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The Impact of the Therapeutic Relationship on Transgender Clients' Perceptions of their
Therapist

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Abstract

The purpose of this study was to explore the relationship between therapist practices, the therapeutic relationship and their impact on how transgender clients feel about their therapist. Previous research on therapist practices and the therapeutic relationship has looked into how these variables influence lesbian, gay, and bisexual clients' feelings about their therapist, but as of yet, the dynamic has not been analyzed for transgender clients. Given the disproportionate prevalence for severe mental health issues in the transgender community, it is urgent that barriers to adequate and meaningful therapy outcomes be identified and addressed. Seventy eight participants were recruited from social media sites, such as Discord and Twitter, and Amazon Mechanical Turk (MTurk), to answer an online survey which included a demographic questionnaire, the Working Alliance Inventory – Short Form, the Real Relationship Inventory – Client Form, the Counselor Rating Form – Short, and the Therapist Practices (Adapted). Both the working alliance and the real relationship were found to significantly predict clients' feelings about their therapists. The working alliance was found to have the strongest predictive power. The real relationship was also found to have significant predictive power. Similar to previous studies, affirming therapist practices did not add significance in predicting clients' feelings about their therapist beyond the working alliance and real relationship.

Keywords: Therapy Relationship, Working Alliance, Real Relationship, Transgender, LGBT

Introduction

The transgender community has a well-documented history of being misunderstood and pathologized in the field of psychology. It was not until 2013 that Gender Identity Disorder (GID), a diagnosis that featured criteria, such as “repeatedly stated desire to be, or insistence that he or she is, the other sex” (4th ed.; DSM-IV-TR, p. 576), was officially removed from the American Psychiatric Association’s (2013) *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; DSM-5). GID effectively pathologized the mere existence of a community and served to reinforce the harmful notion that something was fundamentally wrong with being transgender; such a diagnosis was not dissimilar from the DSM-II’s inclusion of “homosexuality” as a mental disorder (American Psychiatric Association, 1968).

Since GID’s removal, the APA has notably improved its understanding of what it means to be transgender. In place of the diagnosis of GID is *gender dysphoria*, a general descriptive term that refers to the “distress that may accompany the incongruence between one’s experienced or expressed gender and one’s assigned gender” (American Psychiatric Association, 2013, p. 451). As the DSM-5 notes, the updated term shifts the clinical focus on the dysphoria experienced, rather than the individual’s identity. However, strong opposition still remains to the inclusion of any term or diagnosis that pathologizes aspects of being transgender. Castro-Peraza et al. (2019) point out that, despite the name and criteria change, being transgender is still considered a mental illness under the diagnosis of gender dysphoria. They explain that only gender diverse people are pathologized in such a way and argue there is no clinical utility in diagnosing children with gender dysphoria, as they do not need treatment.

Not all transgender people experience this incongruence, but for those who do, it can be an agonizing phenomenon. In fact, there is a significantly increased risk for suicidal ideation,

suicide attempts, and suicide for those experiencing gender dysphoria (American Psychiatric Association, 2013). Gathering data on the prevalence of experienced gender dysphoria has been difficult, and the data we do have are understood to be “modest underestimates” (American Psychiatric Association, 2013, p. 454).

General Prevalence Rates for Mental Health issues in Transgender population

Until very recently, there has existed a dearth of research on the transgender community with respect to mental health issues. However, emerging research in the past few years has provided some alarming data for just how disproportionately affected this population is when compared to their cisgender peers. A recent survey in the US found that those in the transgender community experience higher rates of both anxiety and depression compared to the general population, with 27% of those respondents saying their “psychological distress” significantly interfered with their daily lives in the past 30 days (James et al., 2016). Additionally, more than three fourths (77%) of respondents expressed a desire to receive counseling for reasons pertaining to their gender identity (James et al., 2016). When compared to their cisgender peers, transgender adults, aged 18-26, are significantly more likely to meet criteria for psychological disorders and conditions such as bipolar disorder, attention deficit hyperactivity disorder (ADHD), obsessive compulsive disorder (OCD), specific phobia, bulimia, anorexia, insomnia, anxiety disorders, depressive disorders, and substance use disorder (Oswalt & Lederer, 2017).

Veale, Peter, Travers, and Saewyc (2017) found that, among transgender youth in Canada, aged 14-18, rates of non-suicidal self-injury (NSSI) were reported to be as high as 66%, with approximately one third reporting attempted suicide. Among those, aged 18-25, more than half reported engaging in NSSI, with nearly three quarters citing serious suicidal consideration. Even when participants reported experiencing little enacted stigma (physical and verbal bullying,

social exclusion, and discrimination from peers, relatives, and/or institutions), 38% were still likely to experience serious suicidal ideation (Veale, et al., 2017). Transgender women (i.e., male-to-female) are the most likely, across gender identity groups, to report having attempted suicide (Toomey, Syvertsen, & Shramko, 2018).

Minority Stress Theory

A useful framework for understanding the unique experience faced by transgender people is Meyer's minority stress model. Based on the research of many social theorists and researchers, Meyer (2003) proposed a helpful model for organizing the interaction effects of environmental stressors for individuals of minority populations. In her proposed model, special care is given to minority status, and the role that plays when an individual is faced with circumstances in their environment.

Stress is the result of an individual being required to change their habits or adapt to a new situation due to the introduction of a stressor in one's life (Meyer, 2003). Simply put, a stressor is a stimulus that causes stress, and can be characterized as either relating to one's social environment or personal life. A new company policy that calls for more scrutiny of its workers, for example, can act as an environmental stressor for minority populations. Additionally, prejudice and discrimination can further upset routines and demand adaptation on their own, which has been shown to positively correlate with mental health problems and psychological distress (Veale, et al., 2017; Carmel, Hopwood, & Dickey, 2014; Bockting, et al., 2013; Clements-Nolle, Marx, & Katz, 2006). Minority stress, then, is the "excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position" (Meyer, 2003, p. 675).

