COMPETENCE AND BIAS IN THE PROVISION OF TRANSGENDER MENTAL HEALTHCARE

by

TAYLOR DAHLIA BOLINGER

THESIS

Submitted in Partial Fulfillment of the requirements

for the degree of Masters of Social Work at

University of Texas at Arlington,

December 2022

Supervising Committee:

Dr. Micki Washburn, Advisor

Dr. Amanda Aykanian

Dr. Genevieve Grof

Dr. De'An Roper

Abstract

Historically, clinicians have functioned as gatekeepers to access gender-affirming care for individuals identifying as transgender. However, current best practice standards by reputable professional associations have encouraged clinicians to minimize potential barriers for clients seeking gender-affirming care. This care includes hormone replacement therapy (HRT) and gender confirmation surgeries, and other gender-affirming interventions such as name and gender marker change. This study seeks to describe Texas clinicians' attitudes toward transgender clients and their self-perceived competency to perform gender affirming care. Licensed mental health care clinicians were recruited from various professional associations to complete an anonymous internet-based survey on providing gender-affirming mental health care. Seventy-five clinicians completed all survey measures. Approximately 86.7 % of respondents scored below the clinical cutoff score for effective counseling for transgender clients. Results further indicated that a range of demographic variables of respondents was associated with self-reported levels of competence and bias. Implications for social work education, practice, policy, and research are offered to help support increased competence of social workers in this area.

Table of Contents

Chapter 1: Introduction and Background

In the last decade, there have been considerable positive developments in psychological theory and practice regarding transgender individuals and the process of gender transition. Following the introduction of gender dysphoria as a diagnosis in the DSM-5 in 2013, replacing the prior diagnosis of gender identity disorder, gender-affirming care has become the primary modality through which clinicians interact with transgender clients (American Psychiatric Association, 2013). As such, there has been an increase in the number of clients seeking these treatments, especially at younger ages, with one and a half percent of people eighteen and under in the United States identifying as transgender compared to about half that number for older individuals (Herman et al., 2022). The World Professional Association for Transgender Health (WPATH, 2022) recently updated its standards of care for the health of transgender individuals. This edition is the first to be developed using evidence-based practices and recommends decreasing barriers to gender-affirming care and a move toward informed consent in gender-affirming care. However, the ability of clinicians to provide truly gender-affirming care based on best practice recommendations and updated standards of care remains unclear. Thus, this study investigates clinician attitudes and their self-reported competency toward transgender clients to determine the fit between professional guidance and individual practice in this arena.

Key Definitions

The terms transgender and gender diverse refer to people whose gender expression does not align with the male-female binary. A transgender person's gender identity does not correspond to their sex assigned at birth. This definition is drawn from the WPATH's recently published eighth edition of their standards of care (WPATH, 2022).

In previous editions, transgender, nonbinary, genderqueer, and other similar identities were described with the umbrella term transgender and gender nonconforming (TGNC). The term was recently expanded to be as comprehensive as possible in describing members of the wide range of people and groups around the world with gender identities or expressions different from the sex assigned to them at birth (WPATH, 2022), as well as to help to destigmatize transgender identities through the removal of the term "nonconforming." The newly updated definition is designed to include people who have cultural and linguistic practices of gender that do not align with Western theories of gender (WPATH, 2022). The acronym TGD is commonly used for convenience as a shorthand for transgender and gender diverse people(WPATH, 2022).

Gender dysphoria is a term used to describe the distress caused by a mismatch between a person's internal gender identity and sex assigned at birth (APA, 2013, 2022; HRC, 2022). The DSM-5 defines gender dysphoria in adolescents and adults as a marked mismatch between a client's experience of gender identity and their assigned gender presentation, which lasts at least six months (APA, 2013, 2022). This incongruence in adults must be manifested by at least two of the following six criteria: 1.) Noticeable incongruence between the gender that the patient sees themselves are and their classified gender assignment; 2.) An intense need to do away with his or her primary or secondary sex features (or, in the case of young teenagers, to avert the maturity of the likely secondary features); 3.) An intense desire to have the primary or secondary sex features of the other gender; 4.) A deep desire to live as another gender; 5.) A profound need for society to treat them as another gender; and 6.) A powerful assurance of having the characteristic feelings and responses of the other gender. The second criterion is that the condition should be connected with clinically significant distress or affects the individual significantly socially, at work, and in other important areas of life (APA, 2013; 2022).

Gender Transition and Gender Affirming Care

Gender transition and gender-affirming care is a group of diverse social, medical, and psychological processes that assist a transgender person to live in the gender consistent with their own internal gender identity (TransFamilies, 2022; WPATH, 2022). Gender transition may contain three distinct but interrelated components, including social, medical, and legal transition. Social transition is when transgender people adopt names, pronouns, and gender expressions, such as clothing and haircuts, which match their gender identity (TransFamilies, 2022). Medical transition is the part of the transition process in which some transgender people undergo medical interventions, such as taking masculinizing or femininizing hormones or engaging in surgical procedures to align their physical appearance more closely with their gender identity (TransFamilies, 2022).

Legal transition is the part of transition when a transgender person seeks to change their legal name and gender marker so that their legal documents are consistent with their gender identity and expression. This process may include updating legal documents such as their driver's license, Social Security card, passport, birth certificate, and bank account (TransFamilies, 2022). Engagement in medical transition requires approval from multiple medical and mental health professionals (TransFamilies, 2022).

History of Gender Affirming Care

Historically, doctors who have overseen the medical transition process have collaborated closely with psychologists and social workers to determine their clients' suitability for medical procedures (Gill-Peterson, 2018). The lived experience of transgender people has been intertwined with psychotherapy since gender transition was medicalized in the nineteen twenties

(Mancini, 2010). Over multiple years, extensive assessments were often required to determine clients' readiness for transition, historically putting clinicians in a gatekeeping role. Magnus Hirschfield, the first doctor to authorize these procedures at the Institute for Sexual Study in Weimar Berlin, sent his patients to consult with psychoanalysts before engaging in gender transition (Mancini, 2010). In America in the nineteen fifties, John Money at the Johns Hopkins Gender Clinic enlisted psychoanalysts to encourage transgender children to remain their assigned sex (Gill-Peterson, 2018). So did his colleague in San Francisco, Robert Stoller, the physician who advanced the concept of gender as a distinct construct from sex assigned at birth (Gill-Peterson, 2018). In nineteen seventy-nine, the Harry Benjamin International Gender Dysphoria Association (which would later be renamed the World Professional Association for Transgender Health or WPATH). That same year, it published the first Standards of Care for the discipline, which required two years of psychiatric supervision before and during gender transition (Cavanaugh et al., 2016).

At first, the Standards of Care instructed clinicians to determine the persistence of the patient's dysphoria regardless of the patient's self-reports and referred to a patient's verbal reports as unreliable or invalid as diagnostic information (Cavanaugh et al., 2016). Many early developmental psychologists like Freud and Erikson conceived both same-gender attraction and transvestitism -as it was known at the time- as a passing stage resulting from delayed development (Bennett & Douglass, 2013), which could be modified through engagement in extensive psychotherapy. Thus the role of the therapist as gatekeeper and expert has been well established.

There has been pushback at every stage of the transition process from medical professionals and the larger society. The Hitler Youth destroyed Hirschfield's Institute for Sexual

Study in Germany, and its archive was burned (Mancini, 2010). Whether these procedures were legitimate was controversial at the beginning of gender-affirming care in America in the mid-20th century. Sometimes even surgeries that had already been approved would be disallowed due to a disagreement between practitioners and hospital boards over whether gender-affirming surgeries were licit medical procedures, often centered around the reproductive potential of young bodies (Gill-Peterson, 2018). Strict diagnostic criteria kept many trans people from accessing care and forced others to lie to receive it (Weingand, 2021). As the era of the gender clinic came to an end with the closure of the Hopkins clinic in nineteen seventy-nine, the diagnosis of transsexualism was soon replicated with the (still) pathologizing diagnosis of gender identity disorder in the DSM 3 the following year (American Psychiatric Association, 1980; Markman, 2011), which was retained until the 5th version of the DSM was released in 2013 (APA, 2013).

Transgender people have been taking their transition into their own hands for much longer than gender-affirming care has existed within the clinic, potentially for thousands of years (Steinkeller, 1992). Nevertheless, as Jules Gill-Peterson instructs us in *Histories of the Transgender Child*, telling the story of gender transition from the clinic's perspective elides the fact that gender-affirming care came into existence through the advocacy of transgender people themselves. They wrote letters and asked doctors to apply techniques to their bodies developed to normalize intersex children into the cisgender binary (Gill-Peterson, 2018). Transgender facilitators like Louise Lawrence were instrumental as interfaces between transgender communities and medical and psychiatric clinics, and Reed Erikson was a critical funder of the Johns Hopkins Clinic. Transgender people trained as doctors; Jeanne Hoff even replaced John Money at Johns Hopkins.

The current wave of anti-trans sentiment in the media and politics, including the ongoing bomb scares against hospital gender clinics, has been framed as a response to the increase in trans-affirming care (Sobey, 2022). Thus, we can see that the provision of medical care to transgender people has always been framed as a political issue. As a result of these legacies of tension, there remains some apparent controversy in psychological science about the validity and acceptability of transgender identities. Despite all the significant medical and psychological associations issuing statements of support for gender-affirming care, it is not difficult to find trans-negative studies published in psychological journals in the last ten years (Bailey & Hsu, 2022; Lawrence, 2017; Trans Health Project, 2022). Because clinicians have the role of determining client suitability for hormones and surgery, there is an extent to which the perceptions of a clinician about a transgender client may become an attitudinal barrier to access (Whitman & Han, 2017). It is important to note that this access proceeds along racial lines, with Black transgender patients historically denied access to gender-affirming care or even institutionalized. At the same time, their white counterparts were given medicine and surgery (Gill-Peterson, 2018).

There are still clinicians providing what amounts to "conversion therapy" (interventions designed to make them no longer desire gender transition) for transgender people under the name of gender exploratory therapy (Ashley, 2022). This methodology proceeds with a wait-and-see model, potentially delaying gender transition indefinitely, rather than the mainstream affirmative model of trusting the client's perception of self and desire to live in the gender that is consistent with their internal sense of their gender. This intervention approach has historically been widely used with children and adolescents. It is centered around widening a transgender child's sense of their gender and promoting comfort within those gender norms. Nevertheless, despite the

affirmative-sounding language, the intended outcome is to arrest transition (Ashley, 2022), often resulting in high levels of trauma for those who have undergone such interventions (cite). It should be noted that any interventions designed to change one's sexual orientation or gender identity have been condemned as torture by the United Nations Human Rights Council (UNHRC, 2020).

Social Stigma Related to Transgender Identities

Why do trans people experience such high rates of social stigmatization? In her foundational transgender studies text, *Whipping Girl*, Julia Serrano describes transmisogyny as a form of discrimination primarily against trans women but affecting all gender-nonconforming people (Serano, 2007). As an intersectional oppression, it is the combination of two more widespread oppressions. First, the idea that masculinity is preferable to femininity is associated with traditional sexism. This sexism combines with another, the idea that femininity and masculinity are separable, inflexible, and exclusive categories, which Serano names oppositional sexism (Serano, 2007, p. 23). Thus, transmisogyny places transgender women as the target of sexist violence from both cisgender men and women in upholding patriarchal gender roles. The same problem can also be seen in the experience of people assigned female at birth who present as masculine and people assigned male at birth who present as feminine, like butch lesbians, feminine gay men, or nonbinary people (Halberstam, 1998).

Binary gender is central to a vision of social reproduction that sees specific types of labor accorded to specific types of bodies (Laslett & Brenner, 1989). However, as Money and Stoller found in the mid-20th century, human development is neither neatly binary nor easily subject to scientific modification (Gill-Peterson, 2018). The compulsory relation of bodily sex to gender presentation is policed through coercion and exclusion (Serrano, 2007). Nevertheless, bodies that

defy these assignments, whether intersex or transgender, are the source of considerable anxiety for people invested in current social forms (Makanawa, 2018). As a result of this ongoing historical trauma, trans people carry a disproportionately large trauma load, particularly those without class or racial privilege, and thus often suffer from additional stress-related physical ailments (Reiser, 2016; Richmond et al., 2012). Further, Serano argues that the diagnosis of gender dysphoria folds together the experience of dissonance in what she refers to as subconscious sex with the discomfort of gendered discrimination, rendering the label nosologically problematic (Serano, 2007).

Since the heterosexual family is the ideal to which individuals are expected to conform, and because the family is the basis of social reproduction, transition is seen as irreversible and has a potential for regret because it may affect the future reproductive potential of young people. This discourse is a significant motivator of the argument for denying teenagers access to gender affirming care, causing clinicians to hesitate about their treatment. It has inspired a nationwide legal attack on these practices (MacKinnon et al., 2021).

