Trans and Gender Nonconforming (TGNC) Clients' Experiences of Therapy and Their Gender Identity Related to TGNC-Focused Media

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Abstract

Transgender and gender nonconforming (TGNC) communities experience elevated levels of mental health distress than do their cisgender counterparts (Anzani et al., 2019; Parr & Howe, 2019). TGNC identities have also become increasingly visible in popular media over the last decade (Gillig et al., 2018). Though representation of TGNC narratives and experiences has grown, therapists continue to feel unequipped to work with their TGNC clients (O'Hara et al., 2013), and a third of TGNC clients have reported negative experiences in therapy (Anzani et al., 2019). The current study considers how mainstream representation impacts TGNC clients' experiences of therapy and of their gender identity, asking the research question, What are TGNC clients' experiences of therapy and their gender identity as it relates to media that focuses on TGNC identities? Four participants were interviewed from a feminist standpoint and hermeneutic phenomenological framework. Six themes and 17 subthemes were identified, with participants speaking to their relationships with media within and outside of therapy, affirmative and non-affirmative moments experienced in therapy and their impacts, and their view towards the future of TGNC mental healthcare and the role of media in this care. Participants' testimony can inform work towards more gender-affirming therapy practices, including understanding the salience of media for TGNC communities and the ways it can inform therapeutic processes and relationships.

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Chapter One

Introduction

Increased attention has been drawn in recent years to the state of mental healthcare for transgender and gender nonconforming (TGNC) service users, as it relates to elevated levels of mental health concerns and suicidality for TGNC individuals in comparison with the general public (Anzani et al., 2019; Parr & Howe, 2019). This focus has been mirrored by a growth in media representations of TGNC narratives, histories, and political actualities (Gillig et al., 2018), which have progressively become a core method by which the public understand and relate to the TGNC folks they interact with in their own lives (Kosenko et al., 2018; Miller et al., 2020). The impact of this representation on the mental health field has been understudied, and research on mental health professionals' perceptions of their TGNC clients is primarily limited to general testimony from therapists, rather than to client experiences. Research has demonstrated that therapists feel ill-equipped to adequately serve their TGNC clients (O'Hara et al., 2013), and it follows that the gaps in their knowledge may be filled (consciously or unconsciously) by media depictions of TGNC identity. As mainstream representation often relies on stereotypical, one-dimensional, and pathologising depictions of TGNC narratives (Billard et al., 2019; Krell, 2017), the presence of this source of knowledge in the therapy room is potentially problematic.

The therapy and counselling field currently has little insight into how media representations affect TGNC clients in therapy, and the present study contributes to current knowledge in the literature. My primary research question was: What are TGNC clients' experiences of therapy and their gender identity as it relates to media that focuses on TGNC identities? I drew on feminist standpoint theory as well as hermeneutic phenomenology in the process of addressing these questions, privileging the voices of a traditionally underserved client population while recognising the immutable role of myself as researcher and co-constructor of knowledge. This work is driven by those who it impacts most, in an effort to acknowledge historical and current gender bias in mental healthcare for gender diverse populations (Burnes et al., 2010) and collaborate with TGNC clients from a decolonising research lens (Greensmith & Giwa, 2013).

Semi-structured interviews were conducted with four participants. Purposive sampling was conducted through social media and relevant community organisations across Canada. Interview questions followed the domains of interest of participants' perspectives on TGNC-

centred media, experiences media in the therapy room, and the impact of media on identity. Data analysis followed hermeneutic principles, including thematic analysis following van Manen (1997).

My aim in pursuing this project was to add to the existing literature on TGNC mental healthcare. Ultimately, I hope to heighten therapists' awareness of how media impacts their work with TGNC clients by exploring the intersection of readily accessible sources of information about TGNC identity, as well as TGNC individuals' current experiences of the mental healthcare they receive. In the process, I aim to privilege the voices of TGNC clients to discuss their experiences, and collaboratively envision a better future of TGNC mental healthcare.

Note on Terminology

This study focuses on gender identity, rather than sex characteristics, and I therefore used the term "gender other than that assigned at birth" to designate eligibility for the study. There has been much discussion in recent literature on sex as separate from gender (Schellenberg & Kaiser, 2018), and I do not wish to conflate the two. We are typically assigned a sex at birth, which as we develop, is most often conflated with a corresponding gender identity. I avoid the use of the term sex in this study as I did not wish to imply that only individuals who have surgically or hormonally modified their sex characteristics were eligible for the study. Rather, "gender other than that assigned at birth" indicates that an individual's current gender identity differs from how they were anticipated to identify based on their assigned sex at birth.