We know from Veale et al. (2017) that transgender youth aged 14-18 in Canada experience suicidal ideation at a rate of 38% when social supports are low. However, when the same population reports high enacted stigma, the rate rises to 72%. Knowing the quantifiable impact of enacted stigma, it is concerning that the majority of these youth (69%) reported having experienced harassment related to their gender identity in the past year. A majority (64%) also reported having experienced bullying, taunts, and ridicule in the past year. In the US, similar findings confirm that a majority (70%) of transgender individuals reports experiencing enacted stigma, such as verbal abuse and harassment (Bockting, et al., 2013). In fact, the distress experienced by transgender individuals was shown to be largely associated with both enacted and perceived stigma (Bockting, et al., 2013).

Members of the transgender community may also experience high levels of violence, victimization, sexual abuse, and trauma (Carmel, Hopwood, & Dickey, 2014; Lombardi, Wilchins, Priesing, & Malouf, 2002). Kenagy (2005) also found that out of 182 transgender participants, more than half reported they had been forced to have sex in their lifetimes or experienced physical abuse.

Transgender Clients Seeking Mental Health Treatment

Significant barriers exist which hinder, and in some cases prevent, members of the transgender community accessing healthcare and mental health services. Research has shown it is not uncommon for transgender people seeking these services to be denied medical care, experience discrimination, bias, and even verbal harassment because of their identity (Kenagy, 2005; FRA, 2014; James, et al., 2016; Smith & Turell, 2017; Mirza & Rooney, 2019). The National Center for Transgender Equality's 2015 survey of transgender people in the US found that nearly one in five respondents reported healthcare professionals tried to, "stop them from

being transgender” (James, et al., 2016, p. 109). Similarly, Mirza & Rooney’s (2018) survey of 857 LGBT identified participants found that 29% of transgender respondents reported they were refused service at doctor’s offices and clinics because of their identity as a transgender person, compared to 8% of LGB respondents. Experiences such as these have unfortunately led to nearly one and five transgender people avoiding treatment for fear of mistreatment based on their gender identity (James, et al., 2016).

As such, it can be difficult for transgender clients to find mental health practitioners who truly understand their perspective and connect in a meaningful way. Even though those in mental health services are taught to be more empathic and knowledgeable of diverse populations, they are ultimately still people who are susceptible to the same implicit biases, ingrained cultural norms, and lack of multicultural understanding as anyone else. Sanders, Welfare, and Culver (2017) confirmed as much in their quantitative study surveying over 143 school counselors on their perceived self-efficacy. While most counselors reported feeling confident in their ability to offer therapeutic services, they cited “multicultural competency”, specifically as it pertained to gender, as their main area of concern (Sanders, Welfare, & Culver, 2017).

Among transgender clients, this lack of therapist competency is a commonly-cited barrier for receiving adequate treatment (Shipherd, Green, & Abramovitz, 2010; Morris, Lindley, & Galupo, In Press; Carroll-Beight & Larsson, 2018; Puckett, Cleary, Rossman, Mustanski, & Newcome, 2018; Anzani, Morris, & Galupo, 2019). Rachlin (2002) found that therapists’ gender identity competence was negatively correlated with reported instances of “harm done” (challenging, belittling or judging the client’s gender, and increased despair) by their clients. Conversely, when treatment was affirming of the client’s gender identity, the reported satisfaction and treatment outcome was significantly higher. Therapists rate significantly higher

in areas such as expertness, attractiveness, trustworthiness, and participant positivity towards treatment when their practices are perceived as trans-affirming (Bettermarcia & Israel, 2018). In fact, transgender clients tend to be so accustomed to harmful, non-affirming therapist practices that the mere absence of them is reported as inherently affirming (Anzani, Morris, & Galupo, 2019), which coincides with the community's reported lack of faith in the majority of mental health services (Lev, 2004; Benson, 2013; Carmel, Hopwood, & Dickey, 2014, p. 306).

These instances of non-affirming therapist practices are compounded by the dual role that therapists and counselors play for their transgender clients. In order for transgender clients to receive medical treatments and surgeries to alleviate dysphoria that many clients experience, they require letters of recommendation from mental health professionals vouching for their readiness. This means therapists of transgender clients seeking to transition effectively serve as gatekeepers to such treatments. As Rachlin (2002) observed, this can give therapists the perception of "obstacles to navigate", rather than someone there to help and offer support. This dynamic can undermine the development of a healthy therapeutic relationship, especially if therapists choose to embrace this role (Anzani, et al., 2019). Additionally, it leads to clients seeking out therapeutic services for the sole purpose of obtaining a letter (Rachlin, 2002).

Transgender clients also report feeling the need to misrepresent themselves in therapy. Clients in Sweden report downplaying other mental health concerns out of fear of potentially compromising their access to transition treatments, while others report downplaying their identity out of a fear it would become a distraction from other mental health concerns (Carroll-Beight & Larsson, 2018).

To better accommodate transgender clients, Sennott and Smith (2011) have encouraged clinicians to follow a transfeminist therapeutic model. This proposed model is a re-

conceptualization of feminist theory with a specific focus on treating transgender and gender-nonconforming clients through empowering them and affirming their identity. Sennot and Smith (2011) also developed a workshop for clinicians based in these principles, with the aim of helping them to foster the best practices for working with clients in these populations. This model is in-line with what the ideal therapist would practice for transgender clients (Hopwood & Dickey, 2014, p. 301).

Additionally, there are mental health professionals who specialize in working with clients with presenting issues that deal with gender and gender identity. Referred to as gender specialists, they are well-suited to dealing with gender-nonconforming populations, able to assist clients in processing potential confusion about their gender or learning to more effectively cope with dysphoria. Additionally, they can write letters recommending hormone replacement therapy (HRT). However, it is important to note that no official licensing or qualifications preclude one from becoming a gender specialist. The absence of any formal method by which clinicians can become a gender specialist means that quality of treatment and treatment outcome can be hard to predict (Hopwood & Dickey, 2014, p. 297). Ideally, though, these clinicians can provide a space for clients to seek therapy without harmful or misguided practices being experienced.