To clarify, social reproduction, a feminist critical theory, seeks to understand how gendered and racialized non-waged labor is necessary to reproduce society and the family. This labor includes caretaking, childrearing, cleaning, cooking, volunteering, and other similar tasks that make possible the production of economic value (Bakker, 2007). Thus, as noted previously, it depends on producing cisgender, heterosexual bodies to perform this reproductive labor. This labor must be performed in ways that connect with already posited concepts of traditional and oppositional sexism. This sexism entails that men must be men and love women, and women must be women and love and serve men to reproduce society, both culturally and biologically.

Hence gender transition threatens the legibility of this dynamic hence threatening to produce a future that is not recognizable from the past (Griffiths, 2021).

The Cultural Politics of Transphobia

Despite a shift toward more positive attitudes towards those who identify as transgender and gender diverse since the late twentieth century, the stigma toward transgender people has become more vocal and hostile in the last few years as the populist far-right has experienced a global resurgence (Fraser, 2020). This uptick is partly due to a shared sense of transphobia and disdain for the transgression of gender norms being one of the most effective recruiting tools of the far-right (Makwana et al., 2018). One study put forth by Warriner and colleagues (2013) demonstrated that people who scored more highly on measures of transphobia and homophobia also scored higher on right-wing authoritarianism, religious fundamentalism, sexism, aggression, and sexual identity distress. Another study found comparable results indicating that people scoring higher on the "Need for Closure scale" were significantly associated with transphobia (Makwana et al., 2018). This association manifested both through adherence to social conventions and obedience to authorities (i.e., right-wing authoritarianism) and endorsements of traditional gender roles, as well as through stronger preferences for hierarchy and social inequality (i.e., social dominance orientation) (Makanawa, 2018).

Another noticeable indicator of transphobia, also primarily associated with right-wing politics, is gender essentialism (Blyth & McRae, 2018; Makwana et al., 2018). Gender essentialism is the idea that there is a fundamental underlying reality to masculine and feminine categories, whether based on the idea of a gendered soul or the differential production of gametes (Wong, 1999). The issue of gender transition disrupts this essentialism. It is an issue that still

raises considerable discomfort among many in the mainstream, which also provides far-right actors their inroads into liberal discourse (Makanawa, 2018).

However, the assault on transgender rights does not originate exclusively in far-right activist circles, as transmisogyny also exists within more progressive ideologies. (Worthen, 2022). Much of the language used by the far-right in promoting a gender panic was coined initially by so-called trans-exclusionary feminists, many of whom consider themselves on the political left. As Janice Raymond, regarded as the intellectual standard-bearer of trans-exclusionary feminism, said in her book, The Transexual Empire, "the problem of transsexualism would best be served by morally mandating it out of existence" (Raymond, 1979).

Far-right organizations such as the Heritage Foundation have been more than willing to lend money and legal aid in several court cases brought by feminists in Britain and the United States against transgender rights. These precedents have been cited in anti-trans legislation in the United States. For example, Senator James Lankford of Oklahoma quoted J.K. Rowling's anti-trans writings when he blocked Senate consideration of the Equality Act, an LGBTQ civil rights bill (citation needed for the Equality Act). Abigail Shirer gave testimony against transgender protections on the same article of legislation. Further, the Women's Liberation Front, or WoLF, wrote an amicus brief for the defense in the transgender workplace discrimination case R.G. & G.R. Harris Funeral Homes v EEOC & Aimee Stephens (Mitchell, 2021).

Hence, the author has hesitated to frame this as strictly political because the left is factionalized on this issue. The far-right and so-called gender-critical feminists seek to avoid a specific political outcome: the destabilization of the gender binary. Their motivations are different in each case, with feminists seeking to stabilize the concept of woman as a political category to establish sex-based rights for women to exclude all men, including transgender

women (Worthen, 2022). The far-right seeks to stabilize the binary as part of a long-term political and moral crusade that includes specific ideas surrounding the appropriate behaviors and social roles of individuals based on their birth sex and the disciplining of non-productive sexualities (Federici, 2004).

Chapter 2: Advances in Conceptualization of Gender Affirming Care

In many ways, psychology and social work fields have begun to move beyond these issues in the last decade. Studies show that most mental health care clinicians support a client's right to engage in gender transition (Whitman & Han, 2017). The Harry Benjamin Association is now the World Professional Association for Transgender Health [WPATH] and has moved over successive editions to loosen the requirements for gender-affirming care. The seventh edition, published in 2012, introduced an informed consent pathway to access cross-sex hormones rather than relying extensively on the expertise and clinical judgment of the clinician (Cavanaugh et al., 2016). The eighth edition, published in 2022, advocates even more strongly for the informed consent option. However, therapeutic oversight is still recommended. Moreover, despite most mental health care clinicians' support of TGD identities, a significant minority still do not believe that transgender identities are valid and that gender transition improves psychological health and overall social and occupational functioning (Whitman & Han, 2017).

Transgender and Gender Diverse Need for Therapy

Transgender and Gender Diverse people consume mental health care at an elevated rate. According to a significant study, two-thirds of transgender individuals have pursued psychotherapy, and fourteen percent more expressed a desire to seek psychotherapy (Budge, 2015). By contrast, only three percent of the United States population seeks out psychotherapy (Budge, 2015). The author believes this to be for two reasons. First, they desire access to gender affirming medical care and have, until recently, needed one to two letters from healthcare clinicians. Second, they struggle psychologically with exposure to prejudice and discrimination. These motivations comport with the previously mentioned theorization of the problem of gender dysphoria by Julia Serano (Budge, 2015; Serano, 2007).

Statistics herein are from the 2015 Transgender Survey, the best source for data on transgender outcomes based on transgender self-reporting (James et al., 2016). As we can see then, trans peoples' elevated use of psychotherapy is well justified as TGD people use drugs at three times the rate of the U.S. Average. Half of all transgender people will experience family rejection, with up to ten percent having been attacked by a family member and kicked out of their homes. Sixty-five percent will experience homelessness. Nearly half will be sexually assaulted. They often struggle to receive culturally competent medical care and go without care. Forced into the underground economy and sex work, they live with HIV five times the national average, and one in five trans women of color live with the disease.

The statistics by James et al., (2016) further indicate that more than three-quarters of transgender children are bullied in school, and twenty percent are bullied so badly that they drop out of school. More than one-half of transgender people have experienced bullying in the past year, and ten percent have been attacked. Fifteen percent of trans adults report being fired for their identity. The same amount lives in poverty, three times the national average. A quarter of TGD people face housing discrimination yearly, especially in homeless shelters, where it increases to three-fourths.

Despite the name, the Trans Survey participants rated themself about evenly as one-third transgender women, one-third transgender men, and one-third nonbinary or genderqueer, meaning that it includes data from the TGD umbrella writ large rather than only focusing on transgender people alone (James et al., 2016). This distinction is important because a close reading, as we will discuss later, reveals that much of clinicians' discomfort with trans people stems, in principle, from their discomfort with gender presentations that do not conform to the binary (Whitman & Han, 2017). Much attention has also been paid to intersectional differences

in outcomes from race and class perspectives (James et al., 2017). Black and Indigenous trans people face extreme hardship. In many cases, their outcomes will be more than twice as bad as the average for transgender outcomes along various metrics, which will become important in our discussion of the practice implications of this line of research.

There are numerous studies on trauma in the transgender community (Richmond et al., 2018). The outcome of these processes can be correlated to the inflated risk of suicidality in the transgender and gender-diverse community. Thirty-nine percent of respondents to the Trans Survey experienced severe emotional distress the month before they took the survey, relative to only 5% of the U.S. population. As is well known, forty percent of TGD people have attempted suicide in their lifetime, compared to less than five percent of the U.S. population. This trauma includes the seven percent that attempted suicide just in the past year alone, fourteen times the rate of the general U.S. population.

However, the APA also stipulates that before diagnosing a client with gender dysphoria must have well-controlled mental health and medical concerns if there are any present (Verbeek et al., 2022). However, the term well-controlled has not been clearly defined in the guidelines. This lack of clarity has sometimes led clinicians to hesitate to facilitate access to gender affirming care due to fear of transition regret if the readiness criteria are not strictly followed, contributing to problematic gatekeeping in trans health, resulting in significant barriers to gender-affirming care. This hesitance can be seen as an example of what is known among trans people as the trans broken arm syndrome, where when a TGD client presents with any other medical or psychiatric problems, clinicians often suggest that the discontinue transitioning as well (Paraiso et al., 2022).

A literature review of eleven studies over five years found that gender-affirming care has an overwhelmingly positive psychological effect in adolescents and adults. These positive effects include reduced anxiety, depression, and perceived social distress, as well as improved quality of life and self-esteem for TGD individuals (Nguyen et al., 2018). On the other hand, gender-affirming treatment has also been shown to have a strong positive correlation with improved mental health outcomes (Nguyen et al., 2018; Todoroff, 2022; Turban et al., 2022). In one study, researchers found sixty percent lower odds of depression and seventy-three percent lower odds of suicidality in TGD youths who received gender-affirming treatment (Todoroff, 2022). In another study of 27,715 transgender adults, researchers found that accessing gender-affirming care during early adolescence, late adolescence or adulthood was associated with decreased odds of suicidal ideation in the past year compared to those participants that did not seek care (Turban et al., 2022). Despite this, transgender and gender-diverse clients seeking access to these interventions are often denied access due to preexisting mental health issues (Singh & Burnes, 2010; Verbeek et al., 2022). Thus, as we can see, social support and affirmation of their transition are crucial to transgender people's well-being (Trujillo, 2017).

Cultural Competency and Bias in Mental Health Care

The problem of TGD competency is pervasive in medicine, not only in mental health. One-third of clinicians in the Trans Survey reported having one or more negative experiences with a healthcare clinician because they were transgender (James et al., 2015). Twenty-four percent had to teach the clinician about transgender people to receive appropriate care. Fifteen percent were asked invasive or unnecessary questions about their transgender status that were not related to the reason for their visit. Eight percent were refused gender-affirming health care entirely.

The situation is quite grim within the other medical disciplines related to transition-affirming care -endocrinologists, surgeons, urologists, and family medicine doctors. According to one study, over one-third of endocrinologists refused to provide care to transgender patients, and only sixteen percent were currently caring for more than five transgender patients (Irwig, 2016). The majority had not received training on transgender care. Despite over half of clinicians having read the Endocrine Society's practice guidelines, only five percent could answer specific questions about the side effects of specific sex hormone medications. The authors conclude that participants do not have faith in their ability to provide competent transgender care due to the lack of training and opportunities for them to care for transgender patients (Irwig, 2016).

In another study, all participating endocrinology and psychiatry residents agreed that transgender-affirming care is a part of their scope of practice (Coutin et al., 2018). The numbers were much lower for family medicine and urology, with seventy-one percent and fifty percent of the residents agreeing, respectively. Despite these high numbers, only seventeen percent of residents polled predicted they would feel competent to provide gender-affirming care by the end of their residency. We can see from these studies that there is a willingness to serve this population. However, a lack of clinical exposure and training in postgraduate curricula has resulted in newly graduated clinicians feeling unprepared to meet the healthcare needs of this underserved population (Coutin et al., 2018).

Attitudinal and Structural Barriers to Access

Despite this, access to culturally competent care is still a barrier for the transgender and gender-diverse community. (Irwig, 2016). So the attitudes of clinicians and their staff significantly affect the quality of TGD people's lives. This effect is especially pronounced since, as previously mentioned, trans and gender-diverse people statistically consume psychological

services at an elevated rate and because of the potential for mishandling or gatekeeping that comes from inadequate training or a lack of self-reflection on gender issues as a clinician.

For clinicians working in social service agencies such as homeless shelters, transitional living programs, schools, and the child welfare system, TGD youth make up forty percent of unaccompanied homeless youth while only representing ten percent of the larger youth population (Morton et al., 2018). These youths are overwhelmingly kicked out of their homes by their families of origin for religious or political reasons. Social service agencies, like, as we have seen, clinicians in general, often lack adequate competence in these issues (Polk, 2020). Trans-affirmative family therapies may help keep a trans child with their family of origin, a key element in preventing these adverse outcomes (Coolhart & Shipman, 2017). In some ways, as we will see, affirming mental health clinicians are some of TGD people's only institutional allies.

