parts of the actual therapeutic relationship between a therapist and client.

Interestingly, exploratory analyses show that participants indicated that they had mostly positive or mixed experiences with therapy, and very few (7%) reported having mostly negative experiences. These positive experiences are important given the various negative narratives and mistrust within transgender communities about mental health care providers. The negative experiences transgender individuals have with therapists should not be taken lightly, however, it is also important to note that some transgender people are also having positive experiences with therapists who are knowledgeable and affirming. In fact, in a study on transgender patient satisfaction with psychotherapy, psychiatry, and sexual medicine provided through one sexual health clinic, transgender individuals were just as satisfied with the services provided as cisgender sexual health patients across nine years of survey data (Bockting, Robinson, Benner, & Scheltema, 2004). However, it is also important to note that these data come from one sexual health clinic. It may be that not enough research has focused on the positive experiences of transgender clients, thus, some transgender clients might be having mostly positive experiences, some may be having very negative experiences, and some may be mixed, neutral, or otherwise informed by factors unrelated to the person's gender identity.

Overall, this study provides an empirical exploration that is key to understanding the nuanced factors that may contribute to a positive or negative experience for transgender and gender nonbinary individuals in therapy. The Task Force on Evidence-Based Therapy Relationships concluded that treatment guidelines should address the specific factors that facilitate the therapeutic relationship and how these can be tailored to specific clients to enhance the relationship and the effectiveness of therapy (Norcross & Wampold, 2011). This study answers that call for conducting therapy with transgender and gender nonbinary individuals by providing empirical evidence and insights about affirming and nonaffirming therapy approaches that may affect the therapeutic relationship. The study provides evidence for the potential negative effects that nonaffirming approaches can have on the therapeutic relationship. Further, it provides evidence for the importance and relevance of some of the current professional recommendations and guidelines that exist for conducting therapy with transgender individuals (i.e., ALGBTIC, 2010; APA, 2015; Coleman et al., 2012). The following provides implications for practice, limitations, future directions, and the significance of the present study.

Implications for Practice

The results offer some important implications for the work that therapists do with transgender clients. First, viewing a nonaffirming approach was shown to have significant detrimental effects on a transgender person's perception of the therapist and the session. Individuals rated the nonaffirming video condition as significantly less smooth, deep, and positive and the therapist as less trustworthy, likable, and less of an expert. In addition to an awareness of what might be affirming for transgender clients, it is also important for therapists to know what is not affirming in therapy with transgender clients. If therapists are unaware of what is not affirming for transgender clients, then they may be likely to enact these nonaffirming behaviors with a client, thus rupturing the therapeutic relationship and potentially causing harm (Mikalson, Pardo, & Green, 2012). Though the nonaffirming video depicted a therapist who was trying to be generally warm, supportive, and helpful, the therapist uses various invalidating statements throughout the video. Nonaffirming approaches may include statements about helping a person to reidentify with their birth assigned gender, strengthening the characteristics associate with the birth assigned gender (i.e., become more stereotypically masculine or feminine), a lack of awareness around using correct names and pronouns, and stopping any "cross-gender" mannerisms, play, or self-expression that is "not traditionally aligned" with the gender they were assigned at birth (i.e., make-up, clothing style, body hair, etc.). A well-meaning therapist might fall into the trap of thinking that being nice, warm, friendly, and kind is all that is needed to be affirming to transgender clients without realizing the potential nonaffirming messages and microaggressions that may be quite hurtful and potentially harmful for transgender clients. Thus, nonaffirming therapeutic approaches should *not* be used with transgender or gender nonconforming clients, which means that clinicians need to be aware of the overt and covert biases, stereotypes, and microaggressions that can be damaging and can influence the trust, safety, and strength of the therapeutic relationship.

Additionally, it is important that therapists make space for clients to explore a range of options regarding their gender. There should be space to explore the ambiguity, uncertainty, or fluidity that some clients experience as they process their gender identity, gender presentation, and potential gender dysphoria. Participants rated both affirming conditions positively when exposed to either

a nonbinary or transition affirming message. Throughout this process therapists may meet the needs of a full range of clients by not assuming that a person questioning their gender identity wants to transition, wants to "pass," or is experiencing gender dysphoria because transgender clients are not homogeneous. It may be important that those who are not certain about transitioning, do not identify with binary gender categories, want some part of a medical transition, or are "on the fence" not be discouraged from transitioning for not being "transgender enough." This means that therapists may need to focus on really listening to clients' experiences of their gender identity, gender dysphoria, and their hopes, goals, and potential fears about how they choose to transition or not transition.

All the implications for practice mentioned above require therapists to continue to increase their knowledge, awareness, and skills around working with transgender clients. As additional research, recommendations, and standards of care become available, it is crucial that therapists continue learning, consulting, and attending trainings to keep up with best practices and changes in the field of transgender mental health care. Gender identity labels, and the way in which people explore, experience, and make sense of their gender, shifts over time. Additionally, laws and policies are in constant flux and they impact how transgender individuals access surgery, hormones, legal name changes, and the role of the therapists in providing assessment, therapy, or letters for hormones or surgery. Teaching and training therapists to be knowledgeable and provide supportive and affirming therapy is key to increasing positive experiences, decreasing negative experiences, and building trust with transgender communities. Though a general roadmap of affirming and nonaffirming experiences can be invaluable to understanding therapy with transgender individuals, the heterogeneity of the community requires that therapists approach everyone as they would any other therapy client—a unique person with their own stories, hopes, dreams, and lived experiences.