An integral part of successful treatment outcome in mental health services is establishing a positive therapeutic relationship. An overview of this concept and the importance of understanding and studying it with transgender clients will be addressed next.

The Therapeutic Relationship

The therapeutic relationship has been defined as “the feelings and attitudes that the counseling participants have towards one another, and the manner in which these are expressed” (Gelso & Carter, 1985, p. 159). For a therapist, developing a genuine and positive connection is

just as important for achieving client's improvement as the therapist's chosen orientation; perhaps even more so (Norcross & Wampold, 2018).

Greenson (1967) conceptualized the therapeutic relationship as having two main components: the real relationship and the working alliance. The real relationship is the genuineness shared between client and therapist, along with the realistic perceptions they have of each other (Gelso, 2014). It is possible for a client and therapist to have realistic perceptions of one another that are negative, in which case the real relationship is not beneficial to treatment. When the genuineness and realistic perceptions shared between client and therapist are positive, however, this creates a stronger and healthier real relationship (Gelso, 2014). Also when this relationship is positive, evidence has shown that, on its own, the real relationship is positively correlated with session outcome (Bhatia & Gelso, 2013; Gelso et al., 2005).

Setting aside the genuine human connection between client and therapist, what remains is the will of both parties to accomplish some goal. The working alliance can be defined as "the artifact of psychotherapy in the sense that the only reason for its existence is to allow a piece of work to be done" (Gelso, 2014, p. 120). Bordin (1979) conceptualized the working alliance to be a collaborative effort between both client and therapist that, through their interactions, directly accessed the client's self-defeating habits. He further distilled the working alliance down to having three key components: tasks, bonds, and goals. Tasks refers to the work being done in-session and the degree to which both client and therapist understand its purpose, functionality, and efficacy. Goals refers to the degree to which both client and therapist embrace the stated goals of therapy, and bond refers to the mutual faith and confidence both members of the alliance have in one another.

Of the two components comprising the therapeutic relationship, the real relationship has frequently been shown to account for variance in outcomes above and beyond that of the working alliance. Such was the case in Kelley's (2015) study, which examined the therapeutic relationship with gay and lesbian clients. She found that the real relationship was the strongest predictor of clients' feelings towards their therapists. Lo Coco et al. (2011) produced similar findings when examining these two variables on the outcome of brief psychotherapy. Their results showed that the working alliance did not predict outcome above and beyond the variance accounted for by the real relationship, whereas the real relationship added significantly to the working alliance in predicting outcome. Additionally, Owen et al. (2011) found that the real relationship was the strongest predictor of clients' perceptions of their therapists' multicultural competency, which was ultimately associated with clients' reported psychological well-being. These studies illustrate the importance of establishing a genuine human connection with clients.

However, while the working alliance is sometimes conceptualized as merely a product of the real relationship, it has been shown to positively correlate to session and treatment outcome by itself (Horvath & Symonds, 1991; Marziali & Alexander, 1991; Kivlighan Jr. & Shaughnessy, 2000). Horvath, Del Re, Flückiger, and Symonds (2011) conducted a meta-analysis of over 190 research reports and studies covering the working alliance and treatment outcome. Their findings showed that the working alliance alone bears a moderate, stable correlation coefficient of 0.28 to treatment outcome.

Kelley (2015) found that much work had indeed been done on the impact and nature of the therapeutic relationship between heterosexual clients and their therapists. However, she noticed that very little research on the therapeutic relationship concerned Lesbian, Gay, and Bisexual (LGB) clients and their therapists. In conducting her own study, she found that while

30% of LGB clients expressed a preference for gay, or gay-friendly therapists, and 21% of LGB clients felt their therapist did not understand them, 68% of LGB clients ultimately found their therapeutic relationship to be a positive one.

As Kelley (2015) notes, however, several limitations impacted the study, such as data being gathered solely through self-reporting, utilization of online groups and snowball sampling, and the inability to verify the perceived sexual orientation of a participant's therapist. While fascinating and important, several characteristics of Kelley's work have limited generalizability, due to the lack of control over participants. The sample collected also skewed more heavily towards lesbian clients of psychotherapy and overwhelmingly identified as white, further limiting generalizability. Given the nature of this research and how difficult it was to find participants in-person, such limitations may be inevitable without a significant financial backing.

At present, extensive research on the impact of the various elements comprising the therapeutic relationship with clients as it relates to their sexual orientations and gender identities does not exist (Norcross & Wampold, 2018). Thus, it was the hope of this study to expand on this growing body of research by exploring these elements, specifically as they relate to the transgender community. While it was not possible to account for all of the limitations present in Kelley's study (2015), her work provided the essential framework for what this project sought to do. The goal of this study was to extend the model provided by Kelley's (2015) work to transgender-identified clients of psychotherapy. Given population demographics this study sought to analyze, finding participants proved difficult. This study utilized many of the same methods laid out by Kelley, accepting the limitations associated with them.

Research Questions

The goal of this study was to contribute to the growing body of literature on the transgender experience in mental health settings. Specifically, to expand on the work Kelley (2015) and to analyze how transgender clients' perceptions of their therapist and their practices relate to the therapeutic relationship. Thus, the following research questions were examined.

1.) Do therapist practices, the real relationship, and the working alliance relate significantly to transgender clients' feelings about their therapist?

The working alliance and real relationship have been found to play a significant role predicting positive session outcome with heterosexual clients (Bhatia & Gelso, 2013; Horvath et al., 2011). Additionally, previous research with lesbian and gay clients has shown that all of these variables positively relate to clients' feelings about their therapists (Kelley, 2015). Thus, it was hypothesized that similar results would be found among transgender clients.