This lack of competence also creates problems for clinicians working within prisons. Prisons are the largest mental health providers in the U.S. In the United States, jails and prisons have been more than three times more seriously mentally ill persons than hospitals for more than a decade (Torrey et al., 2010). Inmates with serious mental illnesses account for more than sixteen percent of prisoners, three times as high as forty years ago. Trans people are particularly vulnerable to this carceral dynamic, with sixteen percent having been incarcerated at some point. These are predominantly black and brown trans people. Forty-seven percent have been incarcerated (Grant et al., 2011). This trend correlates with the historical racial discrepancy in outcomes among trans youth noted by Jules Gill-Peterson, wherein white trans people are given access to the clinic while Black trans women sometimes eventually receive treatment after repeated incarceration.

Several studies have shown that TGD people's qualitative reports of bias are born out in assessments of mental health clinicians' cultural competence with trans and gender diverse issues (Bidell, 2017; Santos et al., 2017; Whitman & Han, 2017). In one study, as many as twenty percent of practicing clinicians expressed anti-TGD attitudes (Whitman & Han, 2017). In other studies, clinicians were ambivalent about the psychosocial issues brought to them by their TGD patients (Irwig, 2016).

The American Psychological Association defines competence defines in four primary ways. Firstly, it requires that services be provided in a way that is consistent with the clinician's expert training and experience (APA, 2010). Secondly, it requires that appropriate training be obtained or appropriate referrals provided when the effectiveness of service implementation can be shown to be affected by sociodemographic influences. Thirdly, appropriate training is required before working with a new population. Finally, it requires that where evidence remains unclear, reasonable steps are taken to ensure that competent care is provided. We can see that on this basis, mental health clinician training is not reliably producing culturally competent clinicians for trans and gender diverse individuals.

A systematic review of ten qualitative articles analyzing TGD clients' therapy experiences identified two themes and five subthemes (Compton & Morgan, 2022). The first theme was broken into two sections. The first analytical theme elicited both participants' experiences of how gender was discussed in therapy and the problematic ways clinicians approached discussions of gender. This finding means that TGD individuals participating in these studies perceived their clinician as either neglecting gender or focusing on it in an invalidating way due to their preexisting views. The authors labeled these attitudes as gender

blind or gender blinded, respectively. Another subtheme focused on experiences of rigidity and fixity in clinician viewpoint, which described gender as a problem to be fixed.

The second analytical theme, clinician identity and approach, broke down into subcategories: clinician identity and community visibility, approaches to therapeutic work and advocating for gender minorities (Compton & Morgan, 2022). Clinician identity and community visibility related to TGD clients seeking out LGBT clinicians because they hoped they might express additional sensitivity to experiences of oppression. The study found that their level of additional empathy varied in practice. The subtheme of approaches to therapeutic work while *advocating for gender minorities* related to whether a clinician was open to challenging their normative assumptions about gender identity. The study reports that this subscale was more critical than the clinician's identity. The authors argue that clinicians should be aware of power dynamics in the therapeutic relationship and reflect on how gender issues are discussed within therapy.

Many TGD individuals recognize that clinicians are not trained to meet their needs and approach encounters with healthcare workers with uncertainty about their competence (Irwig, 2016). Specifically, three themes were found to be most detrimental to the therapeutic alliance: overt expressions of disapproval or discomfort with TGD identities, the pathologization of TGD identities, and invasions of bodily privacy (Whitman & Han, 2017). The authors emphasize that these themes often emerge through subtle microaggressions that go unnoticed by the clinician or their staff and are followed up with what the authors describe as difference blindness. This difference blindness entails the unconscious assumptions of dominant norms, such as assumptions about heterosexuality and cisgender identities being normal and LGBTQ identities being deviant or pathological.

Because when clinicians themselves are assessed, nearly one-fourth of clinicians rated a statement suggesting gender diverse identities are not as healthy as cisgender ones as at least true (Whitman & Han, 2017). Additionally, fourteen percent of clinicians indicated that clients should see cisgender identity as the ideal to strive for, and twenty-one percent endorsed the claim that clients should conform to traditional sex roles. The study also indicated that while most clinicians expressed some awareness of cisgender privilege, they did not demonstrate the same level of awareness of the impacts such privilege can have on the therapeutic alliance and therapeutic outcomes. These effect sizes were moderated based on the number of years in practice, with clinicians-in-training demonstrating a higher degree of awareness related to gender and gender identity compared to professionals currently practicing.

Another study, which constructed and validated the Gender Expression Attitudes Towards Transgender Clients (GEATTC) scale, explored students' and clinicians' attitudes about gender expression for transgender and gender-diverse (Santos et al., 2017). The study found three reliable subscales, Emphasis on Assigned Sex Expression, Affirmation of Gender Expression in All Forms, and Generalized Emphasis on Gender Binary Expression (Santos et al., 2017). The first subscale captures the extent to which the clinician's approach to counseling transgender clients resembles conversion therapy. The second subscale captures whether the clinician's attitudes affirm a diversity of forms of gender expression for their transgender clients. The third captures whether the practitioner should treat gender dysphoria by encouraging the adoption of traditional male or female appearance, mannerisms, language, and activities for their TGD clients. The first and third subscales received very few endorsements of anti-transgender items, while only approximately half of the sampled clinicians endorsed items in the second subscale. This result suggests that while they do not explicitly discriminate against transgender

people, neither do they embrace gender diversity more broadly. As we can see between the previous two studies is that it is gender non-conformity or diversity more than transgender identity itself that seems to correlate with negative clinician attitude (Santos et al., 2017; Whitman & Han, 2017).

Finally, a study similarly constructed and validated another measure, the Counselor Competence Gender Identity Scale (CCGIS), which investigated how effective counselors perceive themselves in providing services to those who identify as transgender (Simons, Bahr, & Ramdas, 2021). The study found four factors, Self-Awareness of Clinical Bias, Gaining Knowledge/Skills to Counsel Transgender Clients, Awareness of Barriers to Transgender Practice, and Professional Exposure to Transgender Clients. The study found low correlations between the Awareness of Clinical Bias subscale and the other three subscales, underlining yet again the contradiction that the clinicians were aware of prejudicial attitudes about transgender individuals but lacked exposure or knowledge of actual practice with transgender and gender diverse people. This study also found that geographically, counselors from the southern U.S. reliably had the highest levels of bias and lowest levels of competence.

Given current sociopolitical conversations concerning the validity of transgender identities and the ethics and legality of providing gender-affirming care for youth and adults, it is crucial to explore clinicians' attitudes toward transgender people and their ability to provide competent care for those seeking gender-affirming interventions. Therefore, this study seeks to expand on the literature regarding therapeutic competency in their work with transgender clients and, by extension, gender diverse clients.

Research Questions

This study seeks to determine answers to the following research questions:

1.) What attitudes do licensed clinicians in Texas hold toward transgender people seeking interventions for gender transition?

2.) What are the levels of competence reported by licensed clinicians in Texas in relation to providing appropriate gender-affirming care for transgender individuals?

3.) Is there a correlation between clinicians' ratings of their competence and their attitudes toward TGD people?

4.) Are clinicians' sociodemographic characteristics related to their attitudes toward transgender clients and their self-reported competency to work with this group of clients?

Chapter 3: Methods

Sampling and Recruitment

Before data collection, this study was approved by the Institutional Review Board (IRB) at the University of Texas at Arlington. This study was open to any clinicians licensed for independent practice in Texas (LMFT, LPC, LCSW, or Ph.D. in Psychology). Recruitment emails were sent to the National Association of Social Workers-TX and Texas Psychologists Association listservs. Additional recruitment was done via Facebook posts in local Texan clinician specialty groups. These groups included North Texas Social Workers, Texas Social Workers, Texas Psychologists in Private Practice, and Texas Social Workers, Case Managers, and Discharge Planners. Interested clinicians were invited to take an anonymous thirty-minute online survey about their experiences working with transgender and gender diverse clients. The recruitment email and posts contained a link to the secure online Question Pro survey and a Q.R. code that could be scanned to access the survey.

The introduction email also allowed potential participants to "opt out" of any reminder emails associated with the survey. Once the participant clicked on the link, they were taken to a cover page where they were asked to give consent for participation and affirm that they are licensed master's level clinicians over the age of eighteen in Texas. Potential participants who answered this question as "no" were directed to the end of the survey. Those who selected "no" for consent were thanked for their time, and the survey closed. Those who selected "yes" were taken to the two measures and a demographic questionnaire. A copy of the eligibility screening questions consent document and survey questions are included in the Appendix. Two follow-up emails were also sent to participants at two- and four-week intervals. This survey could be completed on any internet-enabled device through the secure online data collection tool Question

Pro and was available between 8/15/22 and 10/15/22. Participants did not receive any compensation for their participation.

Measures

Eligible study participants completed a demographic questionnaire and two standardized and validated measures assessing their attitudes toward transgender clients and their self-rated competence for working with transgender clients. The demographic questions included: age, years in practice, type of licensure, sexual orientation, gender identity, religion, race/ethnicity, the approximate number of transgender clients they have worked with, and the amount of prior training on working with transgender clients. Following the demographic questions, participants completed the Gender Expression Attitudes Towards Transgender Clients (GEATTC) Scale (Santos, Goldstein, & Tracy, 2017) and the Gender Identity Counselor Competence Scale (CCGIS) (Simons et al., 2021).

The GEATTC (Santos et al., 2017) is comprised of 23 items, each rated on a 5-point Likert scale from 1 (strongly disagree) to 5 (strongly agree). The measure looks at three factors related to attitudes toward transgender people: emphasis on assigned sex expression, affirmation of gender expression in all forms, and generalized emphasis on gender binary expression. This measure has been found to have strong internal consistency reliability, with a Cronbach's alpha level reported by the authors as .89.

The CCGIS (Simons et al., 2021) is a measure of competence related to working with transgender clients in healthcare settings. It consists of 25 items rated on a 7-point Likert scale ranging from 1 (not true at all) to 7 (totally true). It consists of four domains assessing counselor competence, including 1) self-awareness of clinical bias, 2) gaining knowledge/skills to counsel transgender clients, 3) awareness of barriers to transgender practice, and 4) professional exposure

to transgender clients (Simons et al., 2021). This measure has shown high internal consistency with Cronbach's alpha score of .97 (Simons et al., 2021).

Chapter 4: Data Analysis

Cleaning of Data and Scoring of Scales

Approximately two hundred fifty people consented to participate in the study and responded to at least one survey question. One hundred and seventy-five individuals completed the demographic questions but did not complete the study measures, and seventy-five completed both demographics and study measures. Responses from the 175 individuals who completed the demographic questions but did not complete the standardized measures were eliminated from subsequent analyses. There was little missing data for the remaining seventy-five respondents (less than 1% of all responses). To retain as many valid cases as possible, the research team decided to impute the mean for each question where there was missing data. In addition, the study team received two emails from potential participants mentioning that they chose not to complete the survey as they did not like the phrasing of questions in the measures used.

Counts and percentages were calculated for categorical participant demographic questions, while means and standard deviations were calculated for scale variables. Study measures were scored (full scale scores and subscale scores) based on the guidelines provided by the authors of the CCGIS (Simons et al., 2021) and the GEATTC (Santos et al., 2017). For the CCGIS, items on each subscale were summed to determine a subscale score, and then subscale scores were summed to calculate a total scale score. *Higher scores* were indicative of *higher levels of competence*. The GEATTC does not have a full-scale score. Scores for the General Emphasis on Gender Binary were summed to get a subscale score, with *higher scores* indicating more rigid adherence to the gender binary and *negative attitudes* toward those who did not fit into the gender binary. For the Affirmation of Gender Expression in all forms, answers to each question were summed, with *higher scores* indicative of more *positive attitudes* toward multiple forms of gender expression. For the Emphasis on Assigned Sex Expression scale, items were

summed to determine the subscale score, with higher scores indicating respondents had more *negative attitudes* toward a range of gender expressions. The following analyses were performed to answer each of the research questions.

1.) *What attitudes do licensed clinicians in Texas hold toward transgender people seeking interventions for gender transition?* - GEATTC subscale scores, the range of scores, means, and standard deviations were calculated to summarize respondents' attitudes toward transgender people seeking interventions for gender transition.

2.) *What are the levels of competence reported by licensed clinicians in Texas in relation to providing appropriate gender-affirming care for transgender individuals?* - CCGIS full scale and subscale scores, along with the range of scores, means, and standard deviations, were calculated to summarize respondents' self-reported competence to provide appropriate gender-affirming care for transgender individuals.

3.) *Is there a correlation between clinicians' ratings of their competence and their attitudes toward TGD people?* Pearson *r* correlations were performed among each of the subscales of the CCGIS and GEATTC to see if there were any significant associations between respondents' attitudes and various domains of self-reported ability to work competently with transgender individuals.

4.) *Are clinicians' sociodemographic characteristics related to their attitudes toward transgender clients and their self-reported competency to work with this group of clients*? Independent sample t-tests were performed to determine if specific demographic characteristics of respondents were associated with their attitudes towards transgender individuals and their self-reported competence to work with transgender individuals.