Throughout the thesis, I will primarily use the term transgender and gender nonconforming (TGNC) to reference any person identifying as a gender other than that assigned at birth. This includes Two-Spirit, trans, non-binary, genderqueer, genderfluid, bigender, and agender people, as well as those who self-identify with any other label and consider themselves TGNC. Much of the current literature has focused exclusively on binary TGNC identities (i.e., those who identify as trans men or trans women) and nonbinary as an umbrella identity, and I acknowledge the erasure of specific TGNC identities that is inherent to a broad research focus on TGNC as the identity marker – most importantly to Indigenous Two-Spirit communities, whose experience of gender may be outside common signifiers used in Eurocentric research paradigms. I feel that the TGNC designation is useful within the scope of this study, but I would suggest the reader keep in mind that the identities of participants in this study are a limited sample within the broad diversity of TGNC identities.

I also frequently reference media and popular/mainstream media in the thesis. My use of the term 'media' here is broad, and includes film, television, books, newspapers, magazines, theatre, visual art, music, websites, radio/podcasts, video games, and social media (including particular content creators/accounts, blogs, and discussion threads). I will use the term 'TGNC-centred media' as shorthand for media that depicts TGNC identities, experiences, narratives, or histories in some way.

The designation of popular/mainstream suggests widely distributed and funded media sources and objects, whether that be an Oscar-nominated film, a bestselling novel, or a viral tweet. Following the testimony of participants, it became clear that the definition of 'popular' media is evolving within social media in particular; a trans TikTok creator may be well-known within TGNC communities but not identifiable to those outside the community. By contrast, in traditional (non-social) media, mainstream representations like *Degrassi* (2001-2015) or *Orange is the New Black* (2013-2019) were most often mentioned. This definition therefore imprecisely reflects participants' experiences, and relies on the assumption that discussions of media in therapy would primarily reflect mainstream depictions of TGNC identity rather than smaller communities of creators or media that would not be considered traditionally mainstream or popular. I retain the designation of popular/mainstream within the introduction section of the thesis, nuancing it further within my case descriptions, themes, and discussion. My aim here is to reflect the hermeneutic dialogue between my initial perspective as researcher, and the experiences of participants.

Personal Prelude

The field of mental healthcare for TGNC folks is deeply important to me, and I am drawn to carry out this research from a position of care and a commitment to social justice in the therapy/counselling profession. Through personal friendships and community work over the past number of years, I have witnessed how mental healthcare so often fails TGNC individuals and their circles of care, and the enduring harms that are perpetuated by a system that sidelines gender diversity as simply another identity marker of which to be aware. TGNC clients in therapy have complex needs that cannot be reduced to their gender identity, and their experiences are far from homogenous. Popular media is a tool through which many individuals first encounter TGNC identities, though it often reinforces this assumption of homogeneity. I am invested in the significance this media holds for TGNC individuals, as I am in media

representation more broadly. Through this present research I have developed a curiosity for how the domains of media representation of TGNC identities, and current practices in mental healthcare for TGNC folks, may intersect.

I approach this project as an insider/outsider; my gender identity is often variable, and I am primarily out to those closest to me who also identify as TGNC. Simultaneously, I am perceived by many of my family members, friends, and strangers as cisgender and am comfortable with the pronouns most people assume that I use, and therefore benefit from the privilege of passing as the gender I was assigned at birth. I have experienced confiding my gender identity in a trusted other, and recognise the abundance of feelings that come along with that process – even when responses are validating and supportive, there is tremendous vulnerability in allowing another person to see you at this level of selfhood. What does that look like when your trusted other is a therapist? *What informs their responses*, and what impacts do these responses have?

Chapter Two

Literature Review

The first section of the literature review will provide an overview of mental healthcare for TGNC individuals. This will include a consideration of the role of minority stress and microaggressions, a summary of the history of mental and medical healthcare with TGNC populations, discussion of current practices in therapy with TGNC clients, and a look towards emerging approaches. I will then consider the ethical duties of therapists to provide affirmative care for their TGNC clients.

The second section will focus on media representations of TGNC individuals. I will discuss the recent shifts in popular media representation, the significance of this representation for TGNC individuals, and the potential for this TGNC-centred media to be a tool for learning for the broader public.

The third section will bridge the topics of TGNC mental healthcare and media, with a consideration of how media may be present in the therapy room. This will be linked with a summary of the current study, and I will provide the research question.

This review is organised based on the two major themes of this project, TGNC mental healthcare and TGNC-centred media. I aimed to include primarily recent sources in both areas – both have evolved significantly in recent years and continue to do so, and my study is focused on current or recent experiences of participants as they relate to either area. Sources were selected from a broad search of the literature and then narrowed down, often drawing from authors who have built on each other's work. My aim was to provide an overview of the current literature in both areas, as relevant to my study.

TGNC Identity and Mental Health

Throughout the literature review, I will use the term TGNC-affirmative (or TGNC-affirming) care to refer to mental healthcare that accounts for the whole of TGNC persons' identities and experiences, and centres them as experts. Benson (2013, p. 23) defines affirmative therapy as:

> …refer[ring] to a therapeutic approach that adopts a positive view of transgender clients by respecting their self-defined identities and addresses the impact of a normative gender society on their lives. Affirmative therapists possess an understanding of the stigmas that transgender

> clients live with and accept the person as they define themselves in terms of their gender and sex. They grasp the knowledge and skills needed to work with these clients in a manner that does not legitimize bias against them and assist them in exploring complexities in their relationships… Affirmative practice requires that clinicians understand terminology and concepts regarding gender identity.