2.) Do therapist practices add significantly to the working alliance and the real relationship in predicting transgender clients' feelings about their therapist?

Similar to lesbian and gay clients' reports of experiencing heteronormative bias and unhelpful therapy practices (Liddle, 1996), the transgender community also deals with significant discrimination and bias in mental health settings (Kenagy, 2006; James, et al., 2016; FRA, 2014). In Kelley's (2015) study on lesbian and gay clients, therapist practices did not add significantly to the working alliance and real relationship as a predictor. However, due to transgender clients and patients reporting significantly more discrimination from healthcare and social services than their LGB peers, (FRA, EU LGBT Survey, 2014; Mirza & Rooney, 2019) it was estimated that affirming therapist practices would carry more weight. Thus, it was hypothesized therapist practices would significantly add to the working alliance and the real relationship in predicting transgender clients' feelings about their therapist.

3.) Does the real relationship significantly predict transgender clients' feelings about their therapist beyond months in therapy, therapist practices, and the working alliance?

The real relationship consistently appears as a stronger predictor of session outcome variance compared to the working alliance in heterosexual populations (Lo Coco et al., 2011; Owen et al., 2011), as well as clients' feelings about their therapists among gay and lesbian populations (Kelley, 2015). Thus, it was expected this dynamic would hold true in transgender populations, as well.

Methods

Recruitment

Participants were recruited using the Amazon Mechanical Turk (MTurk) service, email, organizations and online communities on social media sites such as Twitter and Discord. The primary source for recruiting respondents was MTurk, an internet-based data collection service that provides thousands of workers and research participants for web-based surveys and has been shown to provide consistent and meaningful data (Johnson & Ryan, 2020; Kees, Berry, Burton, & Sheehan, 2017). Studies on the quality of data collected from MTurk have shown it to be superior to professional marketing research companies, and comparable to that of student samples (Kees et al., 2017). Participants recruited from MTurk were paid \$1.50, as well as entered in the drawing for one of two \$50 Amazon gift cards. Participants recruited from social media, email, organizations and online communities were also entered for a chance to win one of \$50 Amazon gift cards. Of the 157 participants who took the survey, 78 qualified for the study. In order to have qualified, respondents needed to be at least 18 years of age, speak fluent English, identify as transgender, and have completed at least one session with a therapist or counselor in the past seven years. In making the timeframe seven years for clients, this study

ensured the clients' experiences reflected a time when therapists should have been operating under the DSM-5's criteria and did not characterize clients with transgender identities as having Gender Identity Disorder. Participants were asked to answer the questions based on their most recent therapist. A sample size of 78 met the desired power of 80%, with a medium effect size of 0.165 and an alpha level of 0.05.

Participants

Of the 78 participants, transgender men made up most of the sample (51%; $n = 40$), transgender women the second most (45%; $n = 35$), and non-binary participants the least (4%; $n = 3$). The sample was overwhelmingly White (81%; $n = 63$), ages 26-35 (62%; $n = 48$), and deriving from the United States (88%; $n = 69$). Other racial groups present in the sample included Asian (5%; $n = 4$), Latino/a/x (3%; $n = 2$), Black (9%; $n = 7$), and Native American or Alaskan Native (3%; $n = 2$). Other age ranges in the sample included 19-25 (19%; $n = 15$), 36-45 (13%; $n = 10$), 46-55 (4%; $n = 3$), and 56-65 (3%; $n = 2$). Other nationalities present in the sample included India (4%; $n = 3$), Canada (3%; $n = 2$), Brazil (3%; $n = 2$), United Kingdom (1%; $n = 1$), and Norway (1%; $n = 1$). See Tables 3 to 6 in the Appendices for further demographic data.

The amount of months spent with the most recent therapist ranged from 1 to 24 months, with a mean of 6.6 months ($SD = 5.1$). Participants reported the following reasons were the focus of their therapy: family issues (49%), relationship issues (44%), academic issues (24%), anxiety (23%), depression (20%), attention deficit or hyperactivity issues (18%), conduct or legal issues (17%), personality issues (17%), gender identity issues (15%), grief or loss (14%), panic attacks (14%), body image or body dysmorphia issues (8%).

Instruments

Demographic questionnaire (Appendix A). A questionnaire developed by the author of this study to obtain the demographic data of participants.

Working Alliance Inventory – Short Form (Appendix B). A shortened version of the Working Alliance Inventory (WAI; Horvath & Greenburg, 1989), the Working Alliance Inventory – Short Form (WAI-S; Tracey & Kokotovic, 1989) is a brief, 12-item measurement tool based in Bordin's (1975) theoretical conceptualization of the working alliance, which includes three subscales: Goals, Tasks and Bonds. Questions 1, 2, 8, and 12 are task items, questions 3, 5, 7, and 9 are bond items, and questions 4, 6, 10, and 11 are goal items. All item scores are summed positively, with the exception of questions 4 and 10, which are reverse scored. The scores are tallied up, with a higher score indicating a better working alliance. The range of possible scores is 12-84.

The original WAI boasted reliability estimates of .89 for Goals and .92 for Tasks and Bonds, with a Cronbach's alpha value for its 32 items of .93 (Horvath & Greenburg, 1989). The WAI-S was also designed to quantify the quality of the working alliance through assessing these three areas, albeit by a briefer survey. Kelley (2015) found that the WAI-S boasted significant internal consistency (Cronbach's alpha of .95). This instrument was used to assess the participants' perceptions of the working alliance shared between themselves and their therapists.