Chapter 5: Results

Descriptive Statistics

The demographic characteristics of participants are summarized in Table 1. The sample was primarily composed of LCSWs (*N*=48, 64%), followed by LPCs (*N*=, 23%), LMFT (*N*=2, 2.7%), and Licensed psychologists (*N*= 8, 10.7%). Most worked in private practice (*N*= 59, 78.7%), hospital or medical settings (*N*= 11, 14.7%), and to a lesser degree in state agencies (*N*= 7, 9.3%), or for private agencies (*N*= 8, 10.7%). They were heterosexual (*N*= 50, 66.7%), with (*N*=21, 28%) identifying as lesbian, gay, bisexual, or queer. Most participants were cisgender (*N*=66, 88%) though a minority were a gender other than cisgender such as queer, non-binary, gender fluid, or transgender. TGD (*N*=6, 8%). The sample was primarily composed of White therapists (*N*=66, 74.7%), followed by those identifying as Black/African American (*N*= 7, 9.3%), Native American (*N*= 5, 6.7%), and Hispanic/Latino (*N*= 7, 9.3%). Just over 40% of the sample identified as Christian, and (*N*= 31, 41%), about as many indicated no religious preference (*N*= 29, 38.7%), and a small percentage identified as Buddhist (*N*= 3, 4%), Jewish (*N*= 2, 3%), or other religions (*N*= 8, 10.7%).

About a third of the sample indicated they have worked with between one and five transgender clients in their career (*N*= 23, 30.7%), with about a third indicating they have worked with between five and ten (*N*= 23, 30.7%), followed by those indicating they had worked with between ten and fifteen transgender clients (*N=11,* 14.7%). About 5% indicated they had worked with between fifteen and twenty (*N=4*, 5.3%) or more than twenty transgender clients (*N*= 7, 9.3%) in their careers. A few had treated no TDG clients in their careers (*N*=7, 9.3%). About half had heard of the Standards of Care of Transgender, and Gender Diverse individuals (SoC) put forth by the World Professional Association for Transgender Health (WPATH)

(*N*= 37, 49.3%). Half had not (*N*=36, 48.0%). Most of those who had accessed the WPATH SoC had accessed it within the last year (*N*= 28, 49%), and most of the sample had treated three or fewer TGD clients in that same year (*N*= 42, 69. 3%). Most had never written a letter for gender-affirming care (*N*= 48, 64%), a few had written between one and ten letters (*N*= 14, 18.7%), and very few had written more than ten (*N*= 2, 2.7%). Most clinicians had attended ten or fewer hours of training on TGD-related subjects (*N*= 45, 60%), with a range of zero to up to one hundred hours in training. Very few had refused letters for the provision of gender-affirming care to a transgender client (*N*=3, 4%), but those four percent did so because of the client's serious mental health issues at the time of the request.

Figure 1: Sociodemographic Characteristics of Participants

Continuous Variables	N	Percentage	Mean	Stan. Dev.	Min	Max
Age	75	100%	47.45	13.05	27	76
20-30	4	5%				
30-40	24	32%				
40-50	19	25%				
50-60	14	19%				
60+	14	19%				
Years as a Licensed Practitioner	69	100%	12.54	10.24	1	50
Ten or Less	42	61%				
Twenty or Less	12	17%				
Up to 50	15	22%				
Number of GAC Letters Written	64	100%	.75	3.80	1	15
0	51	68%				
1	6	8.0%				
2	3	4.0%				
3	2	2.7%				
15	2	2.7%				

Hours of Training	59	100%	12.14	18.14	0	100
Ten or Less	45	60%				
Twenty or Less	5	6.6%,				
Less than 100	10	11.9%				
Number of TGD Clients	64	100%	3.04	1.38	0	25
None	7	9.3%				
Between 1-5	23	30.7%				
Between 5-10	23	30.7%				
Between 10-15	11	14.7%				
Between 15-20	4	5.3%				
More than 20	7	9.3%				
Categorical Variables	Frequency	Percent				
Race						
White	66	88.0%				
Black/African American	7	9.30%				
American Indian or Alaska Native	5	6.70%				
Korean	1	1.30%				
Hispanic	1	1.30%				
Religion						
Christian (All Denominations)	31	41.3%				
Buddhist	3	4.0%				
Jewish	2	2.7%				
No Religion	29	38.7%				
Any other religion	8	10.7%				
Practice License						
Licensed Clinical Social Worker (LCSW)	48	64.0%				
Licensed Professional Counselor (LPC)	17.00	22.70%				
Licensed Marriage and Family Therapist (LMFT)	2.00	2.70%				
Licensed Psychologist	8.00	10.70%				
Practice Setting						

Private Practice	54	72.0%				
Hospital Setting	18	24.0%				
Social Service Agency- Private	2	2.7%				
Social Service Agency- Public	1	1.3%				
Sexuality						
LGBTQI+	65	86.7%				
Heterosexuality	10	13.3%				
Gender						
Trans and Gender Diverse	8	10.7%				
Cisgender	67	89.3%				
Accessed WPATH						
Yes	37	49.3%				
No	36	48.0%				

Scores on Scales and Subscales

The **Counselor Competence Gender Identity Scale** (CCGIS) produces a total score and scores on its four subscales, **Self-Awareness of Clinical Bias**, **Gaining Knowledge/Skills to Counsel Transgender Clients**, **Awareness of Barriers to Transgender Practice**, and **Professional Exposure to Transgender Clients**. The cut score for effective counseling for transgender clients on the CCGIS is 100 of a possible 150. The **Self-Awareness of Clinical Bias** subscale had a cut score of 40 of a possible 70. In the **Gaining Knowledge/Skills to Counsel Transgender Clients** subscale, the cut score was 24 out of a possible 42; in the **Awareness of Barriers to Transgender Practice**, the cut score was 20 out of a possible 28. For **the Professional Exposure to Transgender Clients** subscale, the cut score was 16 of 28.

There is no total score for the **Gender Expression Attitudes Towards Transgender Clients** (GEATC), on the other hand. This measure only provides scores for the three subscales that measure different constructs. The subscales are **Emphasis on Assigned Sex Expression,**

Affirmation of Gender Expression in All Forms, and **Generalized Emphasis on Gender Binary Expression**. High scores on the **Emphasis on Assigned Sex Expression and The Generalized Emphasis** on **Gender Binary Expression** subscales indicate more negative attitudes toward transgender individuals and those who do not align with the gender binary. In contrast, higher scores on the **Affirmation of Gender Expression in all forms** are associated with more positive attitudes toward transgender people and various forms of gender expression. The full scale scores, subscale scores, ranges, means, and standard deviations are shown in Table 2.

In the present study, the reliability of **the Gaining Knowledge/Skills to Counsel Transgender Clients** subscale was found to be α=.79 on Cronbach's alpha, a satisfactory level. The reliability of the **Awareness of Barriers to Transgender Practice** subscale was also satisfactory, α=.79. The reliability of this subscale was found to be α= .69 on Cronbach's alpha, an acceptable level. The reliability of the **Self-Awareness of Clinical Bias** subscale was .81, a good score, and the **Professional Exposure to Transgender Clients** was α=.79, a reasonable level. Finally, the reliability of the full **CCGIS** was .77, again a good level of reliability.

The reliability of **Emphasis on Assigned Sex Expression, Affirmation of Gender Expression in All Forms** was excellent, α= .93. The reliability of **Affirmation of Gender Expression in All Forms** was satisfactory at α= .75. Reliability of **Emphasis on Assigned Sex Expression and The Generalized Emphasis** was also satisfactory at α= .87.

Figure 2: Scores on Outcome Measures

	N	Minimum	Maximum	Mean	Std. Deviation

Emphasis on Assigned Sex Subscale (GEATC)	75	9.00	27.00	11.9867	4.69472
Affirmation of Gender Expression in All Forms (GEATC)	75	13.00	30.00	25.7867	4.20519
Emphasis on Binary Gender Expression(GEATC)	75	9.00	35.00	15.4267	6.31637
Clinical Bias toward Transgender People (CCGIS)	75	10.00	25.00	11.9600	3.93680
Knowledge and Skills (CCGIS)	75	12.00	36.00	26.8400	6.76445
Awareness of Barriers to Practice (CCGIS)	75	10.00	35.00	27.8667	5.74064
Professional Exposure to Transgender Clients (CCGIS)	75	4.00	28.00	16.5333	7.01607
Full Scale Score CCGIS	75	50.00	109.00	83.2000	14.52863

As we can see, the mean score of the CCGIS in this sample (*M*= 83.20, *SD* = 14.53) was well below the competency cutoff of 100, indicating that respondents did not report adequate levels of overall competence for working with transgender clients. Clinician attitudes about transgender people were overall moderately positive, however. On the **Emphasis on Assigned Sex Expression** subscale, *(N*=7, 9.4%) was in the top quartile, (*N*=12, 16%) was in the second quartile, and (*N*=56, 84%) was in the lowest two quartiles. On **the Affirmation of Gender Expression in All Forms** subscale, sixty-three clinicians, or eighty-four percent of the sample (*N*=63, 84%), were in the top quartile, eleven, or fourteen point seven percent, in the second quartile (*N*=11, 14.7%), one clinician, or one point three percent of the sample (*N*=1, 1.3%) in the third quartile, and none in the lowest quartile. The **Generalized Emphasis on Gender Binary Expression** subscale (*N*= 9, 11.9%) scored in the top quartile, (*N*= 24, 32.1%) in the second quartile, forty-nine (*N*= 65.4%) third quartile, and none scored in the lowest quartile.

For the CCGIS, rather than dividing the results into quartiles, the results were divided by cut score. The **Self-Awareness of Clinical Bias Subscale** mean was 12.03, and the standard deviation was 4.47. The **Self-Awareness of Clinical Bias** subscale had a cut score of 40, and none of the clinicians were above this score. On the **Gaining Knowledge/Skills to Counsel**

Transgender Clients subscale, the cut score was 24, and fifty-six clinicians scored above this threshold. The subscale mean was 27.04, and the standard deviation was 4.46. On the **Awareness of Barriers to Transgender Practice**, the cut score was 20, and seventy-two clinicians scored above this cutoff. The subscale mean was 27.81, and the standard deviation was 5.61. For the **Professional Exposure to Transgender Clients** subscale, the cut score was 16, and 46 clinicians scored higher than that. The subscale mean was 18.05, and the standard deviation was 14.94.

Figure 3: Percentage of Respondents Meeting CCGIS Subscale Competence Cut Scores

Scale	*N*	Percentage
Full CGISS Cut at 100	10	13.3%
Awareness of Clinical Bias Cut at 40	0	0.0%
Knowledge and Skills Cut at 24	49	65.3%
Awareness of Barriers to Practice Cut at 20	69	92.0%
Professional Exposure Cut at 16	40	53.3%

Results also indicate that 100% of respondents met the clinical cutoff for the **Awareness of Bias** subscale, 65.3% met the cutoff for the **Knowledge/Skills** subscale, 92% met the cutoff for **Awareness of Barriers**, and 53.3% met the cutoff for the **Professional Exposure** subscale. The correlations between each of the subscales are shown in Figure 4.

