TGD ADOLESCENTS' AND CAREGIVERS' THERAPY EXPERIENCES

Therapy Experiences of Transgender and Gender Diverse Adolescents and Their Caregivers

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Abstract

Transgender and gender diverse (TGD) adolescents and their caregivers have highlighted the dearth of providers trained in gender-affirming practices as a critical treatment barrier, yet little is known about their specific experiences in mental health therapy. The present study sought to elucidate these experiences. Qualitative description was employed to analyze data from 105 clinical interviews completed with TGD adolescents ($n=49$; ages 11–20) and/or their caregivers ($n=65$; ages 36–84) seeking medical gender transition services at a pediatric gender program in the U.S. Participants highlighted satisfactory experiences with therapists they perceived as gender-affirming and who actively involved caregivers in therapy. Several participants reported unhelpful experiences with therapists viewed as non-affirming. In a few cases, caregivers were alienated from therapy when therapists told them to affirm their adolescent's gender in highly directive ways. Findings underscore the need to train therapists in gender-affirming practices and highlight the importance of thoughtfully engaging caregivers in therapy.

Keywords: gender-affirming, transgender, psychotherapy equity, caregiver engagement, adolescents; qualitative description design

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Transgender and gender diverse (TGD) adolescents (whose gender identities and/or expressions do not conform to culturally-defined norms associated with their¹ birth-assigned sex; Chen et al., 2016) face a heightened risk for mental and physical health concerns compared to cisgender adolescents (whose gender identity is consistent with their birth-assigned sex; Connolly et al., 2016; see these and related definitions in Table 1). This inequity is at least partially explained by their disproportionate exposure to stigma (e.g., discrimination; Veale et al., 2017; bullying/harassment; Reisner et al., 2015) and other forms of adversity (e.g., physical/sexual assault; Johns et al., 2019). Despite these elevated risks, TGD adolescents and young adults report underutilizing or avoiding health services (Goldenberg et al., 2019; James et al., 2016; Rider et al., 2018), including mental health therapy (hereafter “therapy”).

Research on the health care experiences of TGD adolescents and their caregivers is growing and coincides with the recent proliferation of pediatric clinics offering gender-affirming services (e.g., hormone therapy; Chen et al., 2016; Russell, 2020; Pullen Sansfaçon et al., 2019; Spack et al., 2012). TGD adolescents are a particularly important group to study, as gender dysphoria (i.e., distress resulting from incongruence between one’s gender and birth-assigned sex) is often exacerbated by the emergence of secondary sex characteristics during puberty (e.g., body hair, chest growth; Coleman et al., 2012). Despite many TGD adolescents’ developmental capacity to make informed health care decisions (Clark et al., 2020), they often encounter distinct obstacles accessing care: (a) the dearth of providers trained in gender-affirming practices (i.e., those designed to support and understand an individual’s gender identity, which integrate

¹As recommended by the American Psychological Association, the gender-inclusive singular pronouns “they, them, and theirs” will be used throughout this paper.

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providers' knowledge of experiences unique to TGD people and their associations with health; Pachankis, 2018; Rafferty et al., 2018); (b) gender-related mistreatment by providers (e.g., derogatory comments, expressions of dislike, stereotyping); and, (c) a need for caregivers who support their gender and associated treatment (e.g., giving consent for treatment, providing transportation and/or financial assistance; ; Gridley et al., 2016; Guss et al., 2019; Heard et al., 2018; Samargia et al., 2006; Pullen Sansfaçon et al., 2019). While much of this research examines experiences with health care services broadly, therapy experiences remain relatively understudied. Research that comprehensively explores TGD adolescents' experiences in therapy is critical, as it has the potential to inform therapist-focused trainings in gender-affirming practices (Lelutiu-Weinberger et al., 2016) and TGD-specific adaptations to evidence-based therapies (Austin & Craig, 2015; Hope et al., 2016).

TGD Adolescents' Therapy Experiences

Among studies on TGD adolescents' health care experiences, none to our knowledge has exclusively examined therapy, and only a few include questions about therapy. In these studies, participants have noted that therapists communicated judgment or dislike towards TGD adolescents, expressed fear of legal consequences for supporting their gender transition, minimized the potential consequences of delayed gender transition services, and conveyed a lack of TGD-relevant knowledge (Corliss et al., 2007; Gridley et al., 2016). TGD adolescents and caregivers have also reported difficulty locating a therapist who is gender-affirming and accepts their insurance policy (Evans et al., 2017), and they face problems finding affordable therapy and getting insurance approval (Pullen Sansfaçon et al., 2019). These themes are mirrored in research with providers, which indicates that many therapists lack knowledge in TGD health and hold biased attitudes towards TGD clients (Stroumsa et al., 2019). This is not surprising, as training in

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gender-affirming practices is rarely provided to psychology (Cochran & Robohm, 2015) and social work (Martin et al., 2009) trainees.

Despite these obstacles, therapy has been characterized as helpful by some TGD adolescents. Specifically, in a small qualitative study, TGD adolescents noted that discussing their gender identity with their therapist was helpful and said that therapy improved their self-concept and reduced feelings of isolation (Corliss et al., 2007). A recent study on TGD adolescents' experiences in inpatient psychiatric care indicated that providers' use of specific gender-affirming practices (e.g., using affirmed names and pronouns) were perceived by participants as supportive and respectful (Acosta et al., 2019). To deepen this small but growing body of research on TGD adolescents' experiences in therapy, the present study sought to explore: What are the therapy experiences of TGD adolescents and their caregivers seeking gender affirming care?