Real Relationship Inventory – Client Form (Appendix C). The Real Relationship Inventory – Client Form (RRI-C; Kelley, Gelso, Fuertes, Marmarosh & Lanier, 2010) is a supplemental instrument adapted from the Real Relationship Inventory – Therapist Form (RRI-T; Gelso, et al., 2005). The RRI-T serves to assess the therapist's perception of the real relationship between themselves and the client. Acting as a follow-up measure, the RRI-C instead assesses the client's perception of this construct. The RRI-C is fairly brief, containing 24

items along two subscales (genuineness and realism) and spanning 12 subcategories: (1) genuineness, valence, self; (2) genuineness, valence, other; (3) genuineness, valence, relationship; (4) genuineness, magnitude, self; (5) genuineness, magnitude, other; (6) genuineness, magnitude, relationship; (7) realism, valence, self; (8) realism, valence, other; (9) realism, valence, relationship; (10) realism, magnitude, self; (11) realism, magnitude, other; and (12) realism, magnitude, relationship. Respondents are asked to rate the degree to which the statements accurately represent their perceptions of the relationship with their therapist on a 5-point Likert scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). Questions 3, 6, 8, 12, 14, 21, 22, and 24 are reverse scored. A total score is derived from summing the two subscale scores, with a higher score indicating a better real relationship. The range of possible scores is 24-120.

The RRI-C total score and subscales were shown to correlate significantly with all validity measures, with the exception of the private self-consciousness scale, at an alpha level of $p < .05$ or higher. Additionally, the test-retest reliability estimates for the total score and the two subscales (genuineness and realism) were found to be .87, .88, and .84, respectively, as well as a Cronbach's alpha of .96 in a separate study. Additional analyses also revealed that the RRI-C scored significantly greater than the WAI in two validity measures, the Observing Ego Functions Scale ($t(90) = 2.84, p < .01$) and Therapist Real Relationship Scale ($t(90) = 2.62, p < .05$) (Kelley, et al., 2010; Kelley, 2015).

Counselor Rating Form – Short (Appendix D). The Counselor Rating Form – Short (CRF-S; Corrigan & Schmidt, 1983) was designed to assess client's perception of their therapist's relevant traits, such as warmth, preparedness, sincerity, etc. The measure consists of 12 items on a 7-point Likert scale with options ranging from 1 (*not very*) to 7 (*very*). The higher

therapists score on this scale, the more positively perceived they are. The range of possible scores for this scale is 12-84.

The original Counselor Rating Form (CRF; Barak & LaCrosse, 1975) consisted of 36 items and included negative adjectives, as well. The CRF-S sought to increase variance by removing all negative-adjective items and instead replacing them with the option to rate counselors *not very* on the remaining positive-adjective items. The 12 CRF-S items were derived from the original CRF's three dimensions (attractiveness, expertness, and trustworthiness), with four items from each dimension. To assure the CRF-S retained validity of the original, Corrigan and Schmidt (1983) performed confirmatory factor analyses using five competing theoretical models based on prior factor analytic results and/or theoretical populations. The inter-item reliabilities for the 4-item attractiveness, expertness, and trustworthiness scales were shown to be .91, .90, and .87, respectively (Corrigan & Schmidt, 1983). The CRF-S also received a Cronbach's alpha of .96 in a separate study (Kelley, 2015). Previous studies have found that therapists who score high on the CRF dimensions were associated with higher goal attainment scaling (GAS; an objective method of outcome assessment; Kiresuk & Sherman, 1968) scores in the clients who rated them, indicating more successful outcomes (LaCrosse, 1980; Bachelor, 1987). This scale was the criterion variable for the study, which served as the tool that assessed clients' feelings about their therapists.

Therapist Practices (Adapted) (Appendix E). The Therapist Practices (TP; Liddle, 1996) is a 13-item measurement tool designed to assess the approaches and behaviors of therapists and determine how they relate to ratings of client's failure to return for a second session and overall helpfulness in treating gay and lesbian clients. The scale is concerned with assessing whether the therapist's practices are affirming of the clients identity, or potentially

toxic. The tool also gathers demographic data on the therapists, including their gender and sexual orientation. This questionnaire requires clients to rate the accuracy of statements about their therapist's practices on a 5-point Likert scale, ranging from 1 (*very inaccurately*) to 5 (*very accurately*). Items 1-8 were reverse scored, as they represented unhelpful or harmful therapist practices, whereas items 9-12 represented helpful or positive therapist practices. A higher score on the TP indicated a therapist's practices were helpful and affirming, whereas a lower score indicated their practices were unhelpful or harmful. The range of possible scores for this adapted version of the TP was 12-60. The TP has been shown to be reliable, (e.g., Cronbach's alpha of .88; Kelley, 2015). Functionally, the TP served to assess the respondents' perception of their therapists' cultural competency, specifically regarding the transgender community.

As the TP is only designed to work with gay, lesbian, and bisexual populations, it was adapted in order to suit the population being targeted in this study. Thus, the language featured in each item was altered to instead pertain to transgender clients of therapy. Unfortunately, due to the inherent differences between sexual orientation and gender identity, not all questions neatly translated. As the core analytical function could not be translated for the transgender population, item 8, "Your therapist did not recognize the importance of lesbian and gay relationships and/or did not appropriately support these relationships," in the original scale was removed from the questionnaire.

Data Analyses

In order to test the first hypothesis, means, standard deviations, and intercorrelations were calculated for all variables. In order to test the second and third hypotheses, a hierarchical multiple regression analysis was conducted. Based on prior research (Kelley, 2015; Fuertes et al., 2007), months in therapy was entered at step one, TP at step two, WAI-S at step three, and RRI-

C at step four. As the variables were expected to be highly correlated, the variance inflation factor (VIF) for each variable was reviewed throughout the process (Myers, 1990). Reliability estimates were calculated for each of the scales, individually, as well as overall.

Results

Internal Consistency

Cronbach’s alpha coefficients were calculated for each of the four scales, WAI-S, RRI-C, TP, and CRF-S. The values for the WAI-S (.77), TP (.73), and CRF-S (.91) illustrated acceptable to excellent levels of internal consistency (George & Mallery, 2003). However, the RRI-C was shown to have poor levels of internal consistency (.57).