TGNC individuals face numerous barriers when accessing mental healthcare, despite their particular risk for mental health challenges (O'Hara et al., 2013; Parr & Howe, 2019). Mental health considerations and standards of care for TGNC populations are often grouped in with those of lesbian, gay, and bisexual (LGB) individuals (Kelleher, 2009; Meyer, 2003), despite TGNC individuals having unique experiences related to gender-based violence and suicidality (e.g., up to 41% of TGNC individuals have attempted suicide) that should be considered independently (Anzani et al., 2019; Parr & Howe, 2019). Current literature suggests that mental health professionals are rarely well-equipped to respond to the particular needs of TGNC populations or provide TGNC-affirmative care – and client experiences range from beneficial to actively harmful (Benson, 2013; Hunt, 2014; White & Fontenot, 2019). In the 2015 U.S. Transgender Survey, 18% of respondents indicated that a mental healthcare provider had tried to prevent them from identifying as transgender, 33% reported a negative experience with mental healthcare providers in the previous year, and 23% feared prejudice from mental healthcare providers (Anzani et al., 2019).

In a concise analysis of common barriers experienced by TGNC clients in therapy, Mizock and Lundquist (2016) interviewed 45 TGNC therapy clients with the aim of describing what they term "missteps" in therapy with TGNC clients, using a semistructured interview protocol informed by grounded theory. They recruited participants from the Northeastern United States, and their sample included trans women, trans men, and genderqueer or genderfluid individuals. They ranged in age from 21 to 71 and were predominantly white; most were receiving outpatient therapy services at the time of the interview. The authors identified eight core themes from within participants' testimonies: 1) education burdening, or therapists relying on the client to educate them about gender diversity; 2) gender inflation, exaggerating their focus on a client's gender identity at the expense of other concerns; 3) gender narrowing, attempting to box their clients into their own pre-understandings about gender; 4) gender avoidance, brushing

aside the importance of gender in the client's life; 5) gender generalising, assuming that all experiences of gender diverse individuals are the same; 6) gender repairing, treating a client's gender diversity as a problem to be cured; 7) gender pathologising, labelling gender diversity as a mental illness and/or the cause of a client's other mental health struggles; and 8) gatekeeping, controlling access to transition-related medical resources.

A review of the literature conducted by White and Fontenot (2019) considered research that collected mental health data from TGNC persons both the United States and Canada. They included both quantitative and qualitative research that reported TGNC mental health experience data. A total of 96 academic articles met inclusion criteria. Many participants across the studies described welcoming mental healthcare practitioners, who were knowledgeable about TGNC care, used correct names and pronouns, were comfortable and proficient in openly discussing gender, and personally advocated for TGNC communities. Care tended to become less affirming when clients discussed complex topics such as trauma and gender identity directly. They also experienced stigma and invalidation of their experiences, which in some cases made them less interested in seeking mental healthcare in future, even when they felt they needed it. All studies indicated that participants have experienced "incidents of discrimination that include[d] experiences of rejection or insensitivity, denial of services, and/or violence" (p. 205). These invalidations and negative experiences were more pronounced for adults over the age of 60, and for clients who also identified as a racial or ethnic minority. White and Fontenot (2019) conclude that despite these important findings, the representation of TGNC clients' mental healthcare experiences remains limited in the therapy/counselling literature.

A study by Applegarth and Nuttall (2016) found that TGNC clients were fearful about starting therapy due to expectations that their identity or experiences would not be well understood. In qualitative interviews with six participants ranging in age from 30 to 49, the researchers found that clients felt pressured to appear "as [trans] as possible" (p. 70) in order to be taken seriously by their therapists. Participants echoed themes described by Mizock and Lundquist's (2016) participants, namely gender pathologising and gatekeeping. Several participants also described the difficulty of being vulnerable in the therapeutic relationship, but that the relationship was ultimately affirming and led to increased self-confidence and personal growth. TGNC clients' experiences in therapy are as diverse as clients themselves, and while they often benefit from therapy in the same way cisgender clients do, the standard of care they

receive can rarely be described as TGNC-affirming. Anzani et al.'s (2019) interviews with 64 predominantly white TGNC participants illustrates this well. When TGNC participants were asked to describe positive experiences in therapy, "many of their examples were not overtly positive; rather, their examples indicated a lack of negative responses" (p. 263). In fact, basic components of therapeutic work, such as maintaining a structure within session, were perceived as being TGNC-affirming. When experiences of pathologisation and misunderstanding are anticipated by default, the bar is set low for what constitutes affirming care.