Methods

Participants

Adolescent participants were seeking gender-affirming medical services (e.g., hormone therapy) at a pediatric gender clinic in the New England region of the United States. The clinic ascribes to a multidisciplinary *Gender Affirmative Model* of care, which promotes gender exploration without presuming a fixed trajectory and supports TGD adolescents living as they feel most comfortable (Chen et al., 2016; Hidalgo et al., 2013). Most families (77%) seen in the clinic for an initial consultation between 2016 and 2019 consented or assented to have their intake interview data analyzed as part of an ongoing IRB-approved study. Of note, neither previous nor current involvement in therapy was required to receive services at the clinic in which this study was conducted. Though this was explicitly communicated to participants,

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several clinics providing gender-affirming care require mental health therapy before or during the provision of affirming medical services, which may have biased participant reports (e.g., reporting positive experiences in therapy to demonstrate readiness for affirming medical services). Nonetheless, a wide array of positive and negative experiences were provided.

In all, notes from 105 separate adolescent and/or caregiver clinical interviews were coded, reflecting the experiences of 60 adolescents. Of those interviews, 89 included data relevant to the current study (e.g., statements about therapy experiences, difficulties accessing therapy) and represented the experiences of 49 adolescents (ages 11–20; $M(SD) = 15.5(1.7)$). Eight interviews involved only adolescents (i.e., their caregiver(s) did not complete an interview), and one involved only caregiver(s) (i.e., their adolescent did not complete an interview). The remaining 80 interviews were conducted separately with adolescents (40 interviews) and their caregivers (40 interviews). Because many caregivers completed interviews in dyads, the 41 distinct caregiver interviews represent a total of 65 caregivers (see sample demographics in Table 2). The 16 interviews (representing 11 adolescents) without relevant data (i.e., neither they nor their caregiver(s) mentioned therapy) had interview notes that were much sparser than others. Accordingly, we could not reliably determine whether they had therapy experiences and thus excluded them from the final sample.

Procedures

Informed Consent and Assent

Consistent with recommended practices for research with TGD people (Adams et al., 2017), all participants provided informed consent (for caregivers and adolescents 18 and older) or assent (for minor adolescents) both verbally and in writing, and they were given copies of the consent/assent forms to read during and after their initial appointment. They were informed that

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their decision to participate would not impact their care in any way and, if they participated, their deidentified survey and interview data may be used for research purposes. The deidentification process was also described (i.e., replacing protected health information with a code number). Consistent with the larger consent/assent policy for medical care in the clinic, minors were only included in the study if both caregiver consent and adolescent assent were provided.

Clinical Interview

Consistent with the *World Professional Association for Transgender Health's* (WPATH) Standards of Care, participants completed an interview assessment on domains pertinent to a fully-informed and supportive transition (Coleman et al., 2012). This interview was adapted from the widely-used *Clinical Tool for Assessing Youth's Readiness for Gender Transition* (Coolhart et al., 2013), chosen because it is one of the few available tools that comprehensively addresses WPATH-recommended domains for TGD adolescents (e.g., emotional, social, school, and family functioning; Coleman et al., 2012). Both adolescent and caregiver interviews included questions about gender identity (e.g., early awareness of gender), general functioning (e.g., family and peer support), and mental health (see Coolhart et al., 2013 for questions and a detailed rationale). Caregiver interviews included additional questions about adolescents' developmental history (e.g., pregnancy complications). To deepen the tool's utility, a section on trauma history and additional gender-related questions ("What do you look like in your dreams?") were integrated from a similar assessment measure (see Ehrensaft et al., 2014).

Pertinent to the current study, the tool included items explicitly asking participants about adolescents' mental health service history. Example items from the adolescent interview, which closely mirrored the caregiver interviewer, included (a) "Have you consulted with anyone else regarding your desire to transition (e.g., therapist, psychiatrist, religious figure, teacher, etc.)?";

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(b) “Do you have any current physical or mental concerns, diagnoses, or disabilities? If so, have you sought treatment? (Describe concern, treatment and healthcare provider)”; and, (c) “Have you ever sought mental health treatment for any issue? If so, please describe the issues(s), location, provider, timing, duration, and outcome of the treatment(s).” Additional unscripted prompts were used if the interviewer needed clarification or elaboration from participants. Participants also provided information about their experiences in mental health therapy in response to several questions that did not inquire directly about therapy (see full list in Supplemental Table 1).

Interviewers' notes were made electronically and attempted to capture verbatim responses to questions. Interviews were administered by a psychologist, psychology fellow, or a psychiatry fellow, all of whom were trained in its administration by the clinic director, who is a licensed psychologist and expert in gender-affirming care (last author of this study). Interviewers were instructed to type responses verbatim during the interview, so that the detailed reports they subsequently wrote could include direct quotes. On a few occasions, however, technical difficulties (e.g., computers dying) or participants who spoke little, resulted in relatively sparse notes. The detailed reports addressed all interview domains (e.g., family support, trauma history), bolstering the likelihood of thorough annotations. Participants were unfamiliar with their interviewer, though most had briefly met them once prior to their interview while meeting the clinical care team at a preceding intake appointment. No interviews involved adolescents and caregivers together, but rather, were conducted in separate sessions. Interviews typically lasted 1-3 hours and sometimes occurred across two or more appointments.