Intercorrelations

Means, standard deviations, and intercorrelations were calculated for all of the variables. Most variables were shown to be significantly related. Of note, both the WAI-S and the RRI-C were most correlated with clients’ feelings about their therapists (CRF-S) with values of .57 and .42, respectively, $p < .001$. Affirming therapist practices (TP) were significantly correlated with the RRI-C, but not with CRF-S; likewise for months in therapy. The values can be seen in both Table 1, below.

Table 1
Means, Standard Deviations, and Intercorrelations Among the Independent and Dependent Variables

Variable	<i>M</i>	<i>SD</i>	1	2	3	4	5
1. RRI-C	81.3	6.3	-				
2. WAI-S	54.8	9.2	.39**	-			
3. TP	34.9	5.7	.36**	-.01	-		
4. CRF-S	63.4	9.5	.42**	.57**	.002	-	
5. Months	6.6	5.1	.19*	.08	.40**	.13	-

Note. $n = 78$. RRI-C = Real Relationship Inventory – Client Form; WAI-S = Working Alliance Inventory – Short Form; TP = Therapy Practices; CRF-S = Counselor Rating Form – Short Form; Months = months in therapy.

* $p < .05$. ** $p < .001$.

Regression Analysis

A hierarchical multiple regression analysis was conducted to explore whether any of the four independent variables accounted for a significant amount of variance above and beyond the others, in regards to predicting clients’ feelings about their therapists. Based on the work done by Kelley (2015), months in therapy was entered at step one, TP at step two, WAI-S at step three, and RRI-C at step four. At an alpha level of .05, Model 3 was found to have the most predictive power, $\Delta R^2 = .31$, $F(3, 74) = 12.36$, $p < .001$. In Model 4, the real relationship was found to add significant predictive power, $\Delta R^2 = .05$, $F(4, 73) = 11.49$, $p < .001$. The WAI-S accounted for most of the variance in Model 4 ($\beta = .46$, $p < .001$), with the RRI-C accounting for the remaining variance ($\beta = .27$, $p = .014$). The results can be seen in Table 2, below.

Table 2
Regression on the Effects of the RRI-C Ratings on CRF-S After Controlling For Months in Therapy, TP, and WAI-S

	Step 1			Step 2			Step 3			Step 4		
	<i>B</i>	<i>SE</i>	β	<i>B</i>	<i>SE</i>	β	<i>B</i>	<i>SE</i>	β	<i>B</i>	<i>SE</i>	β
Months	.25	.21	.13	.30	.23	.16	.20	.20	.11	.19	.19	.10
TP	--	--	--	-.10	.21	-.06	-.06	.17	-.04	-.22	.18	-.13
WAI-S	--	--	--	--	--	--	.58	.10	.56**	.47	.11	.46**
RRI-C	--	--	--	--	--	--	--	--	--	.41	.16	.27*
<i>F</i>	1.39			.80			12.36			11.49		
df	(1,76)			(2,75)			(3,74)			(4,73)		
<i>R</i> ²	.02			.02			.33			.39		
ΔR^2	.09			.00			.31			.05		
ΔF	1.39			.23			34.62			6.34		
<i>p</i>	.24			.45			$p < .001$			$p < .001$		

Note. $n = 78$. CRF-S = Counselor Rating Form – Short Form; Months = months in therapy; TP = Therapy Practices; WAI-S = Working Alliance Inventory – Short Form; RRI-C = Real Relationship Inventory – Client Form.

* $p < .05$. ** $p < .001$.

None of the predictor variables were found to have a variance inflation factor (VIF) exceeding 1.4, suggesting no issues with multicollinearity (Robinson & Schumacker, 2009).

Research Question 1: Clients Feelings about Their Therapist

Do therapist practices, the real relationship, and the working alliance relate significantly to transgender clients' feelings about their therapist? It was hypothesized that all of these variables would, in fact, relate significantly to transgender clients' feelings about their therapists. The data partly supported this, with both the WAI-S and the RRI-C correlating significantly to the CRF-S (.57 and .42, respectively, $p < .001$), as well as significantly predicting it ($\beta = .46$ and $\beta = .27$, respectively, $p < .001$ and $p = .014$, respectively). Affirming therapist practices were not shown to significantly relate to clients' feelings, nor the working alliance. They were, however, shown to relate significantly to the real relationship (.36, $p < .001$). These results differed from Kelly's (2015) study in which affirming therapist practices were shown to significantly relate to clients' feelings, as well as the working alliance.

Research Question 2: Affirming Therapist Practices

Do therapist practices add significantly to the working alliance and the real relationship in predicting transgender clients' feelings about their therapist? It was hypothesized that affirming therapist practices would add significantly to both the working alliance and the real relationship in predicting transgender clients' feelings about their therapist. Results of the hierarchical multiple regression analysis showed TP did not add significantly as a predictor of clients' feelings about their therapist, $\beta = -.13$, $p = .220$. This result was consistent with the results found in Kelley's (2015) study, in which therapist practices did not significantly add to either the real relationship or working alliance in predicting clients' feelings.

Research Question 3: The Real Relationship

Does the real relationship significantly predict transgender clients' feelings about their therapist beyond months in therapy, therapist practices, and the working alliance? It was hypothesized that, as found in previous research, the real relationship would predict clients' feelings about their therapists above and beyond all other variables. However, the findings only partially support the hypothesis. The real relationship was found to significantly predict clients' feelings above and beyond months in therapy and affirming therapist practices, $\beta = .27, p = .014$. The real relationship did not predict clients' feelings above and beyond the working alliance, though, which accounted for most of the variance and stood out as the strongest predictor of clients' feelings, $\beta = .46, p < .001$. These results contrasted Kelly's (2015) study wherein the inverse of this dynamic was found.