Minority Stress and Microaggressions

Contemporary understandings of the relationship between marginalised identity and mental wellbeing are often informed by Meyer's (2003) model of minority stress. Meyer posits that individuals from marginalised identity groups experience prejudice, systemic oppression, and societal alienation as mental health stressors with impacts similar to those of other personal or psychological stressors. These stressors are often maintained by microaggressions, defined as subtle or unconscious daily instances of discrimination (Anzani et al., 2019; Morris et al., 2020). Relevant examples include identity nonaffirmations (e.g., failure to use correct pronouns) or lack of accommodations (e.g., inviting TGNC speakers to a panel at a venue without gender-neutral bathrooms) [Parr & Howe, 2019]. Microaggressions play a considerable role in the experiences of TGNC clients in therapy, where TGNC clients encounter practitioners who may either overly emphasise the role of gender in their mental health concerns, or express discomfort in discussing gender at all (Morris et al., 2020; WPATH, 2012). The themes outlined by Mizock and Lundquist (2016) in the previous section each represent what might be termed a microaggression, and the cumulative burden of such responses from therapists and counsellors sustain a culture of rejection within mental healthcare for TGNC communities. Speaking to the ubiquity of microaggressions in therapy, 27% of participants in the study by Anzani et al. (2019) reported an absence of microaggressions as evidence of TGNC-affirming practice.

Morris et al. (2020) conducted online surveys with 91 TGNC participants, with the specific purpose of obtaining data on microaggressions experienced by this population in therapy. Their sample was predominantly white, ranged in age from 18 to 62, and were from thirteen countries. Most reported that their primary reason for attending therapy was related to gender identity, and all had attended therapy within the previous five years. Participants spoke to a general lack of respect and judgement from clinicians, having their identity questioned, being

misgendered, and being referred to in sexually objectifying ways. Therapists conflated sexual orientation and gender identity, overemphasised gender in participants' presenting problems, and engaged in gatekeeping around access to letters for gender-affirming surgery or hormone therapy.

It is evident that the line between microaggressions and other harmful experiences in therapy is far from defined, and what one author or participant may define as a microaggression, another may see as a misstep (Mizock & Lundquist, 2016) or simply par for the course (Anzani et al., 2019). Regardless of terminology, I conceptualise all of these experiences as maintaining minority stress, as well as resulting in negative impacts on mental health.

History, Current Practices, and the Future of Mental Healthcare for TGNC People

History

The history of biased practice with TGNC populations in therapy and counselling is acknowledged in standards of care such as those set by the American Counselling Association (ACA) [Burnes et al., 2010]. Western medical interest in gender diversity began in the 19th century, where TGNC identities were often conflated with "homosexuality," and presumed to be a form of psychopathology (Drescher, 2010). Gender confirmation surgery (then called sex reassignment or sex change surgery) became more widespread throughout the early to mid-20th century, a shift which was opposed by many physicians and psychiatrists. A survey of American physicians in the 1960s showed that the majority of physicians were opposed to gender reassignment surgery, and that close to 30% believed that TGNC people were either "severely neurotic" or "psychotic" (Drescher, 2010, p. 427). Gender identity disorder (GID) appeared in the third edition of the DSM in 1980, mostly through efforts of physicians who believed that TGNC people deserved access to appropriate medical care and understanding from the medical and psychiatric community. A diagnosis of GID, now called gender dysphoria, was necessary for TGNC patients to receive transition-relevant medical care. As Drescher notes, psychiatric classification may serve to increase public empathy for those suffering from a 'disorder' versus those making a lifestyle choice; however, the pathologising connotations of 'mental disorder' rarely ensure that such groups are viewed with full respect. Standard E.1 of the ACA guidelines states that therapists should be aware of the history of classification of gender diversity as a mental disorder in the Diagnostic and Statistical Manual of Mental Disorders (DSM), and how

mental health professionals have historically provided substandard care for TGNC clients and their families due to gender bias (Burnes et al., 2010).

Current Practices in Therapy with TGNC Clients

The diagnosis of gender dysphoria is included in the current version of the DSM, and was included in previous versions from the DSM-III under the name of gender identity disorder. The World Professional Association for Transgender Health (WPATH) Standards of Care 7 (2012) defend this inclusion as disorders "[are] a description of something with which a person might struggle, not a description of the person or the person's identity" (p. 5). It might be contested whether the public understands the term 'disorder' in this way, and whether all TGNC persons experience their gender identity as a struggle. A diagnosis of gender dysphoria continues to be required in most regions of the United States and Canada in order for an individual to commence surgical or hormonal transition, which many TGNC individuals have described as gatekeeping by mental healthcare providers and other medical staff (Benson, 2013).

Best practice for therapists working with TGNC clients is available, and is disseminated by large-scale organisations such as WPATH and the ACA. These competencies are also reflected and upheld in official statements and position papers published by Canadian organisations such as the Canadian Psychological Association (CPA). These standards of care, despite their official backing, are optional reading for therapists who are motivated to seek them out, and are limited in scope even when they are accessed. The WPATH Standards of Care (2012) are intended as global guidelines for healthcare work with TGNC clients, though in their attempt to be relevant across international healthcare contexts, they fail to consider the diversity of healthcare systems, financial requirements, procedures for referral, and so forth that TGNC clients and their healthcare providers will encounter. WPATH guidelines specific to mental healthcare include assessing for gender dysphoria, preparing clients for hormonal or surgical transition, facilitating the coming-out process, and advocating for clients in their communities (2012). There are few details or specifics that therapists can draw from these guidelines in terms of therapy process, and much of the information is specific to medical rather than mental health professionals.