Figure 4: Correlations Among Subscales

		Full Scale Score CCGIS	Clinical Bias toward Trans	Knowledge and Skills	Awareness of Barriers to Practice	Professional Exposure to Transgender Clients	Emphasis on Assigned	Affirmation of Gender Expression	Emphasis on Binary Gender Expression

			People				Sex Subscale	in All Forms	
Full Scale Score CCGIS	Pearson Correlation	1	-.105	.833**	.526**	.896**	.102	.129	-.065
	Sig. (2-tailed)		.369	<.001	<.001	<.001	.383	.271	.577
	N	75	75	75	75	75	75	75	75
Clinical Bias toward Transgender People	Pearson Correlation	-.105	1	-.270*	-.398**	-.192	.494**	-.485**	.170
	Sig. (2-tailed)	.369		.019	<.001	.098	<.001	<.001	.146
	N	75	75	75	75	75	75	75	75
Knowledge and Skills	Pearson Correlation	.833**	-.270*	1	.203	.746**	-.040	.211	-.025
	Sig. (2-tailed)	<.001	.019		.081	<.001	.736	.069	.834
	N	75	75	75	75	75	75	75	75
Awareness of Barriers to Practice	Pearson Correlation	.526**	-.398**	.203	1	.299**	-.168	.369**	-.128
	Sig. (2-tailed)	<.001	<.001	.081		.009	.150	.001	.273
	N	75	75	75	75	75	75	75	75
Professional Exposure to Transgender Clients	Pearson Correlation	.896**	-.192	.746**	.299**	1	.111	.033	-.102
	Sig. (2-tailed)	<.001	.098	<.001	.009		.345	.777	.383
	N	75	75	75	75	75	75	75	75
Emphasis on Assigned Sex Subscale	Pearson Correlation	.102	.494**	-.040	-.168	.111	1	-.422**	.331**
	Sig. (2-tailed)	.383	<.001	.736	.150	.345		<.001	.004
	N	75	75	75	75	75	75	75	75
Affirmation of Gender Expression in All Forms	Pearson Correlation	.129	-.485**	.211	.369**	.033	-.422**	1	-.235*
	Sig. (2-tailed)	.271	<.001	.069	.001	.777	<.001		.042
	N	75	75	75	75	75	75	75	75
Emphasis on Binary Gender Expression	Pearson Correlation	-.065	.170	-.025	-.128	-.102	.331**	-.235*	1
	Sig. (2-tailed)	.577	.146	.834	.273	.383	.004	.042	
	N	75	75	75	75	75	75	75	75

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Correlations Between Attitudes and Competence

When the measures were analyzed with a Pearson correlation of the subscales between themselves, The **Counselor Competence Gender Identity Scale (CGISS)** subscales, the **Professional Exposure to Transgender Clients** subscale correlates weakly with **the Awareness of Barriers to Practice** subscale (.299) and strongly with **the Gaining Knowledge/Skills to Counsel Transgender Clients** subscale (.746). The **Clinical Bias toward Transgender People** subscale is also moderately inversely correlated with the Professional Exposure to Transgender subscale (-.398). Low levels of inverse correlation were also present between the **Clinical Bias toward Transgender People** and **Gaining Knowledge/Skills to Counsel Transgender Clients** subscales (-.270).

There was a correlation between the **Awareness of Barriers to Practice** subscale of the **CCGIS** and the **Affirmation of Gender Expression in All Forms** subscale of the **GEATC** (.369). This correlation suggests that an acceptance of gender diversity correlates with the clinician's understanding of their power in their relationship with these clients. The inverse correlation between the **Clinical Bias Toward Transgender People** and the **Affirmation of Gender Expression in All Forms** subscale (-.485) on the GEATC suggests that acceptance of gender diversity is correlated with decreases in their level of bias toward TGD clients.

Associations Between Demographic Categories and Subscales

Independent t-tests were used to determine if there were any differences in the total scale score of the **CGISS**, its subscales, and the **GEATC** based on the demographics of clinicians. Demographic variables with more than two categories of responses (such as practice license) were dichotomized to ensure adequate cell size. The variables recoded were age, years in practice, practice license, practice setting, sexual orientation, gender identity, race, whether the

clinician held Christian beliefs, whether the clinician held any religious beliefs or identified as non-religious, and if the clinician had worked with transgender clients. For age, the cut point was forty-five years old. For the years in practice variable, the cut point was ten years. These cut points were chosen because they were natural cut points between clusters of scores. The religion questions, practice questions, sexual orientation, gender binary, race, and transgender client questions were all dichotomized. These demographics were chosen based on prior empirical literature on clinician attitudes toward transgender people. The t-tests that yielded significant results are shown in Table 5.

Figure 5: Demographic Associations with Measures

Demographic	Category	N	Mean	Std. Deviation	t-value	p-value	Degrees of Freedom
Age							
Affirmation of Gender Expression in All Forms	Over 45	36	24.53	4.39	-2.74*	.004	71
	Under 45	37	27.11	3.63			
Awareness of Barriers to Practice	Over 45	36	25.94	5.63	-3.57*	<.001	71
	Under 45	37	30.14	4.33			
Years in Practice							
Clinical Bias toward Transgender People	Less than 10	37	10.95	2.01	-2.00*	.02	67
	10 or more	32	12.72	4.93			
Christian							
Emphasis on Assigned Sex Subscale	Non-Christian	42	10.93	4.138	-2.24*	.01	71
	Christian	31	13.35	5.09			
Affirmation of Gender Expression in All Forms	Non-Christian	42	27.05	3.26	3.20*	.001	71
	Christian	31	24.03	4.78			
Clinical Bias toward Transgender People	Non-Christian	42	10.45	1.45	-4.04*	<.001	71
	Christian	31	23.65	4.84			
Knowledge and Skills	Non-Christian	42	28.98	5.06	3.48*	<.001	71
	Christian	31	23.77	7.70			
Awareness of Barriers to Practice	Non-Christian	42	29.38	4.79	2.57*	.006	71
	Christian	31	26.10	6.12			
Full Scale Score CCGIS	Non-Christian	42	86.45	12.61	2.33*	.01	71

	Christian	31	78.65	16.02			
Religious Preference							
Emphasis on Assigned Sex Subscale	No religious preference	30	10.30	3.48	-2.61*	.005	71
	Religious preference	43	13.12	5.13			
Affirmation of Gender Expression in All Forms	No religious preference	30	27.10	2.96	2.32*	.01	71
	Religious preference	43	24.84	4.73			
Clinical Bias toward Transgender People	No religious preference	42	10.45	1.45	-3.66*	<.001	71
	Religious preference	31	13.65	4.84			
Knowledge and Skills	No religious preference	30	29.80	4.53	3.42*	<.001	71
	Religious preference	43	24.65	7.32			
Practice License							
Full Scale Score CCGIS	LCSW	27	88.15	10.70	2.27*	.013	73
	Other	48	80.42	15.72			
Professional Exposure to Transgender Clients	LCSW	27	18.89	6.08	2.24*	.01	73
	Other	48	15.21	7.22			
Sexual Orientation							
Full Scale Score CCGIS	Heterosexual	50	79.96	13.58	-3.14*	.001	69
	LGBQ	21	91.24	14.28			
Clinical Bias toward Transgender People	Heterosexual	50	12.44	4.18	2.08*	.02	69
	LGBQ	21	10.48	1.63			
Knowledge/Skills	Heterosexual	50	25.42	7.02	-2.58*	.006	69
	LGBQ	21	29.86	5.48			
Awareness of Barriers to Practice	Heterosexual	50	26.58	5.628	-4.01*	<.001	69
	LGBQ	21	31.95	3.17			
Gender Identity							
Full Scale Score CCGIS	Cisgender	66	81.33	13.76	-3.35*	<.001	70
	Transgender or Gender Diverse	6	100.50	7.77			
Knowledge/Skills	Cisgender	66	25.85	6.54	-3.34*	<.001	70
	Transgender or Gender Diverse	6	34.83	1.472			
Professional Exposure to Transgender Clients	Cisgender	66	15.80	6.82	-2.80*	.003	70

	Transgender or Gender Diverse	6	23.83	5.27			

Results of GEATTC Subscales

On the **Assigned Sex Expression** subscale, the participants who identified as Christian (*M*= 13.35, *SD*= 5.09) demonstrated average scores significantly higher (*t*= -2.24, *p*= .01, df= 71) than the participants who identified as non-Christian subscale (*M*= 10.93, *SD*= 4.18). A similar difference was found (*t*= -2.61 *p*= .005, df= 71) when comparing participants who identify with any of the traditional religions (*M*= 13.12, *SD*= 5.13) compared to non-religious people (*M*= 10.30, *SD*= 3.48).

On the **Affirmation of Gender Expression in All Forms**, the thirty-one Christian participants (*M*= 24.03, *SD*= 4.78) again demonstrated average scores significantly lower (*t*= 3.21 *p*= .001, df=71) than non-Christian participants (*M*= 27.05, *SD*= 3.26) on this subscale. The same pattern can also again be noticed (*t*= 2.32 *p*= .012, df=71) when comparing traditionally religious participants who identify with any of the traditional religions (*M*= 24.84, *SD*= 4.73) compared to non-religious (*M*= 27.10, *SD*= 2.964). This subscale also showed a significant difference for age, for age (*t*=.-2.74, *p*=.004, df= 71), with those clinicians older than forty-five (*M*= 24.54, *SD*=4.38) scoring lower than those participants younger than forty-five (M= 27.11, *SD*= 3.63

On the **Generalized Emphasis on Gender Binary Expression**, the participants who identified as Christian (*M*= 13.65, *SD*= 4.84) again had a statistically significantly lower mean score (*t*=-4.04, *p*= <.001, df= 71) than participants who identified as non-Christian (*M*= 10.45, *SD*= 1.45). This finding was again similar (*t*= -3.66 *p*= <.001, df= 71) to the mean score of all practitioners of traditional religions (*M*=13.02, *SD*= 4.41) compared to non-religious people (*M*= 10.07, *SD*= .25).

Results of CCGIS Full Scale Score and Subscales

On the full **CCGIS**, sixty-five clinicians scored below the cut score for effective therapy of one hundred (*M*=79.97, *SD*=12.78). Only ten clinicians scored above the cut score (*M*= 104.20, *SD*=2.86), with strong variation between the two average scores (*t*= -5.39 *p*=<.001, df=). The Christian clinicians (*M*= 78.65, *SD*=16.02) scored significantly lower (*t*= 2.33 *p*=.011, df= 71) than the non-Christian clinicians (*M*= 86.45, *SD*= 12.60). The LCSWs showed an overall higher level(*t*= 2.27, *p*= .013, df= 73) of competence (*M*= 88.15, *SD*= 10.70) compared to the other clinicians (*M*=80.42, *SD*=15.72) (*t*= 2.27, *p*= .013). The heterosexual clinicians (*M*= 79.96, *SD*= 13.58) demonstrated much less overall competency (*t*= -3.14, *p*= .001, df= 69) as well, compared to the LGBQ clinicians (*M*= 91.23, *SD*= 14.28) as did (*t*=-3.35, *p*= <.001, df= 70) the cisgender clinicians (*M*= 81.33, *SD*= 13.76) compared to the transgender or gender diverse clinicians (*M*= 100.50, *SD*= 7.77), the only group with a mean overall average of more than the effective counseling cut off.

On the **Clinical Bias toward Transgender People** subscale was sexual orientation, with the heterosexual clinicians (*M*= 12.44, *SD*= 4.18) scoring moderately higher in levels of bias (*t*= 2.08, *p*= .02, df= 69) than the clinicians identifying as LGBQ (*M*= 10.48, *SD*= 1.63). Christian clinicians (*N*=31, *M*=24.03, *SD*= 4.78) reported higher levels of bias (*t*=-4.04, *p*= <.001, df= 71)than did non-Christian clinicians (*M*=10.45, *SD*=1.45). Moreover, the same was true for religious clinicians (*M*=10.45, *SD*=1.45), who showed the same elevated levels of bias (*t*= -3.66, *p*= <.001, df= 71) compared to non-religious clinicians (*M*=13.65, *SD*=4.84).

On the **Gaining Knowledge/Skills to Counsel Transgender Clients** subscale, the twenty-six clinicians who scored lower than the cut at twenty-four (*M*= 19.00, *SD*= 4.06) and forty-nine (*M*=31.00, *SD*=3.32) scored, on average, significantly higher (*t*= 13.78, *p*= <.001,

df=). The Christian participants Christian (*M*= 23.77, SD= 7.70) again had significantly lower average scores (*t*= 3.48, *p*= <.001, df= 71) than participants who identified as non-Christian (*M*= 28.98, *SD*= 5.06). We again find a pattern of co-occurrence with overall traditional religiosity (*t*= 3.4 *p*= <.001, df=71) when we compare people of faith (*M*= 24.65, *SD*= 7.32) compared to secular people (M= 29.80 *SD*= 7.05). The heterosexual clinicians (*M*= 25.42, *SD*= 7.02) reported significantly less knowledge and skills on TGD counseling issues(*t*= -2.58, *p*= .006 df= 69) than the LGBQ clinicians (*M*= 29.86, *SD*= 5.48). The same (*t*= -3.34, *p*= <.001, df= 70) was found for the cisgender clinicians (*M*= 25.85, *SD*= 6.54) compared to the transgender and gender diverse clinicians (*M*= 34.83, *SD*=1.47).

On the **Awareness of Barriers to Transgender Practice** subscale, the clinicians that scored below the score cut of twenty had a considerable variation (*t*= -7.11 *p*= <.001, df=) in their mean scores (*M*=15.50, *SD*= 4.637) compared with those who scored higher than the cut score.

Chapter 6: Discussion & Implications

This study set out to answer four research questions. First, we sought to learn what attitudes licensed therapists in Texas hold toward transgender people seeking interventions for gender transition. Second, we asked how licensed therapists in Texas reported their level of competence regarding gender-affirming care for transgender individuals. Third, we asked if there was a correlation between self-reported ratings of therapist competence and attitudes toward TGD people. Finally, we asked whether therapists' sociodemographic characteristics were associated with their attitudes and self-reported competency toward transgender clients.