Discussion

The purpose of this study was to examine the role the therapeutic relationship plays in influencing the perception transgender clients had of their therapists. Additionally, it was to explore how affirming therapist practices contribute to this perception. The findings were very similar to that of Kelley's (2015) work on LGB clients, of which the framework of this study was based upon. Both the working alliance and the real relationship were both strongly correlated and significantly predicted clients' feelings about their therapists, adding further support to the wide body of research showing the real relationship and working alliance are the most vital components to successful therapy outcomes. However, it was the working alliance which stood out at the best predictor, not the real relationship, as was the case in Kelley's (2015) study. One potential interpretation of this result is that transgender clients may approach mental health services such as therapy with a level of cynicism. So common is a lack of cultural competence surrounding transgender and non-binary issues among mental health professionals that clients'

expectations may be justifiably low. This is all to theorize that a good working alliance may be viewed as the more realistic hope for some clients seeking these services.

Additionally, the dual relationship of therapists serving as gatekeepers to letters of recommendation for transitioning and hormone treatments may serve as a factor in these results. If transgender clients feel as though they have to tread carefully so as not to compromise their chances of receiving a letter, then the development of a real relationship may not even be feasible in every case. Of course, the real relationship was still a significant predictor on its own, adding support to previous research suggesting the development of a real bond with clients is still important for therapists.

Also similar to Kelley's findings was that affirming therapist practices did not significantly predict clients' feelings about their therapists. It was hypothesized in this study that affirming therapist practices would, in fact, add significantly to both the real relationship and the working alliance due to the amount of enacted stigma the transgender population faces in comparison to all other groups. However, just as in Kelley's (2015) study, therapist practices did not serve as a significant predictor. This is not to say therapist practices were irrelevant, of course. Affirming therapist practices were found to be significantly related to both the real relationship and months spent in therapy, suggesting a trans-affirming approach and cultural competency play a role in developing a real relationship and keeping clients around. Interestingly, though, therapist practices were not significantly correlated with either the working alliance or clients' feelings. These two discrepancies deviate from the correlations found in Kelley's (2015) work on LGB clients.

The main goal of understanding how all of these variables influence transgender clients' feelings about their therapists was the hope that barriers to effective therapy could be identified

and ultimately corrected. This study sought to replicate the work of Kelley (2015) with a different population. In doing so, results were found that deviated from the findings presented in her work. The working alliance was found to be the most important predictor for clients' feelings about their therapists, not the real relationship. Therapist practices were correlated with both months in therapy and the real relationship, but not the working alliance or clients' feelings. These findings were in contrast with research that has placed the real relationship above the working alliance, in terms of important therapy components (Lo Coco et al., 2011; Owens et al., 2011; Kelley, 2015). They also indicated that the transgender population cannot be lumped in with the lesbian and gay populations; that transgender clients' psychological and therapeutic needs, and the prescriptions required, are distinct.

Limitations and Future Studies

While this study sought to feature a more diverse sample in terms of racial background, respondents were still overwhelmingly white (81%). This limits the generalizability of the study, as such a homogenous sample may not yield results truly reflective of transgender people of color. Future studies should pay special care to recruit a more diverse sample of clients, so as to gain a more universal understanding. Additionally, due to lack of time and financial constraints, more participants could not be recruited. It likely would have been possible to increase the sample size, increasing the power of the study, as well as recruit more participants from places other than MTurk. As the data gathering phase for this study took place in the summer, services such as SONA system, a resource for researchers that provides student participants, could not be utilized feasibly. In general, the transgender community can be a guarded one, making recruitment an inherently difficult task without adequate resources. The internal consistency for the RRI-C was also found to be poor (.57). Finally, in terms of gender identity, the sample was

nearly an even split between transgender men (40) and women (35). If time had permitted, more tests could have been conducted in an effort to compare how these two populations varied, if at all.

Future research exploring the therapy relationship and transgender clients should also pay special care to the non-binary population, specifically. While falling under the umbrella of transgender, this community is likely to have distinct characteristics of their own. It would also be of value to incorporate qualitative analysis into future studies on the subject. Pairing qualitative with quantitative data could have helped illuminate some of the discrepancies found between this study and Kelley's (2015).

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Appendices

Table 3

Gender Identity of Participants

Gender Identity	<i>n</i>	%
Trans Female/Female	35	44.9
Trans Male/Male	40	51.3
Non-binary	3	3.8

Note. *n* = 78

Table 4
Race of Participants

Race	<i>n</i>	%
Asian/Pacific Islander	4	5.1
Latino/a/x	2	2.6
Black	7	9.0
White	63	80.7
Native American/Alaskan Native	2	2.6

Note. *n* = 78

Table 5
Age of Participants

Age	<i>n</i>	%
19 – 25	15	19.2
26 – 35	48	61.5
36 – 45	10	12.8
46 – 55	3	3.8
56 – 65	2	2.6

Note. *n* = 78

Table 6
Nationality of Participants

Nationality	<i>n</i>	%
United States	69	88.4
Canada	2	2.6
India	3	3.8
United Kingdom	1	1.2
Brazil	2	2.6
Norway	1	1.2

Note. *n* = 78

Appendix A: Demographics Questionnaire

Instructions: Please provide responses to the following questions

1. What is your age?

- 17 or younger
- 18-24
- 25-34
- 35-44
- 45-54
- 55 years or older

2. What is your race?

- Asian
- Latinx
- Black or African American
- White or Caucasian (Non-Latinx)
- Middle Eastern or North African
- Native American or Alaskan Native
- Native Hawaiian or Pacific Islander
- Prefer to self-describe _____
- Prefer not to say

3. What is your gender?

- Male
- Female
- Non-binary

- Prefer to self-describe _____
- Prefer not to say

4. Do you identify as transgender?

- Yes
- No

5. Which best describes your sexual orientation?

- Heterosexual
- Gay/Lesbian
- Bisexual
- Pansexual
- Asexual
- Prefer to self-describe _____
- Prefer not to say