The availability of trainings for working with TGNC clients has increased in recent years, though they are rarely integrated within formal academic training programs for therapists (Applegarth & Nuttall, 2016; Benson, 2013; O'Hara et al., 2013). Qualitative research with

cisgender therapists of TGNC clients suggests that they have a limited knowledge of the particularities of TGNC mental health, and feel initially unprepared to work with this client population (O'Hara et al., 2013); research with TGNC clients suggests they feel likewise about their therapists' competencies (Benson, 2013). O'Hara et al. (2013) conducted a focus group with seven therapists-in-training in the United States. Participants described their main sources of learning about TGNC identities as personally knowing someone who was TGNC and seeing representations of TGNC issues in the news and media. Information on working with TGNC clients was also included in some course textbooks and lectures. The researchers also surveyed 87 participants at the same university, assessing them using the Gender Identity Counsellor Competency Scale. Their results demonstrated that more advanced students did not score higher in competency for working with TGNC clients than did beginner students, and students who had completed a practicum did not score higher in competency than those who had not. The authors therefore conclude that quantity of academic training and direct client experience are not correlated with increased competency in working with TGNC clients. They do not explore, however, where these gaps in training are most significant, or how therapists apply their informal training (e.g., through the media) to their work with TGNC clients.

O'Hara et al. (2013) posit that increased professional contact with TGNC clients would help mediate these deficiencies in training, and that such contact is necessary for an adequate multicultural foundation in therapist education. In a survey of 95 participants, Kanamori and Cornelius-White (2017) found that therapists and therapists-in-training are generally likely to view TGNC clients positively, with female therapists demonstrating more acceptance than male therapists, and queer therapists demonstrating more acceptance than heterosexual therapists. Personal familiarity with TGNC persons was significantly correlated with interpersonal comfort with TGNC clients. In contrast with O'Hara et al.'s (2013) suggestion, Kanamori and Cornelius-White (2017) found that increased professional training with TGNC individuals was not significantly correlated with increased comfort working with TGNC populations, nor with perceiving TGNC clients as having higher value as human beings.

Another recent study with healthcare workers demonstrated that increased quantity of education around standards of care for TGNC clients does not lead to greater knowledge of such competencies. Rather, competency post-training was related only to pre-existing beliefs about TGNC identities, such as degree of transphobia (Stroumsa et al., 2019). In other words, research

suggests that neither increased training experience with TGNC clients, nor further education around how best to care for TGNC clients, may be related to more comfort or competence when working with TGNC clients, or respect for them as individuals – in fact, it may negatively impact these domains.

It is notable that both of these studies considered experience and education with TGNC clients in quantitative terms, and we have little information on whether the *quality* of education or experience has an impact on the mental healthcare TGNC clients receive. Some of these authors have speculated about the effectiveness of certain types of training or direct client experience in increasing therapist competency (O'Hara et al., 2013; Stroumsa et al., 2019), but it remains unclear which interventions may help or harm their ability to adequately support a gender diverse clientele.

Emerging Affirmative Practices with TGNC Clients

As noted by Spencer et al. (2021, p. 38), much recent work on designing more trans-inclusive mental healthcare has been limited to "the 'dos' and 'don'ts'" of therapy with TGNC clients. Some researchers in the field have begun to expand on these fundamental publications, and to generate more integrative approaches to TGNC mental healthcare. The book *Affirmative Counselling with LGBTQI+ People* (2017), published by the ACA, offers several chapters on working with transgender, nonbinary, Two-Spirit, and genderqueer clients, and includes comprehensive summaries of the history of care with these populations, common issues and barriers experienced, appropriate terminology, relevant counselling skills, and multicultural considerations. Though much of its content is specific to the American context, it is significant in its attempt to go beyond the introductory content of many similar resources.

Spencer et al. (2021) outline their Gender-Affirmative Life Span Approach (GALA) for therapy with TGNC clients, and also suggest its relevance for healthy gender identity development for all clients. It is composed of six core therapeutic components: developing gender literacy, building resiliency, moving beyond the binary, supporting pleasure-oriented positive sexuality, and making empowering connections to medical interventions. They include three case studies for implementing the model with clients of various ages, describing one client who reviewed popular media that engaged with themes of gender in-session, as a conduit for exploring her own relationship to gender. The authors note that while GALA is an innovative

approach to psychotherapy that is grounded in existing research on TGNC-affirmative therapy, it requires further empirical validation and adaptation to diverse therapeutic contexts.