Analysis

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Qualitative description design, an inductive approach commonly used to provide information about how to improve health care practice from the perspective, and in the language, of consumers (Sullivan-Bolyai et al., 2005), was utilized in conjunction with content analysis (i.e., the systematic analysis of textual data to identify patterns; Vaismoradi et al., 2013). Interviewers' notes were coded by four of the authors [masked for review] over five months under the supervision of the first author [masked for review]. During an initial hour-long group discussion prior to analysis, coders identified potential biases related to their identities and experiences that might influence their interpretation of data. For instance, all coders indicated that they were proponents of gender-affirming care and had professional experiences (e.g., clinical and research work) with TGD adolescents. Additionally, researchers acknowledged that their gender identities and racial/ethnic backgrounds, though diverse, did not fully reflect those of participants.

Coding focused on elucidating participants' experiences with therapy, defined here as any engagement in, or attempts to engage with (e.g., searching for therapists), mental health services (e.g., psychotherapy, school counseling). Open coding (i.e., approaching data without preset codes) allowed for the emergence of codes throughout the process. Interview data were initially coded by 2 to 4 coders each until *code saturation* (i.e., the point after which no new codes emerged; Hennink et al., 2017), which was achieved after coding 18 adolescent and 22 caregiver interviews, resulting in a finalized codebook. Open coding results in a continuously evolving codebook prior to saturation, and thus intercoder reliability was not assessed. Moreover, reliance on intercoder reliability risks inadequately capturing the nuances of participants' experiences by foregrounding agreement on existing codes over the identification of new codes and their discussion from multiple perspectives (Hill et al., 1997). Rather, to enhance reliability, the

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research team engaged in a consensus building process, meeting weekly to discuss emerging codes and resolve coding discrepancies (Hill et al., 2005). When discrepancies were identified, they were discussed during group meetings, and coders were invited to reflect on how their biases may have affected coding. Next, the research team reviewed the codebook, and the lead author asked each coder to share their code choice and supporting rationale. Discussion proceeded until the team reached a consensus on the final code. Memos of decisions were retained throughout the coding process.

Remaining interviews were independently coded by single coders (41 adolescent and 24 caregiver interviews) and subsequently validated by the first (and senior) author, who reviewed their consistency with the final codebook and resolved any discrepancies with the research team. Specifically, the first author reviewed and verified that all codes and associated quotes were both consistent with codebook definitions and credible (i.e., accurately portraying the meaning of participants' words), illustrative (i.e., sufficiently descriptive and contextualized, whenever possible), representative (i.e., providing multiple perspectives to elucidate similarities and differences between and within codes; e.g., from adolescents and caregivers), and applicable to the research question (Cypress, 2017; Morse, 2015; Whittemore et al., 2001). Consistent with consensus building, and to avoid potential threats to validity (i.e., trustworthiness; Lincoln & Guba, 1986), the first author presented any identified discrepancies between the codebook and individual codes during weekly team meetings, and the entire coding team discussed them until they came to a mutually agreed on coding decision.

Results

According to adolescent and/or caregiver participants, 48 of the 49 adolescents in the final sample had a history of therapy (11 of the original 60 adolescents did not have relevant

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data). Some had seen multiple therapists across their lifespan, while others began therapy more recently. The sole adolescent without a therapy history discussed attempts to access therapy. Four themes emerged from the interviews: (1) therapists' gender affirmation and/or perceived expertise; (2) therapists' *lack* of gender affirmation and/or perceived expertise; (3) engaging caregivers in therapy; and, (4) alienating caregivers from therapy. The quotes included below with each theme are taken directly from interviewers' notes. Age and affirmed gender of each adolescent participant who provided the quote and/or who is referred to by their caregiver is provided for each quote to aid in interpretation. Though some of these demographic characteristics are repeated across quotes, most quotes were provided by distinct adolescents or caregivers and no individual participant is quoted more than once within a theme (see Supplemental Table 2).

Therapists' Gender Affirmation and/or Perceived Expertise

Both caregivers and adolescents reported positive experiences with therapists who were affirming of an adolescent's gender or indicated that they had experience or knowledge relevant to working with TGD adolescents. Specifically, this was coded when a participant stated that a therapist engaged in discussions of gender and/or health that reflected support of the adolescent's affirmed gender, had "experience" working with TGD clients, and/or demonstrated "expertise," "education," or "specialization" in TGD health and/or identity. In many cases, families sought out therapists with such expertise, as described by the caregivers of a 15-year-old transgender male:

"Found [therapist] on Psychology Today [when] specifically looking for [a] gender-affirming therapist. [Adolescent] engaged in therapy [while] coming out and [was] worried about making [us] upset."