The central finding of this study is that approximately eighty-seven percent of clinicians who completed our study scored below the effective counseling threshold score on the Counselor Competence Gender Identity Scale. An additional twenty-six clinicians, or thirty percent, scored within one standard deviation below the cut score, higher than eighty-eight. The remaining thirty-seven clinicians, or fifty-eight percent, scored more than one standard deviation lower than the cut score. Thus it appears, at least for this sample, that most clinicians do not have the self-reported requisite training/experience (competence) to work with this unique client population.

In terms of the second question, overall, the resemblance between the clinical practices of this sample and conversion therapy was moderately low, as were levels of gender essentialism. Attitudes regarding the diversity of forms of gender presentation were high. Despite this, however, levels of self-awareness of bias were low. Knowledge of TGD issues was adequate in almost two-thirds of the sample. The entire sample showed moderate awareness of barriers to TGD mental health. However, over half the sample had inadequate professional exposure to TGD clients and training on their issues.

The subscales were analyzed using Pearson Correlation to answer the third research question. Before describing the findings, it is worth remembering what each subscale measured. On the GEATC, the **Emphasis on Assigned Sex Expression** subscale captures the extent to which the clinician's approach to counseling transgender clients resembles conversion therapy. The **Affirmation of Gender Expression in All Forms** subscale captures whether the clinician's attitudes affirm a diversity of forms of gender expression for their transgender clients. The **Generalized Emphasis on Gender Binary Expression** subscale captures whether the practitioner perceives that they should treat gender dysphoria by encouraging the adoption of traditional male or female appearance, mannerisms, language, and activities for their TGD clients (Santos, Goldstein, & Tracy, 2017). Consistent with what has been found in previous literature, clinicians hold moderately positive attitudes towards transgender and gender diverse people, despite lacking adequate knowledge to work with them effectively.

Correlations were found between the **Emphasis on Assigned Sex Expression** and **Generalized Emphasis on Gender Binary Expression** subscales, suggesting that accepting attitudes toward TGD people may correlate with an increased acceptance of gender diversity as well. A correlation was found between the **Affirmation of Gender Expression in All Forms** and **Generalized Emphasis on Gender Binary Expression** subscales, suggesting a correlation between gender essentialism and acceptance of gender diversity. We can gather from this that the level of gender affirmation in a clinician's practice could be moderately correlated with their level of gender essentialism.

The **Professional Exposure to Transgender Clients** subscale was also found to correlate with the **Awareness of Barriers to Practice** subscale and the **Gaining Knowledge/Skills to Counsel Transgender Clients** subscale. The **Clinical Bias toward**

Transgender People subscale was also found to correlate with the **Professional Exposure to Transgender** subscale. These results suggest that experience with transgender and gender diverse clients is correlated with the clinician's understanding of their power concerning their transgender clients. It also suggests that this exposure is correlated with a propensity to educate oneself on TGD issues and decrease clinical bias. A correlation was also present between the **Clinical Bias toward Transgender People and Gaining Knowledge/Skills to Counsel Transgender Clients** subscales, which could suggest that a clinician educating themselves on transgender issues is correlated with decreases in their level of bias towards these clients.

When the two scales were correlated, the **Awareness of Barriers to Practice** subscale was found to correlate with the **Affirmation of Gender Expression in All Forms** subscale of the GEATC. In that case, acceptance of gender diversity is correlated with the clinician's understanding of power in their relationship with these clients. **Clinical Bias Toward Transgender People** was also found to correlate with **Affirmation of Gender Expression in All Forms**, which implies that acceptance of gender diversity could correlate with decreases in their bias toward TGD clients. Additionally, the correlation between **the Clinical Bias Toward Transgender People** and the **Emphasis on Assigned Sex** subscale may also allow us to infer a connection between a higher level of gender essentialism on the part of the clinician and a higher level of bias towards transgender and gender diverse clients.

Therefore, the results of this study make it evident that despite a moderately high understanding of transgender and gender diverse issues, this sample of mental health clinicians in Texas does not have enough training or experience serving transgender clients to provide culturally competent service confidently.

Regarding research question #4, a few demographic variables are associated with self-reported competency. We found that LCSWs reported higher levels of competence than other groups of providers; and that lesbian, gay, bisexual, or queer clinicians self-reported higher levels of competence, as did transgender and gender diverse clinicians. We found that younger clinicians tend to report higher levels of competence than older clinicians and that non-religious clinicians scored higher than all religious clinicians, with Christian clinicians reporting the lowest level of competence of the three groups.

The logic behind some of this variation is obvious, LGBTQ+ clinicians share many of the same experiences as their clients and have personal and professional experiences with TGD people. They are also more likely to be tuned in to developments in this area for the same reasons. Younger clinicians report higher levels of knowledge, no doubt because of the increased social visibility of transgender individuals in the last decade. However, it is also probably because university mental health licensure programs have begun to include some mention of transgender issues in their curriculum. Christian and other religious doctrines are clear that gender is immutable, and hence resistance to concepts around transgender identity and gender diversity is to be expected.

Why do LCSWs seem more aware of TGD issues than other clinicians? There could be several reasons for the association with youth. It could be that social work education is more sociologically focused than other mental health clinicians. Alternatively, it could be that social workers tend to have more experience in social service agencies serving vulnerable populations, including transgender people. Younger clinicians reported higher levels of awareness of barriers to accessing mental health services for transgender clients and higher levels of exposure to these clients. Clinicians younger than forty-five also predicted a higher score on the full counselor

competency measure. Transgender visibility has become a significant point of contention within politics in the last ten years. Younger people are more supportive than older cohorts in recent polling, likely because of this visibility (Mitchell, 2022).

These speculations are borne out in as much as we found that LCSW licensure was correlated with both an increased awareness of barriers to accessing mental health services for transgender clients and with increased exposure to transgender clients in a professional setting. LCSW licensure also predicted a higher score on the full counselor competence measure. The results also show that LGBQ clinicians report a higher self-awareness of their biases and more knowledge and skills for counseling transgender clients. They also reported being more aware of barriers to accessing mental health services for transgender clients and having had more professional exposure to these clients. A non-heterosexual orientation also predicted a higher score on the full counselor competency measure.

Similar effects were found for transgender and gender diverse clinicians. They reported higher levels of affirmation of a diversity of forms of gender expression for their transgender clients, a higher level of knowledge and skills in this area, higher levels of awareness of barriers to accessing mental health services for transgender clients, and more exposure to TGD clients. Transgender and gender diverse clinicians were among the only groups to score higher than the effective counseling cutoff on average, meaning they are likely to be the best allies to TGD clients. However, it is interesting that despite TGD clinicians scoring the highest of any group, their mean score is still just above the adequate counseling cutoff. It may be possible that even these clinicians have some internalized transphobia that also lowered their scores.

Christian clinicians reported that their approach to counseling transgender clients bore, on average, more resemblance to conversion therapy than non-Christians' approaches did. These

clinicians were, on average, less likely to affirm a diversity of forms of gender expression for their transgender clients. They also reported lower levels of awareness of barriers to accessing mental health services for transgender clients, lower levels of knowledge and skills to counsel these clients, and less self-awareness of their own clinical bias. Identifying with Christianity was also associated with significantly lower scores on the counselor competency measure.

Religious clinicians showed the same heightened likelihood of approaching their counseling transgender clients similarly to conversion therapy as Christian clinicians but to a slightly lesser degree. In the same manner, they also showed a lower inclination to affirm a diversity of forms of gender expression for their transgender clients, a lower level of self-awareness about their bias, fewer skills, and less knowledge about counseling these clients, and a lower level of awareness of barriers to accessing mental health services for transgender clients. It again also predicted a lower score on the full counselor competency measure. However, religious people reported slightly higher levels on every variable than Christians alone.

Limitations

As with any study, there are some limitations to this research. First, the small sample size did not allow for multivariate analysis. The study also relied on self-reported data and is therefore bound by limitations associated with this data collection method. These limitations include social desirability bias, i.e., the desire to appear more affirming to others than one truly feels oneself to be since the measure was a measure of explicit bias. Another limitation was the low response rate relative to the number of clinicians receiving the email and the significant number of clinicians who completed the demographic questions but not the measures. There could be multiple reasons for this, including the length of the survey, a legitimate burden for busy clinicians, or a lack of baseline knowledge of the subject matter such that a clinician would not

consider answering the survey. It is also important to note that because the respondents were homogenous, the generalizability of the results to clinicians outside of Texas and the population of all Texas behavioral health providers is limited.

There are also two potential sampling limitations. First, only those clinicians on F.B. or in professional associations got the survey link. Second, both those clinicians who have negative attitudes towards trans people and those clinicians who know their competency in this area is low may have opted out if the survey questions made them feel uncomfortable. As mentioned in the Methods section, approximately 175 clinicians started the survey. They answered at least one of the demographic questions but not any of the study measures, indicating potential discomfort when they realized what the survey was assessing. These limitations suggest that the actual situation regarding provider competence in Texas may be worse than these results suggest, given the limitations above.

Implications for Practice

The results of this research have several important implications for behavioral health practice in general and social work practice specifically. Suppose transgender and gender diverse clients were to attempt to access mental health services in Texas. In that case, they may prefer to look for younger, non-religious, LGBTQI+ LCSWs in private practice (or some combination of these) to (presumably) achieve the best results and experience the least invalidation during therapy. Clinicians should also be willing to go outside their comfort zone with transgender and gender diverse clients and listen to these clients' narratives of their gender, even if those narratives provoke discomfort in the clinician. This exposure is critical to several other competence and bias factors mentioned here. However, this recommendation cannot be extended to clinicians who may feel that their worldview makes working with TGD clients difficult.

Suggestions for these clinicians to moderate their opinions on transgender and gender diverse individuals are included in the Implications for Education section below. In general, though, the moderately high level of supportive attitudes found for transgender and gender diverse clients suggests that many clinicians would indeed be able to deliver an adequate level of gender-affirming care despite their concerns about lack of practical experience.

Clinicians working with TGD clients should strive to develop a comprehensive understanding of gender identity and expression and spend some time reflecting on these themselves. Clinicians should also seek to create an environment where transgender clients feel safe and respected and provide respectful care for transgender people and their identities. Practices should also seek to hire transgender and gender diverse clinicians when possible. Additionally, practices that frequently work with this population might consider a mentorship program to pair experienced clinicians with transgender clients with novice clinicians so that they can provide support and guidance. If they have not done so, clinicians should educate themselves on trauma-informed practices and specific information on gender-affirming therapies to improve their outcomes with these clients.

Although social work clinicians may be familiar with the advocacy aspect of their clinical practice, clinicians from other backgrounds not as social justice-focused may be uncomfortable with the multiple advocacy efforts required to truly support TGD clients. Clinicians should be willing to advocate for TGD clients to insurance companies to cover services related to gender transition, such as hormone replacement therapy and gender-affirming surgeries. Clinicians should also work to ensure that their agency or practice complies with WPATH standards. Compliance with these standards could be incentivized by creating a network of allied social service agencies that work to provide transgender care that adheres to the WPATH standards.

WPATH could also work with accrediting agencies such as NASW or CSWE to integrate their standards more thoroughly into the training curriculum. Finally, clinicians should ensure that their practice is inclusive and create a supportive work environment for their transgender colleagues and should be willing to advocate for them as well, if necessary.

Implications for Education

Masters-level mental health programs have added more curricula relating to transgender issues over time. However, a nationwide review of the training curriculum in this area could be a potential avenue for further research (Nolan et al., 2020). This review could be supported by a study like the current one but with a more diverse nationwide sample group. This research would allow a standardized lesson plan involving evidence-based, culturally competent best practices for transgender care to be written and made available for lecturers. This education should include information on the specific challenges faced by transgender people, such as discrimination, stigma, and lack of access to healthcare. For example, graduating clinicians should be at least aware of WPATH and its recommendations and some details of the Transgender Survey. This training material should also include recommendations that transgender or gender diverse people be invited to speak in classrooms to help to create a better understanding of the unique needs of transgender people.

These results also suggest that colleges training future behavioral health providers should make additional efforts to enroll LGBTQ+ students, particularly TGD students, in their programs. This inclusion would not only increase students' exposure to transgender people while in school but also bring the lived experiences of TGD students into the classroom. Students in programs other than LMSW programs would particularly benefit from this experience. Furthermore, these training modules should be made available for clinicians already in practice

through CEU training, conferences, and workshops. Finally, training students in clinical programs in gender-neutral language would help new clinicians use respectful and affirming language of transgender people.