In a review of the literature, Collazo et al. (2013) identify emerging issues in TGNC mental healthcare, and note several areas of focus necessary to TGNC-affirmative care. They argue that therapists should consider gender concerns and sexuality, body image and dysmorphia, the role of discrimination and harassment, and social supports in their assessment of TGNC clients. The authors recommend that therapists educate themselves about TGNC-relevant barriers to care and other challenges, such as by watching documentaries, rather than expecting clients to educate them. They emphasise the role of community for TGNC clients, and suggest that therapists encourage their clients to find a feeling of community either in person or through social media.

Other authors describe specific types of interventions that may be beneficial for TGNC clients. Lancaster and Terepka (2021) describe media as a tool for generating dialogue about gender identity, when therapists or clients may otherwise hesitate. Integrating the importance of social support and the increasing accessibility of TGNC-relevant media, the authors argue that media is uniquely meaningful to TGNC and LGB clients. They offer guidelines on how to safely integrate this intervention, a case study detailing how it might function, and potential challenges. In an applied example, Budge et al. (2021) designed a pilot training program for therapists they called Building Awareness of Minority-Related Stressors + Transgender Affirmative Psychotherapy (BAMS). This training included psychoeducation about causes of mental health stressors in TGNC communities, and instructions to prompt clients to reflect on experiences of minority stress each week. They conducted a randomised controlled trial of a 12-session BAMS protocol in comparison with treatment as usual (therapists who had general knowledge of TGNC-specific experiences and conducted person-centred therapy) for twenty TGNC-identified participants. Though no significant differences were found in psychological distress between baseline and posttreatment for either condition, participants in the BAMS condition did experience a (not statistically significant) reduction in internalised transphobia and nonaffirmation experiences that were sustained at 6-month follow-up. Notable in terms of qualitative data is that all participants characterised their experience as positive, and stated they would participate again.

These newer approaches and recommendations are important, and demonstrate that there is an interest in the literature toward moving beyond introductory material, or theoretical guidelines, on working with TGNC clients. However, much of this work is exploratory, and the focus remains on how therapists can feel more equipped to work with TGNC clients, rather than how clients are themselves impacted by these interventions. The impact of therapist education or beliefs on outcomes for TGNC clients is unknown (Budge et al., 2021). Research on the experiences of TGNC clients in therapy does not often discuss particular interventions or theoretical orientations, and as such therapists and counsellors have a limited picture of *what specifically* is working (or not) in therapy with TGNC clients.

Ethics and Harm

The evidence around therapist lack of preparedness to work with TGNC clients, and general dearth of research on how clients are impacted by the therapy they receive, is concerning – particularly when considered in relation to the ethical duties to which therapists are bound. Issues of autonomy, justice, and nonmaleficence are particularly salient here (LaSala & Hyatt, 2019), as is the CPA's statement of responsibility to protect vulnerable individuals and groups (CPA, 2017). Microaggressions are ethical violations, and are enacted in ways that are population-specific – for example, a TGNC client brings up a piece of media or news story relevant to their gender identity, and the therapist responds with apathy or dismissal. What might have been a client's attempt to broach cultural connection with their cisgender therapist has now become a missed opportunity to discuss identity in a meaningful way – a nonaffirmation that could be considered a microaggression (Anzani et al., 2019; Morris et al., 2020). Lack of competency with TGNC clients itself serves as an ethical violation, where many professional codes of ethics (e.g., that of the CPA) state that therapists must only service populations with whom they are competent, and to engage in self-reflexivity around the limitations of their knowledge (Morris et al., 2020). Therapists wishing to self-educate on working with TGNC clients are increasingly able to do so, but the accessibility of this material is limited, and there is little information on whether it is being integrated into formal training programs.

I will now move from a consideration of TGNC mental healthcare and its relationship to the therapy and counselling profession, to a discussion of the role that media plays in influencing public perceptions of TGNC populations.

Media Representing TGNC Identities

Media representations of TGNC narratives and histories have increased since the 1970s (McInroy & Craig, 2015), though only in the past few decades have empathetic and humanising portrayals of TGNC lives become more dominant (Cavalcante, 2017). From the use of gender nonconformity to provoke fear in films such as *Psycho* (1960) or *The Silence of the Lambs* (1991), to the sensationalising of victimhood portrayed in *Boys Don't Cry* (1999) or *Dallas Buyers Club* (2013), TGNC individuals have rarely been given authority over their own stories in popular media, though they endure the repercussions of these representations nonetheless. A study published by Trans Media Watch (2010) demonstrated that TGNC individuals feel that negative media representations inform the attitudes of loved ones toward their identity, and they report both verbal and physical harassment as a result of these stereotypical depictions.