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Adolescents noted helpful discussions with therapists about issues relating to TGD identity, including transitioning, coming out to others, gender dysphoria, and coping with unsupportive caregivers:

“First time in therapy. Talk about anxiety sometimes. Nice, relaxing. Talk about transitioning [or] if I am feeling bad that day. Parents thought I should have a therapist. I wanted one because of gender identity.” (15-year-old transgender male)

Another adolescent, a 16-year-old transgender male, similarly described a positive therapy experience:

“[The] first time [I] saw a therapist was when [I] came out to [my] mom. I was scared to tell mom. Mom said [it] felt like a kick in the teeth, [but] she will love me no matter what. [Therapist] is great. She felt like a friend rather than someone [I] had to talk to. Understood everything. Talk about surgery the most, then T.”

A 14-year-old transgender male participant noted that after coming out, he terminated with a therapist who he perceived as not having TGD-relevant experience (for more examples, see next theme) and found a more helpful therapist who facilitated their access to hormone therapy:

“I saw [new therapist] after coming out. Didn’t want to see first therapist again because I felt she wasn’t experienced enough. [New therapist] wrote a letter for [endocrinologist]. Now [I] get the shot on a monthly basis.”

Some adolescents described receiving support from therapists when coming out. For instance, a 17-year-old transgender female connected this experience to their immediate clinical progress:

“[I saw] a social worker [in] 10th grade. Needed help coming out. It was great. [Therapist] was great. Just to get advice, insight on what to do. Saw once a month for two months. Didn’t need to see her after that.”

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Similarly, an adolescent described a “helpful” therapist who helped them navigate recent stressors and decisions, including those related to gender:

“This summer, [I experienced] negativity from people saying [I] shouldn’t cry or feel sad. [My] therapist told dad I am allowed to feel emotion. [I] talk to therapist about telling others. Talked about telling ones [I’m] closest to. I don’t know if I should tell my parents not to cut hair. They would say it’s too long. I think the opposite. [I] would like to grow out [my hair] over break. [I] will talk to [my] therapist and see if [my parents and I] can come up with [an] agreement.” (15-year-old transgender female)

Likewise, a 17-year-old transgender male adolescent described discussing gender with a therapist they viewed as understanding:

“He’s good. He’s younger and gay, so he understands a lot more. He’s not patronizing at all. He treats me like an adult. Talk about family life the most, anxiety, [and] depression. Anxiety has gotten a lot better. Talked about gender at first few appointments. Talked about transition.”

Adolescents also noted appreciating when therapists provided education on TGD health and related resources, including one 16-year-old transgender male who relayed that his “[therapist] mentioned guidelines [and] legally changing your name.” Likewise, a 17-year-old gender fluid adolescent shared what they learned from their therapist about gender roles/expressions:

“Gender expression conveys how [one] feels. Gender roles...traditionally [that] females are weaker...not realistic with [the] world now. It’s okay if you don’t fit into roles or stereotypes. Shouldn’t be ashamed of it. Feel comfortable with who [you] are.”

Caregivers, too, cited therapists’ previous experience and/or expertise in TGD health when speaking positively about adolescents’ therapy experiences. For example, one caregiver

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stated that the therapist of their 17-year-old gender fluid adolescent had a “better understanding of triggers” and was a “strong advocate” due their experience leading a LGBT youth program.

Describing her adolescent’s relationship with their therapist, the mother of a 13-year-old transgender male said:

“[They] immediately clicked. [Therapist] has worked with trans kids and kids in [middle school]. [Therapist] is easy to relate [to]. Helped pull things out of toolkit. Brought [adolescent] out of darker place.”

A mother of a 14-year-old transgender male described her rationale for seeking out a therapist with relevant expertise:

“[Adolescent] restarted therapy after seeing a pediatrician to talk about stopping periods. Anything moving forward medically would require therapy...since you need to know where someone’s at. Current therapist has done a lot of work with transgender things. Seems like this therapist gets it.”

Consistent with adolescent interviews, caregivers also expressed satisfaction with their adolescent’s gender-affirming experiences and resulting progress in therapy:

“At [adolescent’s] first visit with therapist, [they] talked [about] school, politics, etc. [The] next week, [adolescent] said, ‘Oh, one more thing, [I] think [I] might be trans. Definitely will talk [with therapist] next week.’ [Therapist] helped her. [I] felt so much relief that [adolescent] shared this with me...to [know] something about [her] internal life...because [she] didn’t give anything before that. By the time [adolescent] came out to dad, [I was] so happy [she] could figure [that] out about [her]self. [Adolescent] sees therapist weekly. Treatment going well. [Adolescent] seems confident about self-knowledge [and] where she is at... [has a] therapeutic afterglow.” (Caregivers of a 15-

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year-old transgender female)

Therapists' Lack of Gender Affirmation and/or Perceived Expertise

Therapists' lack of "expertise" or training in TGD health and treatment was cited by both adolescents and caregivers as a reason for perceiving therapy as unhelpful and/or terminating therapy. As one 15-year-old transgender male adolescent noted:

"Therapist didn't feel comfortable talking about trans issues. Wasn't specialized in that.

[I] was comfortable with her [but] not her expertise."

Similarly, when one therapist discussed gender, this did not resonate with a 17-year-old transgender male adolescent, who highlighted the therapist's lack of specialization:

"[Therapist] talked about gender but didn't get it. Didn't have specialty in it."