Transgender diversity is listed in the CSWE competencies for Social Work education, but as this study demonstrates, that alone has not been adequate. Since there are several religious universities in Texas, is there a way to build competence in faith-based providers beyond just active self-reflection? One starting point may be for these programs to include sexual orientation and gender identity in their existing non-discrimination statements. Moreover, faith-based schools may wish to remove any content referring to homosexuality as "sinful" or "prohibited" from their student, faculty, and staff codes of conduct. Removing this language would reflect a more inclusive environment that does not discriminate against certain students, faculty, or staff groups because of their sexual orientation or gender identity (SOGIE).

A supervision model may be a good fit here or a course of volunteer work for students or their faculty at an agency that focuses on serving transgender clients. Other means to promote competency in transgender issues among religious students could be to invite transgender people of faith or even transgender priests to discuss their gender and its impact on their faith with students. Another avenue would be to invite cisgender faith leaders whose outlooks on transgender rights have evolved to share their stories with students about how this change took place. Typically, Christian acceptance of transgender identities is premised on Christ's universal love rather than the Old Testament statements about the creation of man and woman.

Relatedly, Christian therapy students and professionals could engage with James Fowler's stages of faith. Specifically, they could focus on the difference between Stage Three and Four, "Synthetic-Conventional" faith and" Individuative-Reflective" faith. Synthetic-conventional faith

is based on identification with a religious institution, belief system, or authority. Challenges to one's beliefs are often ignored because they threaten one's identity. Individuative-Reflective faith is the next step in which the individual takes personal responsibility for her beliefs or feelings. Beliefs gain nuance, and open-mindedness increases (Fowler, 1981). Since examples of gender diversity might be a helpful teaching tool, it should be noted to religious clinical trainees that the Jewish Talmud outlines eight different genders, including various "androgynous" genders, providing a possible textual basis for transgender acceptance (Scheinermann, 2022). Moreover, the Council on Social Work Education (CSWE) should consider not accrediting or re-accrediting Schools of Social Work lacking SOGIE inclusive non-discrimination policies. This exclusion should also extend to those who prohibit non-heterosexual activity, non-cisgender gender identity, and gender expression within their Codes of Conduct.

Implications for Policy

The current political atmosphere in the state of Texas creates some specific policy and social challenges regarding transgender acceptance. Thus any changes to policy regarding transgender and gender diverse people will have to result from bottom-up advocacy. This advocacy is already pursued by anti-trans groups and is the cause for the increase in the expression of anti-transgender attitudes in public discourse in the state in the last few years. Several organizations are already pursuing this issue in the state, like the Trans Family Network, The Trans Formations Project, The Trans Pride Initiative, the Resource Center in Dallas, and many others. So it would be well-advised for transgender allies of whatever form to do the same.

Social services in the state are also chronically underfunded. This lack of funding makes it difficult to decrease barriers to access to mental health services overall, not just for TGD people. Part of social work ethics requires that the social worker do advocacy work and whatever

form of additional practice they concentrate on in their career. As such, it is impingent on us as social workers to advocate for decreased barriers to access as citizens in our communities. Clinicians should also actively push back against any future state legislation that criminalizes transgender identity and refuse to comply with its mandates in keeping with the advice of the NASW-TX.

Similarly, clinicians should work in their own lives to push back against stigma of various kinds, including stigma against transgender and gender diverse people. Finally, community mutual aid has been a significant component of transgender life in the past, as with many vulnerable groups. As such, social workers should be open to leveraging these preexisting networks to help their members improve their well-being and life outcomes on their terms.

Implications for Research

This line of research is only in its infancy. The study could be repeated using only the CCGIS, which might encourage increased participation since it would be shorter and because the GEATC did not turn out to be as explanatory as the CCGIS due to a lack of cut scores and scoring instructions. Similar research on clinician competence in transgender mental health could be done nationwide and internationally. Additionally, measures that determine levels of implicit bias could be used rather than the traditional self-reports used in this study to control for the limitations of the data collection method.

The current political climate in the United States undoubtedly also has a chilling effect on research on transgender issues. This chilling effect is particularly salient in Texas and other similar states that have explicitly anti-transgender ordinances. Transgender children and their families have been most affected, and many have begun to move away from the state. Another instance of this chilling effect is the drop-off found in this study between the number of people

willing to answer the demographic questions but not the measures. These difficulties bear on the difficulty that this study found in measuring these attitudes in the first place.

As noted in the limitations section, clinicians who have negative attitudes towards trans people and those clinicians who know their competency in this area is low might not have felt comfortable answering the particular questions on the measures. Even moderately trans-affirming clinicians may have rated themselves more highly on the measures than they honestly assessed themselves as being, for appearances or to assuage their conscience. However, the tension surrounding this issue in current events also likely accelerated the social desirability bias one way or the other. Despite the anonymous nature of the survey, clinician social self-perception could lead to wanting to be seen scoring as best as one could or not taking it at all, depending on one's attitude.

Other suggestions for future research in this same line could be, for instance, an examination of the impact of training on mental health clinicians' attitudes and beliefs about transgender mental health. Other studies, especially apt in the current political climate in Texas, could analyze the effect of stigma and discrimination on mental health clinicians' willingness to provide services related to transgender mental health or the role of organizational culture in mental health clinicians' attitudes.

References

American Psychiatric Association. (1980). Diagnostic and Statistical Manual of Mental Disorders (3rd ed.).

American Psychological Association. (2010). Ethical principles of psychologists and code of conduct. Retrieved from http://www.apa.org/ethics/code/

American Psychiatric Association. (2013). Gender Dysphoria. In Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Arayasirikul S. & Wilson E.C. (2019). Spilling the T on trans-misogyny and microaggressions: An intersectional oppression and social process among trans women, Journal of Homosexuality, 66:10, 1415-1438, DOI: 10.1080/00918369.2018.1542203

Ashley, F. (2022). Interrogating Gender-Exploratory Therapy. Perspectives on Psychological Science, 0(0). https://doi.org/10.1177/17456916221102325

Bailey, J.M., Hsu, K.J. (2022). How Autogynephilic Are Natal Females? Archives of Sexual Behavior. https://doi.org/10.1007/s10508-022-02359-8

Bakker, I. (2007). Social reproduction and the constitution of a gendered political economy, New Political Economy, 12:4, 541–556, DOI: 10.1080/13563460701661561

Bennett, J. L., & Douglass, K. E. (2013, April 18). Growing pains: An Eriksonian view of the arc of presenting concerns in an LGBT community mental health center - clinical social work journal. Clinical Social Work Journal. Retrieved March 3, 2022, from https://link.springer.com/article/10.1007/s10615-013-0442-5

Bidell, M. P. (2017). The Lesbian, gay, bisexual, and transgender development of clinical skills scale (LGBT-DOCSS): Establishing a new interdisciplinary self-assessment for health providers. Journal of Homosexuality, 64:10, 1432–1460, DOI: 10.1080/00918369.2017.1321389

Blyth, C., McRae, P. (2018). "Death by a thousand paper cuts": Transphobia, symbolic violence, and conservative Christian discourse. In: Blyth, C., Colgan, E., Edwards, K. (eds) Rape Culture, Gender Violence, and Religion. Religion and Radicalism. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-319-72224-5_7

Budge, S. L. (2015). Psychotherapists as gatekeepers: An evidence-based case study highlighting the role and process of letter writing for transgender clients. Psychotherapy, 52(3), 287–297. https://doi.org/10.1037/pst0000034

Burns, K. (2019, September 5). The rise of anti-trans "radical" feminists, explained. Vox. Retrieved November 10, 2022, from https://www.vox.com/identities/2019/9/5/20840101/terfs-radical-feminists-gender-critical

Cacioppo, J. T., Berntson, G. G., & Decety, J. (2010). Social neuroscience and its relationship to social psychology. Social cognition, 28(6), 675–685. https://doi.org/10.1521/soco.2010.28.6.675

Cavanaugh, T., Hopwood, R., & Lambert, C. (2016, November 1). Informed consent in the medical care of transgender and gender-nonconforming patients. Journal of Ethics | American Medical Association. Retrieved September 28, 2022, from https://journalofethics.ama-assn.org/article/informed-consent-medical-care-transgender-and-gender-nonconforming-patients/2016-11

Compton, E. & Morgan, G. (2022). The experiences of psychological therapy amongst people who identify as transgender or gender non-conforming: A systematic review of qualitative research, Journal of Feminist Family Therapy, DOI: 10.1080/08952833.2022.2068843

Coolhart, D., & Shipman, D. L. (2017). Working toward family attunement: Family therapy with transgender and gender-nonconforming children and adolescents. The psychiatric clinics of North America, 40(1), 113–125. https://doi.org/10.1016/j.psc.2016.10.002

Coutin, A., Wright, S., Li, C., & Fung, R. (2018). Missed opportunities: are residents prepared to care for transgender patients? A study of family medicine, psychiatry, endocrinology, and urology residents. Canadian medical education journal, 9(3), e41–e55.

Federici, S. (2004). Caliban and the witch. New York: Autonomedia.

Fitzsimmons, T. (2020, June 19). GOP senator quotes J.K. Rowling while blocking vote on LGBTQ bill. NBCNews.com. Retrieved November 10, 2022, from https://www.nbcnews.com/feature/nbc-out/gop-senator-quotes-j-k-rowling-while-blocking-vote-lgbtq-n1231569

Fraser, B., Pierse, N., Chisholm, E., & Cook, H. (2019, July 26). LGBTIQ+ homelessness: A review of the literature. Retrieved November 10, 2020, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6695950/

Fowler J. W. (1981). Stages of faith: the psychology of human development and the quest for meaning (1st ed.). Harper & Row.

Grant, J. M., Mottet, L.A., Tanis, K., Harrison, J., Herman, J.L., and Keisling, M. Injustice at every turn: A report of the national transgender discrimination survey. Washington: National Center for Transgender Equality and National Gay and Lesbian Task Force, 2011.

GLAAD Accountability Project. (2022, May 31). Abigail Shrier. GLAAD. Retrieved November 10, 2022, from https://www.glaad.org/gap/abigail-shrier

Gill-Peterson, J. (2018). Histories of the transgender child. University of Minnesota Press. https://doi.org/10.5749/j.ctv75d87g

Glossary of terms. Human Rights Campaign. (2022). Retrieved July 3, 2022, from https://www.hrc.org/resources/glossary-of-terms

Griffiths, K. D. (2021). Queer workerism against work: Strategizing transgender laborers, &. Social reproduction & class formation. in Gleeson, J. J., O'Rourke, E., Rosenberg, J. (Eds.). Transgender Marxism. p. 133–146. Pluto Press.

Halberstam, J. (1998). Female masculinity. Durham: Duke University Press.

Herman, J.L., Flores, A.R., O'Neill, K.K. (2022). How many adults and youth identify as transgender in the United States? The Williams Institute, UCLA School of Law

Irwig M. S. (2016). Transgender care by endocrinologists in the United States. Endocrine practice: official journal of the American College of Endocrinology and the American Association of Clinical Endocrinologists, 22(7), 832–836. https://doi.org/10.4158/EP151185.OR

James, S. E., Herman, J.L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). Report of the 2015 U.S. transgender survey. Washington, DC: National Center for Transgender Equality

Laslett, B., & Brenner, J. (1989). Gender and social reproduction: historical perspectives. Annual review of sociology, pp. 15, 381–404. https://doi.org/10.1146/annurev.so.15.080189.002121

Lawrence, A. A. (2017). Autogynephilia and the typology of male-to-female transsexualism: Concepts and controversies. European Psychologist, 22(1), 39–54. https://doi.org/10.1027/1016-9040/a000276

MacKinnon, K. R., Ashley, F., Kia, H., Lam, J. S. H., Krakowsky, Y., & Ross, L. E. (2021, October 11). Preventing transition "regret": An institutional ethnography of gender-affirming medical care assessment practices in Canada. Social Science & Medicine. Retrieved July 3, 2022, from https://www.sciencedirect.com/science/article/pii/S0277953621008091

Mancini, E. (2010). Magnus Hirschfeld and the quest for sexual freedom: A history of the first international sexual freedom movement. United Kingdom: Palgrave Macmillan.

Makwana, A.P., Dhont, K., De keersmaecker, J. et al. (2018). The motivated cognitive basis of transphobia: The roles of right-wing ideologies and gender role beliefs. Sex Roles 79, 206–217 https://doi.org/10.1007/s11199-017-0860-x

Markman, E.R. (2011). Gender identity disorder, the gender binary, and transgender oppression: Implications for ethical, social work, Smith College Studies in Social Work, 81:4, 314-327, DOI: 10.1080/00377317.2011.616839

Meyer I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. Psychological Bulletin, 129(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Mitchell, C. (2021). TERF wars: feminism and the fight for transgender futures, Community Development Journal, https://doi.org/10.1093/cdj/bsab016

Mitchell, T. (2022, June 28). Americans' complex views on gender identity and transgender issues. Pew Research Center's Social & Demographic Trends Project. Retrieved December 15, 2022, from https://www.pewresearch.org/social-trends/2022/06/28/americans-complex-views-on-gender-identity-and-transgender-issues/

Morton, M. H., Samuels, G. M., Dworsky, A., & Patel, S. (2018). Missed opportunities: LGBTQ youth homelessness in America. Chicago, IL: Chapin Hall at the University of Chicago.