Future Research

Given the paucity of empirical research exploring transgender clients' experiences in therapy and the findings of this study, additional research is needed. For example, there are interesting trends in the demographic data for this sample that may warrant further investigation. First, participants tended to report having high levels of education, however, most reported being poor, working class, or lower-middle class. One possible explanation for the high number of participants rating of low socioeconomic status (SES) is that many of the participants might currently be students, which seems to fit with the statistics gathered about education. However, it is also possible that participants are facing more unemployment, underemployment, and thus, lower SES despite having postsecondary education. Research shows that transgender individuals face higher unemployment and under employment (Grant et al., 2010) and may also face additional financial burdens related to gender confirmation surgeries if they choose to undergo a medical transition. Second, some participants indicated seeing a large number of therapists, which may be due to a number of factors including nonaffirming experiences with therapists or interpersonal difficulties related to personality and diagnosis, among other reasons. It may be useful to study characteristics of therapists and clients for transgender clients who have had a number of dissatisfying therapy experiences. Finally, it might be beneficial to explore how demographic data, such as age, might affect experiences of therapy, especially considering the age at which people sought therapy and how long ago the therapy occurred, as these might change how the results are interpreted for both older and younger adults.

Additional research is also needed to further explore both the positive and negative experiences that transgender individuals have when accessing therapy. There is still so much that is not known about the positive experiences transgender people have in therapy and what makes them positive, though there are some indications of what may contribute to helpful and unhelpful therapy experiences (Israel, Gorcheva, Burnes, & Walther, 2008). It may also be helpful for transgender people to know that some transgender people do have positive experiences in therapy rather than fearing or avoiding therapy because of the preponderance of negative experiences and stories. Interestingly, the positive and negative impact of affirming and nonaffirming approaches with gender diverse clients might be quite similar to the impact that these approaches have on sexual minority clients' experiences of the therapeutic relationship, though additional research would be needed to explore the similarities and differences.

It is also important that therapists see beyond a transgender person's gender identity and focus on the whole person, as would be done with any other client. For some clients seeking therapy, the main focus may be gender identity exploration; however, transgender people may also struggle with depression, anxiety, relationship concerns, and other stressors that may or may not be related to their gender identity concerns. Additional research is needed to further explore the affirming ways in which therapists work with transgender individuals whose presenting concern is about their gender identity specifically or not related to gender identity concerns. As with any social identity, one's experience of their world may be influenced by their identities to a greater or lesser extent, yet the potential for hyperfocus on gender identity or a lack of attention to gender identity factors may impact the extent to which a transgender person feels supported and affirmed. Similarly, it might also be interesting to explore client's reactions to the therapist who is affirming through an exploration of affect, rather than providing options in a solution-focused fashion, as was done in this study. This study focused on providing different options for the client to help relieve discomfort and dysphoria, but a therapist might also provide support without suggesting any solutions. Research is needed to understand the various factors that might influence how a client feels affirmed and supported in various contexts and with different therapeutic styles and approaches.

Limitations

As with every study, there are some limitations worth noting. First, the analogue research design used in the study allowed for careful manipulation of the conditions, though it is possible that using a video might not have been a strong enough manipulation. Video was favored over a written vignette or audio-recorded mock therapy vignette given that the video would likely produce a strong manipulation. However, participants might have had a stronger or different reaction if faced with an in vivo therapy session that utilized some version of one of the three conditions. The conditions and experience would likely feel more real to the participants,

thus affecting their ratings of the therapist and the session in potentially stronger ways, though there would likely be ethical considerations in the design of an in vivo session that would need to be considered.

Although the video conditions were identical other than differences in the therapist verbal response to the client's gender exploration, the affirming and nonaffirming video conditions reflected different tasks and goals that participants might have been responding to as well. The therapeutic relationship measures used in this study focus primarily on the bond within the therapeutic alliance, that is, the connection, attachment, trust, and interpersonal factors that help therapy outcomes (Lambert & Barley, 2001). However, the tasks and goals of therapy also differed between affirming and nonaffirming conditions. For example, the tasks, or the agreement about the actual work of therapy, and the goals for therapy differed between the conditions. The affirming conditions utilized different ways of supporting the client's process of exploring gender identity, though they provided different means by which this might occur (i.e., transitioning or using a flexible gender identity). However, in the nonaffirming condition the therapist attempted to support the client by offering ways of being more similar to the client's birth assigned sex, something that is often felt as nonaffirming by those who identify as transgender. Thus, the tasks of therapy and the goals of therapy differed between the affirming and nonaffirming conditions in ways that might also affect the rating of the therapeutic relationship for these participants, though it is unclear given the design of the present study.

Conclusion

The proliferation of research about transgender individuals and their experiences of therapy has been notable over the past few years. Similarly, there has been an increased awareness and focus on transgender issues, experiences, and policy on a global scale. The APA guidelines for working with transgender people notes that the last two decades have seen a substantial increase in the research being done about transgender people which has led to a positive shift toward more transgender affirming practices (APA, 2015). However, the guidelines also noted that although the number of peer-reviewed publications is increasing, it is still an emerging field of study and the evidence for the guidelines also comes from books and chapters because there are simply not enough empirical, peer-reviewed studies (APA, 2015). There are several professional guidelines that support affirming care with transgender individuals, yet we do not have the science to support therapy and theory. This study contributes to the literature by helping to fill the gap between science and practice by providing empirical evidence for the detrimental effects that a nonaffirming therapy approach can have on transgender people's perceptions of the therapist and the session. As the landscape changes for transgender individuals, it is crucial that this underserved community receives supportive and affirming care from trans-knowledgeable and trans-affirming therapists who they are being asked to trust. Additional research, training, and education is needed to ensure that transgender individuals are receiving the best quality mental health care that affirms their identities, experiences, and resilience.

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