Most quotes for this theme were from adolescents, with the exception of a few caregivers. For example, the caregivers of a 16-year-old transgender male shared:

"Previous therapist [was] not affirming. [Adolescent] was with [therapist] one year. She worked a lot with 70s AIDS patients and hadn't evolved."

However, adolescents often described how caregivers were implicated in negative therapy experiences (e.g., encouraging them to see or continue working with non-affirming therapists):

"[I] tried to have a therapist but wasn't happy about how [therapist] tried to do things. [I] went in freshman year for maybe 3-4 months...for gender dysphoria. [I] didn't like therapist because [I] felt like [I] was educating therapist. Mom wanted [me] to go." (16-year-old transgender male)

Adolescents cited therapists' lack of support their gender transition as a reason for ending therapy:

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“It had been a while. [I] didn’t feel it was helping as much as far as transitioning and where to go from; there, so talked to mom [who] said it was okay to stop. Therapist wasn’t quite as educated in the topic of transgender stuff. She was kind of a general therapist, and we didn’t feel it was a great fit. Wanted to find someone who knew more about the topic...because we knew that if [I] wanted to progress medically, it’d be easier if we had therapist on our side.” (14-year-old transgender male)

When asked about whether they had consulted with anyone about their desire to transition, one adolescent noted that they told their psychiatrist about their gender dysphoria, but they did not feel comfortable discussing it further after the psychiatrist refrained from treating it:

“Former psychiatrist treated [me] for depression but did not treat for gender dysphoria. [I] did not like him...not helpful because [I] never felt comfortable talking to him about gender dysphoria. Saw [psychiatrist] after suicide attempt. Stopped seeing because [I] did not feel comfortable talking to him.” (20-year-old transgender female)

Finally, an 18-year-old transgender male, described their painful history of conversion therapy:

“[I saw therapist] on and off for a while. Conversion therapy...until 16. Every week for a month...then stop for three months...then come back. Horrible, hated. Told [therapist] to [expletive] off.”

Several non-affirming therapist behaviors were reported as therapy barriers. For instance, an 18-year-old transgender male noted that his therapist refused to provide a letter of support for their medical gender transition:

“[I was] sent to [first therapist] who wouldn’t write letter. Then went to [current therapist].”

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Additionally, both caregivers and adolescents noted a general dearth of gender-affirming therapists. Even when participants identified gender-affirming therapists, they reported that these therapists were located far away or did not accept new clients and/or their insurance plan.

Engaging Caregivers in Therapy

Both adolescents and caregivers described multiple forms of positive caregiver involvement in therapy. Adolescents described caregivers assisting them in identifying a therapist, attending therapy sessions with them, and/or participating in family therapy:

“[Therapy] helpful. Strategies and how to be mindful. Parents are involved always.

Sometimes alone, sometimes together.” (15-year-old transgender female)

One adolescent likened the nature of family therapy to a team:

“Started seeing [therapist] more than a year [ago]. Parents wanted to find someone to learn more about transition...what they were dealing with. [I] have [an] occasional session with her [but] mostly with family. [Therapy] is mostly about transitioning and being [a] team.” (18-year-old transgender female)

As noted by this same participant, adolescents appreciated therapists who provided psychoeducation to their caregivers on TGD identity, expression, and/or related stressors:

“Therapist talked [about transition]. Good. Helpful. [Therapist] sees [me] with parents.

Often if they are confused about something. [Therapist] can differentiate between trans and teen behavior.”

Echoing reports from adolescents, caregivers described helpful therapists who facilitated their understanding of TGD identity and supportive behaviors (e.g., what to say) through psychoeducation:

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“[I] saw [adolescent] as tomboy. [I] went to a therapist to learn about trans stuff. Realized [being transgender is] not just in [adolescent's] head. There were some things not to say.”

(Parents of 15-year-old transgender male)

Caregivers described positive interactions with therapists who engaged them in their adolescent's individual therapy sessions, including instances in which therapists (with adolescents' permission) facilitated communication regarding gender identity:

“[We] weren't aware of [adolescent's] identification as transgender until therapist shared in 7th grade. Wish [we] would have known to be more supportive.” (15-year-old transgender male)

Caregivers of a 13-year-old transgender male similarly discussed learning about their adolescent's affirmed name from their adolescent's therapist (with the adolescent's permission):

“[We] call [adolescent] by [affirmed initial] at home. [Adolescent] appreciates us trying. Last week, therapist said [adolescent] doesn't want to be called [birth-assigned name]. Wants [affirmed name]. [I] worry what other people will say. [Adolescent] doesn't seem overly anxious about this recently. [I'm] really trying.”

Caregivers also reported valuable experiences attending sessions with their adolescent:

“[I] know [adolescent] may lose friends [and] family members. In time, [those people] will change. [I] told [adolescent] in session with therapist...that dad, brother, and I are on [adolescent's] side.” (Mother of 15-year-old transgender female)

A mother and stepfather of a 13-year-old transgender male described how their adolescent's therapist helped him navigate discipline, which he had been responding to with threats of self-harm or suicide:

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“[Adolescent] would use triggers words: will ‘kill self, hurt self.’ Hard to navigate [because adolescent was] holding [this] over our heads with discipline. [This] made [our] job harder. [We] felt trapped. [Therapist] helped to navigate that. [Therapist explained,] ‘You are [the] parents [and] have to discipline.’ [Therapist] gave us opportunity and verification at the end of [session]. Helped [adolescent] be more accountable on lies. [Therapist was] not aggressive.”