Time Magazine coined the "transgender tipping point" in 2014, where positive visibility for TGNC narratives in popular media was at an all-time high, partly attributed to the popularity of the character of Sophia on *Orange is the New Black* (2013-2019), played by Black trans actress Laverne Cox (Gillig et al., 2018). Television shows such as *Pose* (2018-2021) and *Euphoria* (2019-present) continue this trend, centering the experiences of increasingly dynamic TGNC characters. These mainstream depictions of TGNC narratives nonetheless mirror cultural norms of oppression; representations of thin, able-bodied, middle- to upper-class, white TGNC individuals are those most privileged (Krell, 2017). Simultaneously, mainstream media remains focused on those TGNC individuals who pass (i.e., are perceived as cisgender) most effectively, and on those who occupy binary rather than fluid or nonbinary gender identities. This attentional sphere fails to consider how ideas of gender conformity are themselves informed by racism, colonialism, and classism, through a privileging of Eurocentric standards of beauty and dualistic notions of gender (Krell, 2017). Moreover, popular fictional depictions of TGNC identity are overwhelmingly produced, written, and directed by cisgender individuals, and are therefore informed by stereotypes and identity oversimplification even when attempting to be sympathetic (Billard et al., 2019). In both documentary and fictional media, cisgender viewers often appear to be interested by TGNC narratives only when their medical history is sensationally on display (Baril, 2018), or when they are the victims of violence (Billard et al., 2019).

Significance of Media for TGNC Populations

Recent work has also explored the relationship that TGNC viewers have with media depicting TGNC identities. Media that represents TGNC identities, despite its frequent reliance on stereotype and catering to a cisgender audience, offers a source of resilience for TGNC individuals, whether as a resource for establishing social connections with other TGNC folks, a tool for exploring possible expressions of their identity or the process of transitioning, or as a translation of lived experiences for loved ones who may be otherwise ignorant of TGNC identities and stories (Cavalcante, 2017; Craig et al., 2015; Kosenko et al., 2018; McInroy & Craig, 2015). Simultaneously, many TGNC voices in the literature are critical of how their identity is depicted in the mainstream. One study on TGNC identity nonaffirmations found that the most significant nonaffirmation reported by participants was being dehumanised in the media (Parr & Howe, 2019). Media plays a complex role in the lives of TGNC people across a broad range of representations, a complexity which should be considered when broaching discussions of media in therapy.

Several researchers in recent years have conducted interviews with TGNC-identified participants on representations of TGNC identities in media. Cavalcante (2017) found that participants felt that media depictions of TGNC identities were progressing in a positive direction, but that they also fostered an invasive and sensationalising attitude towards TGNC people by the general public. Participants used media to promote cultural understanding around their identities for friends and family members, a function that was also echoed by participants in Kosenko et al. (2018). Kosenko et al.'s (2018) participants furthermore described using both on- and offline media to make sense of their own identities, and create shared meaning and a sense of community with other TGNC people. They described media as the beginning of their education about different TGNC identities and transition options, and online (social) media as a platform to record their own gender identity development. Both Cavalcante (2017) and Kosenko et al. (2018) acknowledge that TGNC-centred media has expanded dramatically since their interviews were conducted, and recommend further research that considers these more recent developments.

McInroy and Craig (2015) and Craig et al. (2015) reported on a set of interviews they conducted with TGNC youth (aged 18-22) on their perspectives of TGNC representations in media. Participants in their study described differences in representations in online and offline media, and a general lack of representation was identified, and a lack of positive representation specifically. Many participants had differing views on the same TV show or movie, in terms of

whether they felt it to be a positive or negative representation of a TGNC person. Participants used media to create online community and identify shared experiences, as well as to fight back against stereotypes and online harassment. They also identified with celebrity role models from media, both TGNC-identified and allied. Despite their complex relationship with TGNC-centred media, TGNC youth described media as offering an escape, providing a break from regular discrimination in their daily lives.

Media as a Tool for Encounter and Learning

Looking more broadly, it is essential to reflect on the potential impacts of this increasing mainstream media representation of TGNC identities. It is well established that much of our societal knowledge stems from the media we consume (Kosenko et al., 2018), and as noted by one participant in Cavalcante (2017, p. 544), "if you've never met a trans person before, everything you know is from media." Importantly, research suggests that media consumption may play a role in shaping perceptions of TGNC identity specifically, such as whether surveyed participants believe TGNC people to be moral or trustworthy, or support the rights of TGNC people to use their bathroom of choice (Jones et al., 2018). This finding is echoed by the testimonies in Kosenko et al. (2018) and Cavalcante (2017), where TGNC-identified participants used media as a tool for cultural understanding between themselves and their friends and relatives. Through the parasocial contact established between media consumers and TGNC media figures, an audience may come to feel a connection with members of a particular identity group, while their direct interpersonal contact with group members remains limited (Miller et al., 2020). The attitudes formed while following, for example, the transition of a public figure such as Elliot Page, are likely to inform attitudes toward other TGNC individuals that a person encounters – if not TGNC identities as a whole (Miller et al., 2020). As media representing TGNC narratives becomes increasingly abundant and dynamic, the interpersonal relevance of media to cisgender and TGNC people, including therapists/counsellors and clients, remains understudied.