Nathanson, Donald L. (1992). Shame and Pride: Affect, Sex, and the Birth of the Self, New York: Norton,

Nguyen, H.B., Chavez, A.M., Lipner, E. et al. (2018). Gender-affirming hormone use in transgender individuals: Impact on behavioral health and cognition. Current Psychiatry Reports 20, 110 https://doi.org/10.1007/s11920-018-0973-0

Nolan, I. T., Blasdel, G., Dubin, S. N., Goetz, T. G., Greene, R. E., & Morrison, S. D. (2020). Current State of Transgender Medical Education in the United States and Canada: Update to a Scoping Review. Journal of Medical Education and Curricular Development, 7. https://doi.org/10.1177/2382120520934813

Paradiso, C., Arca-Contreras, K., Brillhart, S. J., Macchiarola, J., & Curcio, D. L. (2022). Integration of transgender health: A multi-modal approach. Teaching and Learning in Nursing. Retrieved October 12, 2022, from https://doi.org/10.1016/j.teln.2022.06.001

Polk, A. (2020, February 20). Improving equity in shelters for Texas' transgender youth. TNOYS. Retrieved July 3, 2022, from https://tnoys.org/improving-equity-in-shelters-for-texas-transgender-youth/

Raymond, J. G. (1979). The transsexual empire: The making of the she-male. Boston: Beacon Press.

Richmond, K. A., Burnes, T., & Carroll, K. (2012). Lost in trans-lation: Interpreting systems of trauma for transgender clients. Traumatology, 18(1), 45–57. https://doi.org/10.1177/1534765610396726

Reisner, S. L., White Hughto, J. M., Gamarel, K. E., Keuroghlian, A. S., Mizock, L., & Pachankis, J. E. (2016). Discriminatory experiences associated with posttraumatic stress disorder symptoms among transgender adults. Journal of Counseling Psychology, 63(5), 509–519. https://doi.org/10.1037/cou0000143

Santos, C. E., Goldstein, A. L., & Tracey, T. J. G. (2017). Development and evaluation of the gender expression attitudes towards transgender clients scale. The Counseling Psychologist, 45(3), 353–386. https://doi.org/10.1177/0011000017702966

Serano, J. (2007). Whipping girl: A transsexual woman on sexism and the scapegoating of femininity. Berkeley, CA: Seal Press

Serano, J. (2020). Autogynephilia: A scientific review, feminist analysis, and alternative 'embodiment fantasies' model. The Sociological Review, 68(4), 763–778. https://doi.org/10.1177/0038026120934690

Scheinerman, R. (2022, May 3). The eight genders in the Talmud. My Jewish Learning. Retrieved December 11, 2022, from https://www.myjewishlearning.com/article/the-eight-genders-in-the-talmud/

Simons, J. D., Bahr, M. W., & Ramdas, S. M. (2022). Counselor competence gender identity scale: Measuring bias, knowledge, and skills among school counselors. Professional School Counseling, 26(1). https://doi.org/10.1177/2156759X221110790

Singh, A.A. & Burnes, T.R. (2010). Shifting the counselor role from gatekeeping to advocacy: Ten strategies for using the competencies for counseling with transgender clients for individual and Social Change. Journal of LGBT Issues in Counseling, 4:3-4, 241-255, DOI: 10.1080/15538605.2010.525455

Sobey, R. (2022, August 31). Boston Children's Hospital is target of bomb threat after 'false information' spreads about transgender care. Boston Herald. Retrieved October 3, 2022, from https://www.bostonherald.com/2022/08/31/boston-childrens-hospital-is-target-of-bomb-threat-after-false-information-spreads-about-transgender-care/

Steinkeller, P. (1992). Third-millennium legal and administrative texts in the Iraq Museum, Baghdad.

Tomczyk, S., Schmidt, S., Muehlan, H. et al. A Prospective study on structural and attitudinal barriers to professional help-seeking for currently untreated mental health problems in the community.

Journal of Behavioral Health Service Resources 47, 54–69 (2020). https://doi.org/10.1007/s11414-019-09662-8

Tordoff, D. M., Wanta, J. W., & Collins, A. (2022, February 25). Mental health outcomes in transgender and nonbinary youths receiving gender-affirming care. JAMA Network Open. Retrieved March 5, 2022, from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2789423

Torrey, E.F., Kennard A.D., Eslinger, D., Lamb, R., Pavle, J. (2010). More mentally ill persons are in jails and prisons than hospitals: A survey of the states. Treatment Advocacy Center. Retrieved from: https://sanmateo.networkofcare.org/library/final_jails_v_hospitals_study1.pdf

Trans Health Project. (2022). Medical Organization Statements on transgender health care. Retrieved May 3, 2022, from https://transhealthproject.org/resources/medical-organization-statements/

Trujillo, M. A., Perrin, P. B., Sutter, M., Tabaac, A., & Benotsch, E. G. (2017). The buffering role of social support on the associations among discrimination, mental health, and suicidality in a transgender sample. The international journal of transgenderism, 18(1), 39–52. https://doi.org/10.1080/15532739.2016.1247405

Turban JL, King D, Kobe J, Reisner SL, Keuroghlian AS (2022). Access to gender-affirming hormones during adolescence and mental health outcomes among transgender adults. PLoS ONE 17(1): e0261039. https://doi.org/10.1371/journal.pone.0261039

Verbeek, W., Baici, W., MacKinnon, K. R., Zaheer, J., & Lam, J. S. H. (2022). “Mental Readiness” and Gatekeeping in Trans Healthcare. The Canadian Journal of Psychiatry. https://doi.org/10.1177/07067437221102725

Whitman, C. N. & Han, H. (2017). Clinician competencies: Strengths and limitations for work with transgender and gender non-conforming (TGNC) clients, International Journal of Transgenderism, 18:2, 154–171, DOI: 10.1080/15532739.2016.1249818

Warriner, K., Nagoshi, C. T. & Nagoshi, J. L. (2013). Correlates of homophobia, transphobia, and internalized homophobia in gay or lesbian and heterosexual samples. Journal of Homosexuality, 60:9, 1297–1314, DOI: 10.1080/00918369.2013.806177

Wiegand, A. (2021). Barred from transition: The gatekeeping of gender-affirming care during the Gender Clinic Era. Intersect: The Stanford Journal of Science, Technology, and Society. Retrieved May 3, 2022, from https://ojs.stanford.edu/ojs/index.php/intersect/article/view/2056

White, B. P., & Fontenot, H. B. (2019). Transgender and non-conforming persons' mental healthcare experiences: An integrative review. Archives of psychiatric nursing, 33(2), 203–210. https://doi.org/10.1016/j.apnu.2019.01.005

Wong, J. (1999). The anti-essentialism v. essentialism debate in feminist legal theory: The debate and beyond, 5 Wm. & Mary J. Women & L. 273 https://scholarship.law.wm.edu/wmjowl/vol5/iss2/2

World Professional Association for Transgender Health. (2012). Standards of Care for the Health of Transsexual, Transgender, and Gender Nonconforming People [7th Version]. https://www.wpath.org/publications/soc

World Professional Association for Transgender Health. (2022). Standards of care for the health of transsexual, transgender, and gender non-conforming people [8th Version]. https://www.wpath.org/publications/soc

Worthen, M.G.F. (2022). This is my TERF! Lesbian feminists and the stigmatization of trans women. Sexuality & Culture https://doi.org/10.1007/s12119-022-09970-w

Understanding transitions. TransFamilies. (2022). Retrieved July 3, 2022, from https://transfamilies.org/understanding-transitions/#1605463554910-ca4ba775-dfdf

United Nations Human Rights Council. (2020). Practices of so-called “conversion therapy.” https://documents-dds-ny.un.org/doc/UNDOC/GEN/G20/108/68/PDF/G2010868.pdf?OpenElement

Appendix A- Copy of the Measures

CCGIS

Self-Awareness of Clinical Bias Subscale (CCGIS-CB)

1. Personally, I think being transgender is a mental disorder or a sin and can be treated through counseling or spiritual help.
2. I believe that transgender couples don't need special rights (domestic partner benefits, or the right to marry) because that would undermine normal and traditional family values.
3. The lifestyle of a transgender client is unnatural or immoral.
4. When it comes to being transgender, I agree with the statement: "You should love the sinner but hate or condemn the sin."
5. I think that my clients should accept some degree of conformity to traditional gender identities.
6. I believe that all transgender clients must be discreet about their gender identity or expression around children.
7. It would be best if my clients viewed a non-transgender lifestyle as ideal.
8. I believe that transgender clients will benefit most from counseling with a non-transgender counselor who endorses conventional values and norms.
9. It's obvious that a relationship involving a transgender person is not as strong or as committed as one involving a non-transgender person.
10. I believe that being highly discreet about their gender identity is a trait that transgender clients should work towards.

Gaining Knowledge/Skills to Counsel Transgender Clients Subscale (CCGIS-KS)

1. I have received adequate clinical training and supervision to counsel transgender clients.
2. At this point in my professional development, I feel competent, skilled, and qualified to counsel transgender clients.
3. I feel competent to assess the mental health needs of a person who is transgender in a therapeutic setting.

4. I check up on my transgender counseling skills by monitoring my functioning/competency via consultation, supervision, and continuing education.
5. I have been to in-services, conference sessions, or workshops, which focused on transgender issues in counseling.
6. Currently, I do not have the skills or training to do a case presentation or consultation if my client were transgender.

Awareness of Barriers to Transgender Practice Subscale (CCGIS-AB)

1. I am aware that counselors frequently impose their values concerning gender identity or expression upon transgender clients.
2. Prejudicial concepts and transphobia have permeated the mental health professionals.
3. I am aware of institutional barriers that may inhibit transgender people from using mental health services.
4. I am aware some research indicates that transgender clients are more likely to be diagnosed with mental illnesses than are non-transgender clients.
5. There are different psychological/social issues impacting transgender men versus transgender women.

Professional Exposure to Transgender Clients Subscale (CCGIS-PE)

1. I have experience counseling bisexual transgender (male or female) clients.
2. I have experience counseling male-to-female transgender couples.
3. I have experience counseling female-to-male transgender clients.
4. I have experience counseling transgender couples.

GEATC

Factor I – Emphasis on Assigned Sex Expression

1. Transgender clients should practice sitting the proper way for their assigned sex.
2. I think it is critical for all transgender clients to participate in activities that are traditional for their assigned sex.
3. Transgender clients should practice walking the proper way for their assigned sex.

4. Transgender clients should always use pronouns associated with their assigned sex.

5. I should make sure that transgender clients emphasize an appearance that's consistent with their assigned sex.†

6. Transgender clients should always speak in a way that's consistent with their assigned sex.†

7. If a transgender client is undecided about transitioning to a different gender, I should encourage the client to remain in their assigned sex.**

8. Transgender clients should talk to religious/spiritual leaders in order to identify with their assigned sex.**

9. Transgender clients should avoid identifying with members of an opposite sex.**

Factor II – Affirmation of Gender Expression in All Forms

1. Some transgender clients benefit from choosing gender neutral pronouns.

2. Some transgender clients benefit from not conforming to a male or female gender identity.**

3. I think transgender clients should appear according to their own preferences (masculine, feminine, etc.), regardless of assigned sex or affirmed gender.†

4. I should ensure that transgender clients speak according to their own preferences (masculine, feminine, etc.), regardless of their assigned sex or affirmed gender.†

5. I should ensure that transgender clients walk according to their own preferences (masculine, feminine, etc.), regardless of their assigned sex or affirmed gender.

6. If a transgender client is undecided about transitioning to a different gender, I should encourage the client to take some more time to consider the options.**

Factor III – Generalized Emphasis on Gender Binary Expression

1. All transgender clients should choose a male or female pronoun that is consistent with their affirmed gender.**

2. All transgender clients should participate in activities that are traditional for their affirmed gender

3. I think it is critical for all transgender clients to sit like members of their affirmed gender.
4. I think it is critical for all transgender clients to walk like members of their affirmed gender.
5. I think it is critical for all transgender clients to emphasize an appearance consistent with their affirmed gender.†
6. I think it is critical for all transgender clients to speak in a way that's consistent with their affirmed gender.†
7. All transgender clients were born in the wrong body.**
8. If a transgender client is undecided about transitioning to a different gender, I should encourage the client to transition to his/her affirmed gender.**
9. All transgender clients should come out to their friends and family quickly.**.