Caregivers also described positive experiences and outcomes within the context of family therapy with their TGD adolescents:

“We butt heads. Both of us want to have the last say, [that’s] why we’re in therapy. I always wanted [adolescent] to understand my point right away. [Adolescent] was very stubborn when it comes to discipline. [Adolescent] didn’t want to listen to what I had to say. We always make up if we have a fight, especially more so now. We are able to be more mindful of each other.” (Mother of 15-year-old transgender male)

The mother of 15-year-old transgender female described a family therapist who helped her support her adolescent’s coming out process:

“[Adolescent] has been talking to therapist [about] wanting to come out to friends. Trying to come out this year: new year, new life. [Adolescent] wants to throw a party and come out to all. When talking to therapist, [we] talked about coming out to extended family.”

In another case, when asked about their relationship with their adolescent, caregivers of an 18-year-old transgender female stressed the value of family therapy:

“[We] sought family counseling. Process of going to counseling made [our] relationship better. Relieved to be somewhere else. [We are] now more whole.”

Alienating Caregivers from Therapy

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A few adolescents shared instances of caregivers who expressed discomfort or terminated therapy in response to therapists' directive advice to support their adolescent's gender:

“[First therapist] said [to caregivers], ‘[Your] son is trans. You should support him.’

[Caregivers] found someone else. [Second therapist] specialized in trans youth. [We]

worked on coping because [parents] were not supportive. I was frustrated and angry.

Parents didn't like [being] the focus [of therapy]. [Therapist] would meet with me, then

them. Told them same thing as [first therapist].” (18-year-old transgender male)

A 17-year-old transgender male described a similar response from his father following a therapy session, which may have related, in part, to the therapist's inexperience working with families:

“My therapist doesn't do family therapy, but he has met with my mom and dad. My dad

said it didn't go over well. He thought my therapist was using the ‘gay agenda.’”

Underscoring these adolescent reports, caregivers of a 19-year-old transgender female shared their perception of a therapist they viewed as overly confrontational:

“[Therapist] was setting up [therapy] as adversarial. This will be harder. Told [us that

adolescent] needs to transition in next year. Told [us], “You need to get on

bandwagon...or [adolescent] will do it [alone] at 18.”

Discussion

Our qualitative analysis of clinical interview data from TGD adolescents and/or their caregivers revealed that therapists' gender affirmation and engagement of caregivers in therapy were central to their experiences. Many participants highlighted satisfactory experiences with therapists they perceived as gender-affirming, while several reported unhelpful experiences with those viewed as non-affirming. Both adolescents and caregivers highlighted the value of engaging caregivers in therapy in ways that were explicitly gender-affirming (e.g., providing

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TGD-specific psychoeducation to caregivers) as well as in ways common in youth therapy broadly (e.g., setting boundaries around discipline). Finally, a few participants reported that caregivers were alienated from therapy when therapists were directly confrontational in expressing the importance of affirming their adolescents' gender.

Gender Affirmation is Important to TGD Adolescents and Their Caregivers

Both TGD adolescents and their caregivers described a variety of positive experiences with therapists perceived as gender-affirming or having expertise in therapy with TGD adolescents. Adolescents especially appreciated opportunities to discuss gender-related stressors (e.g., coping with unsupportive caregivers, gender dysphoria) and processes (e.g., transitioning, coming out to others) and therapists who provided TGD health resources. Notably, many of these practices represented small modifications to therapy that addressed many other concerns (e.g., anxiety, stressors at school). Results also suggest that therapists' *lack* of knowledge in TGD health and identity can hinder treatment satisfaction and engagement (Corliss et al., 2007; Guss et al., 2019). Consistent with previous research (Gridley et al., 2016), even when participants identified gender-affirming therapists, they did not always accept relevant insurance and/or were unable to see new clients.

Future Directions

These findings add to the growing body of research highlighting the need for more therapists trained in gender-affirming practices (Hope et al., 2016). Participants perceived small modifications (e.g., TGD-specific psychoeducation) to therapy as gender-affirming and satisfactory, suggesting that minor additions to a therapist's practice may signal expertise, comfort, or a gender-affirming stance. Indeed, gender-affirming skills are not specific to any therapy orientation or modality and can thus be easily integrated into any practice (American

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Psychological Association, 2015). Though evidence on the effectiveness of provider trainings in gender-affirming care is nascent, preliminary studies suggest that knowledge in TGD-specific health significantly improves after a brief training (Hughto & Clark, 2019; Lelutiu-Weinberger et al., 2016). While these findings are promising, the systematic development, implementation, and dissemination of provider-training interventions in gender-affirming care may be essential to increasing the number of adequately trained therapists. A list of training and education resources (e.g., online courses, recommended articles, professional guidelines) in gender-affirming care for therapists, with an emphasis on recommendations for clinical work with TGD youth, is provided in Table 3.