6. Have you sought out mental health services, such as counseling or therapy before?

- Yes
- No

7. When was the last time you used these services?

- 2021
- 2020
- 2019
- 2018
- 2017
- 2016

- 2015
- 2014
- 2013
- 2012 or before
- I don't remember

8. Which topics prompted you to seek out therapy or counseling?

- Familial issues
- Relationship issues
- Academic issues
- Conduct issues
- Attention or hyperactivity issues
- Anxiety
- Depression or Sadness
- Gender identity
- Panic attacks
- Personality
- Body image or body dysphoria
- Prefer to self-describe _____
- Prefer not to say

9. Have you seen more than one therapist?

- Yes, I have seen more than one therapist
- No, I have only seen one therapist

10. How many therapists have you seen?

- 2
- 3
- 4
- 5
- More than 5

11. Are you currently seeing a therapist or counselor regularly?

- Yes
- No

12. About how many months have you spent in therapy with the most recent therapist?

- Numerical value (1-2 digits)

13. What is the highest degree or level of school you have completed?

- Less than a high school diploma
- High school degree or equivalent
- Some college
- Associate's degree
- Bachelor's degree (e.g., B.A. or B.S.)
- Master's degree (e.g., M.A., M.S., or MEd)
- Doctorate (e.g., PhD, EdD, or PsyD)
- Other _____
- Prefer not to say

14. Which annual income group best describes your household?

- Less than \$20,000
- \$20,000-\$34,000

- \$35,000-\$59,000
- \$60,000-\$89,000
- \$90,000-\$129,000
- \$130,000-\$159,000
- \$160,000-\$200,000
- Greater than \$200,000
- Prefer not to say

Appendix B: Working Alliance Inventory – Short Form (WAI-S)

Instructions: For this section, we will list sentences that describe some of the different ways a person might think or feel about their therapist (or counsellor). As you read the sentences, mentally insert the name of your most recent therapist (or counselor) in place of _____ in the text. After reading each item, please rate the degree to which you think or feel the same way, but about your own therapist.

Response Scale:

1 (Never) 2 (Rarely) 3 (Occasionally) 4 (Sometimes) 5 (Often) 6 (Very Often) 7 (Always)

1. _____ and I agree about the things I will need to do in therapy to help improve my situation.
2. What I am doing in therapy gives me new ways of looking at my problem.
3. I believe _____ likes me.
4. _____ does not understand what I am trying to accomplish in therapy.
5. I am confident in _____'s ability to help me.
6. _____ and I are working towards mutually agreed upon goals.
7. I feel that _____ appreciates me.
8. We agree on what is important for me to work on.
9. _____ and I trust one another.
10. _____ and I have different ideas on what my problems are.
11. We have established a good understanding of the kind of changes that would be good for me.
12. I believe the way we are working with my problem is correct.

Appendix C: Real Relationship Inventory – Client Form (RRI-C)

Instructions: For this section, we will list a set of statements that describe various aspects of the relationship between a client and their therapist. For each item, please read the statement and rate how characteristic it is of the relationship you share (or shared) with your most recent therapist.

Response Scale:

1 (Strongly Disagree) 2 (Disagree) 3 (Neutral) 4 (Agree) 5 (Strongly Agree)

Genuineness

1. I was able to be myself with my therapist.
3. I was holding back significant parts of myself.
4. I appreciated being able to express my feelings in therapy.
7. I was open and honest with my therapist.
10. My therapist seemed genuinely connected to me.
11. I was able to communicate my moment-to-moment inner experience to my therapist.
12. My therapist was holding back his/her genuine self.
15. My therapist and I were able to be authentic in our relationship.
17. My therapist and I had an honest relationship.
19. My therapist and I expressed a deep and genuine caring for one another.
22. I felt there was a significant holding back in our relationship.
24. It was difficult for me to express what I truly felt about my therapist.

Realism

2. My therapist and I had a realistic perception of our relationship.
5. My therapist liked the real me.
6. It was difficult to accept who my therapist really is.

8. My therapist's perceptions of me seem colored by his or her own issues.
9. The relationship between my therapist and me was strengthened by our understanding of one another.
13. I appreciated my therapist's limitations and strengths.
14. We do not really know each other realistically.
16. I was able to see myself realistically in therapy.
18. I was able to separate out my realistic perceptions of my therapist from my unrealistic perceptions.
20. I had a realistic understanding of my therapist as a person.
21. My therapist did not see me as I really am.
23. My therapist's perceptions of me were accurate.

Appendix E: Therapist Practices (TP)

Instructions: This questionnaire asks a number of questions about the practices of your counselor or therapist. For each item, please rate the degree to which the item accurately describes your most recent counselor or therapist's practices.

Response Scale:

(very inaccurately) 1 2 3 4 5 (very accurately) 

1. Your therapist gave some indication that he or she had automatically assumed you were cisgender, before you indicated your gender identity.
2. Your therapist indicated they believed that an identity other than a cisgender one was bad, sick, or inferior.
3. Your therapist discounted, argued against, or pushed you to renounce your gender identity.
4. Your therapist blamed your problems on your gender identity or insisted on focusing on gender identity without evidence that your gender identity was relevant to your problems.
5. Your therapist suddenly refused to see you any more after you disclosed your gender identity. (Do *not* include cases where the therapist made a sensitive and appropriate referral to a therapist who was especially skilled in your expressed areas of concern.)
6. Your therapist lacked the basic knowledge of gender identity issues necessary to be an effective therapist for you and/or you had to constantly educate them about these issues.
7. Your therapist pressured or advised you to come out to someone in spite of the fact that you believed it was too risky.
8. Your therapist apparently did not understand the problems of societal prejudice against transgender people and/or internalized transphobia.

9. Your therapist was quite knowledgeable about the transgender community and other resources (so that they could have put you in touch with useful books or important community resources).
10. Your therapist never made an issue of your gender identity when it was not relevant.
11. Your therapist was not afraid to deal with your gender identity when it was relevant.
12. Your therapist helped you feel good about your gender identity.