Effectively Engaging Caregivers Can Improve Therapy

Results highlight the importance of engaging caregivers in therapy with TGD adolescents, such as providing gender-affirming psychoeducation and resources to caregivers (e.g., about ways to support their adolescent) and involving them in therapy sessions (e.g., discussing the process of coming out to extended family). These findings are consistent with broader youth therapy research demonstrating the value of active caregiver engagement (e.g., Haine-Schlagel et al., 2012; Martinez et al., 2017) and its association with stronger treatment outcomes (Dowell & Ogles, 2010). Our results also mirror findings from studies of gender-affirming medical care, indicating that caregivers of TGD adolescents appreciate when clinicians provide TGD-specific knowledge (Schimmel-Bristow et al., 2018) and act in supportive and non-judgmental ways without pressuring caregivers to make decisions (Pullen Sansfaçon et al., 2020). Indeed, existing clinical guidelines (e.g., Rafferty, 2018) suggest that caregiver engagement is facilitated by therapists using a gradual and supportive approach while providing TGD-specific psychoeducation and advice on gender-affirming parenting practices. Of note,

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however, therapists should carefully consider if and how to engage unsupportive caregivers in therapy with TGD adolescents (e.g., with adolescents' permission, beginning with separate sessions), and caregiver engagement is *not* recommended when it poses a risk to adolescents' safety (Coolhart & Shipman, 2017).

In a few cases, therapists who assertively directed caregivers to support their adolescent's gender (e.g., "get on the bandwagon") alienated them, sometimes resulting in caregivers terminating therapy. These findings are similar to recent studies indicating that caregivers of TGD adolescents sometimes feel pathologized by providers (Alegria, 2018; Gregor et al., 2014). Notably, research suggests that listening to and validating caregivers' experiences may increase their engagement in therapy, at least in part, by reducing the discomfort associated with feeling judged by their adolescent's therapist or blamed for their adolescent's struggles (Baker-Ericzen et al., 2013). Thoughtful and effective caregiver engagement may be especially important for caregivers who experience vicarious stress related to their adolescent's gender identity (e.g., fear that their adolescent will experience gender-related victimization; Hidalgo & Chen, 2019).

Future Directions

Future studies would benefit from exploring strategies for caregiver engagement in therapy, such as examining gender-affirming therapists' perceptions of successful and unsuccessful methods of caregiver engagement. Though we could not reliably distinguish between caregiver involvement in an adolescent's individual versus family therapy for each participant, those who were explicit about modality expressed satisfaction with both forms of involvement. While clinical guidance for gender-affirming family therapy is mounting (e.g., Bernal & Coolhart, 2012; Coolhart & Shipman, 2017), determining the best practices for involving caregivers in both modalities is an important area for future research.

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Strengths and Limitations

Relative to most qualitative studies on TGD health care experiences, the current study had a large sample of adolescents and caregivers and explicitly examined therapy, an important yet understudied health service. However, reliance on interviewer notes rather than verbatim transcripts may have resulted in missed themes (i.e., interview notes may be less comprehensive than transcripts and vulnerable to interviewer subjectivity; Hojilla et al., 2016). Moreover, more themes may have emerged if the interview protocol included additional questions specific to therapy experiences. Extant studies on TGD people's health care experiences with therapy-specific findings have been limited to samples of TGD adults (Benson, 2013) and older adolescents (Corliss et al., 2007; Sperber et al., 2005), and few have included caregiver perspectives (Gridley et al., 2016). Our study's inclusion of younger adolescents and caregivers yielded unique findings not previously explored in, and potentially less relevant to, older samples. However, this study is limited in its focus on families accessing gender-affirming medical care. That is, in addition to having knowledge of a gender-affirming clinic, participants also had economic and social privileges enabling treatment access. Likewise, our sample was predominantly White, and most had private health insurance. The racial and socioeconomic homogeneity of this sample is consistent with other studies of TGD adolescents recruited from gender clinics (Edwards-Leeper et al., 2017; Olson-Kennedy et al., 2019) but not representative of the racial and socioeconomic diversity found in large samples of TGD people (James et al., 2016). While participants shared many negative experiences in therapy, it is possible that these were underreported due to participants' desire to communicate readiness for gender-affirming medical care. Finally, most adolescents in this study had some level of caregiver support, as the majority had caregivers who participated in an interview and consented to treatment. In other

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words, our sample was not representative of TGD adolescents with respect to caregiver support, which population-based studies have shown is especially low (e.g., Eisenberg et al., 2017).

Accordingly, our results may not be generalizable to TGD youth broadly, but rather, primarily reflect the needs and experiences of those that have some support from at least one caregiver.

Conclusion

Mental health inequities among TGD adolescents (e.g., in symptomatology; Connolly et al., 2016; in therapy access; Evans et al., 2017) represent a serious public health concern (Institute of Medicine, 2011). By elucidating positive (e.g., provider knowledge on TGD health and resources) and negative (e.g., preventing access to transition-related care) therapy experiences from the perspectives of TGD adolescents and their caregivers, our study reveals the urgent need for, and potential benefits of, therapist-focused trainings in gender-affirming practices. This approach may be invaluable to affirming TGD adolescents' identities and experiences and appropriately engaging their caregivers in therapy, which has considerable potential to improve TGD adolescents' access to and outcomes in therapy.

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Table 1*Definitions of Frequently Used Terms*

Term	Definition
Affirmed name	Name chosen to best reflect one's gender identity (i.e., chosen name; not the name assigned at birth; Vance et al., 2020)
Cisgender	Individuals whose gender is consistent with their birth-assigned sex (Rafferty et al., 2018)
Conversion therapy	Treatment models used to dissuade TGD individuals from identifying as transgender and/or exhibiting gender-diverse expressions (Rafferty et al., 2018)
Gender-affirming care	Practices designed to support and understand an individual's gender experience, which integrate providers' knowledge of experiences unique to TGD people and their associations with health (Pachankis, 2018; Rafferty et al., 2018)
Gender dysphoria	Distress resulting from incongruence between one's gender and birth-assigned sex (Rafferty et al., 2018)
Gender expression	Outward presentation of gender, including how one looks (e.g., hairstyle, use of makeup), dresses, and/or behaves (e.g., vocal inflection, mannerisms; Rafferty et al., 2018)
Gender identity	An individual's intrinsic sense of self as male, female, or another gender (e.g., genderqueer), which may or may not be consistent with their sex assigned at birth (Rafferty et al., 2018)
Gender transition	Shifting from a gender presentation consistent with one's birth-assigned sex to a gender presentation consistent with one's affirmed gender (Coleman et al., 2012)
Transgender and gender diverse (TGD) people	Individuals whose gender identities or expressions do not conform to culturally-defined norms associated with their birth-assigned sex (Chen et al., 2016)

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Table 2*Interview Participation and Participant Demographics*

Interview Participation (n)		Participant Demographics (n)	
Adolescent only	8	Adolescent (n=49)	Caregiver (n=65)
Caregiver only	1	Age (range, M(SD))	11-20, 15.5(1.7) 36-84, 48.1(7.6)
Adolescent and caregiver (separate)	80	Race/Ethnicity	
<i>Total interviews with codable data</i>	<i>89</i>	African American	1 0
Caregiver Relationship to Adolescent		Asian	1 0
<i>Two caregivers completed interview</i>	<i>46</i>	Latinx	8 3
Father	23	Non-Hispanic White	37 44
Mother	20	Non-Hispanic Other	2 1
Stepmother	1	Missing	0 17
Adoptive mother	1	Adolescent Gender Expression, Identity, and Birth-Assigned Sex	
Adoptive father	1	<i>Self-identified gender expression</i>	
<i>One caregiver completed interview</i>	<i>19</i>	Nonbinary/nonconforming	5
Father	4	Transgender	44
Mother	12	<i>Self-identified gender identity</i>	
Foster mother	1	Gender fluid	1
Missing	2	Gender queer	1
Insurance Type (by Adolescent)		Nonbinary	4
Public (e.g., Medicaid)	12	Transfemale	9
Military insurance	2	Transmale	34
Private	35	<i>Birth-assigned sex</i>	
		Birth-assigned male	11
		Birth-assigned female	38

TGD ADOLESCENTS' AND CAREGIVERS' THERAPY EXPERIENCES

Table 3*Resources for Therapists Seeking Training & Education in Gender-affirming Care*

Resource Type	Details
Free webinars, publications, and videos on transgender health	Learning resources for behavioral health providers provided by The National LGBTQIA+ Health Education Center at https://www.lgbtqihealtheducation.org/resources/in/behavioral-health,transgender-health/
Online courses (some free of cost) on counseling competencies with LGBTQ clients, including courses specific to TGD clients	Provided by the American Counseling Association at https://aca.digitellinc.com/aca/lessons/1
Recommended articles detailing gender-affirming practices for mental health clinicians working with TGD youth and their families	<p>Austin, A. (2018). Transgender and gender diverse children: considerations for affirmative social work practice. <i>Child and Adolescent Social Work Journal</i>, 35(1), 73–84. https://doi.org/10.1007/s10560-017-0507-3</p> <p>Austin, A., & Craig, S. L. (2015). Transgender affirmative cognitive behavioral therapy: Clinical considerations and applications. <i>Professional Psychology: Research and Practice</i>, 46(1), 21–29. https://doi.org/10.1037/a0038642</p> <p>Edwards, L., Goodwin, A., & Neumann, M. (2019). An ecological framework for transgender inclusive family therapy. <i>Contemporary Family Therapy</i>, 41(3), 258–274. https://doi.org/10.1007/s10591-018-9480-z</p> <p>Edwards-Leeper, L. (2017). Affirmative care of TGNC children and adolescents. In A. Singh & dickey (Eds.), <i>Affirmative counseling and psychological practice with transgender and gender nonconforming clients</i>. (pp. 119–141). American Psychological Association. https://doi.org/10.1037/14957-006</p>
Professional practice guidelines for therapists working with TGD clients	<p>American Counseling Association. (2010). American Counseling Association Competencies for Counseling with Transgender Clients. <i>Journal of LGBTQ Issues in Counseling</i>, 4(3–4), 135–159. https://doi.org/10.1080/15538605.2010.524839</p> <p>American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. <i>American Psychologist</i>, 70(9), 832–864. https://doi.org/10.1037/a0039906</p>

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[includes guidance specific to TGD youth]