The Presence of Media in the Therapy Room

The current literature suggests that popular media can play a significant role in the identity formation of TGNC individuals, and in how cisgender consumers of media construct their perceptions of TGNC populations. However, no research to date has specifically investigated the impact of media depictions of TGNC narratives within the therapy room –

though it appears plausible that what impacts the general media-consuming population would likewise impact mental health professionals and their clients, particularly as the vast majority of practitioners feel that their formal training in supporting TGNC populations is limited at best (O'Hara et al., 2013). Media could present itself in both direct, structured ways, such as through a therapist proposing that their TGNC client read a particular book that they will subsequently discuss, or more spontaneously, such as a client making a passing reference to a TGNC-centred news story that was published the previous weekend (Lancaster & Terepka, 2021; Schulenberg, 2003). It is also necessary to consider the potential impacts of a therapist's failure to reference relevant popular media or disclose their own encounters with stereotypical portrayals of TGNC identity, and the resulting conspicuous absence of shared knowledge between TGNC clients and their therapists.

More structured media references in the therapy room have most typically taken the form of cinematherapy. Cinematherapy as a technique ranges from making recommendations to clients on films to watch, to exploring film narratives together in session (Schulenberg, 2003). While there are no studies to date on the experiential use of cinematherapy (or other media-informed techniques) with TGNC clients, guidelines for the use of cinematherapy with particular client groups have been published. Lancaster and Terepka (2021) suggest that cinematherapy may provide a beneficial medium through which LGBT [sic] clients can explore their own experiences. Clients identify with the narratives depicted, while simultaneously remaining somewhat distanced from their own harmful or traumatic experiences that may feel unsafe to explore in earlier stages of therapy. By bringing film into the therapeutic space, therapists can work to strengthen the therapeutic alliance in multiple ways – learning more about clients' marginalised identities, broaching challenging emotions and themes in a safer way, and better supporting clients in their therapeutic aims as they converge with or differ from those of film characters (Lancaster & Terepka, 2021).

Though cinematherapy represents one modality of bringing media into the therapy room, it is plausible that most therapists and clients who reference media in the therapy room do so with less intentionality or structure. Researchers have examined the ways that popular, stereotype-reliant media representations make their way into the therapy room, and how those less intentional encounters can be transformed into opportunities for an enhanced therapy relationship and outcome. West (1995) described common stereotypical representations of Black

women in film and television, and offered insight into how these stereotypes show up for therapists working with Black women. Ashley (2014) later expanded on West's (1995) work to offer a case study of how explicitly naming media stereotypes in session, in this case that of the "angry Black woman," can help contextualise and validate the lived experiences of marginalised clients. Though working in a more spontaneous way than traditional cinematherapy, Ashley's (2014) case study demonstrates how the detrimental effects of racist media representations can be worked through in therapy, and that broaching awareness of the representations themselves is likely the first step. This naming requires critical awareness of, and comfort working with, common media representations of marginalised populations.

These more spontaneous references are equally important as those used structurally, as an avenue for clients to gain insight on their therapists' level of understanding and humility around marginalised identities, as well as for clients to relate their own experiences to the media they consume. The literature has so far not considered the impact of a therapists' or clients' off-hand reference to a documentary about a trans jazz singer (*No Ordinary Man*, 2020), for example, or perhaps more likely (following Billard et al., 2019) to a news story about the murder of a Black trans sex worker. Nor has it considered the impact of a therapist failing to reference contemporary events in the media that may impact TGNC clients' lives, such as anti-TGNC legislation being introduced in Texas (Torchinsky, 2022), or a lack of awareness of more systemic media stereotypes of TGNC people, following West (1995) and Ashley (2014). As TGNC-centred media becomes increasingly part of our normative media landscape, it is important to consider the interpersonal consequences of not only in-depth therapeutic analysis of TGNC-centred media, but also less intentional interactions with media.

The Current Study

Current literature provides little insight into how TGNC clients are impacted by references to media, or lack thereof, in the therapy space. There is some work around the influence of media stereotypes of other nondominant groups on the practice of psychotherapy (Ashley, 2014; West, 1995), but it has yet to be connected to work with TGNC clients. Further, the literature has not prioritised clients' first-hand experiences of references to media, regardless of demographic – the view of media in the therapy room that we do have has been dictated by the perceptions of therapists and academic researchers. The mainstream media landscape depicting TGNC identities is multifaceted, with many TGNC individuals both positively

impacted by and critical of the ways by which they are represented. Much of the existing literature in this area demonstrates that public attitudes about TGNC populations do often stem in part from media (Jones et al., 2018), including attitudes held by mental health professionals (Kanamori & Cornelius-White, 2017; O'Hara et al., 2013). Simultaneously, much of existing research on TGNC-centred media (outside the field of media studies) is relatively dated in terms of what films, television shows, or contemporary events are considered, while it frequently subsumes representation of TGNC narratives into those of LGB populations. As TGNC identities in media continue to expand and diversify, it is important that the impacts on TGNC clients in therapy are recognised and examined.

Day-Vines et al. (2007) discuss the concept of "broaching culture," the process by which cultural differences are acknowledged and interrogated in the therapy room. Though their work specifically discusses broaching behaviour around race, their argument for broaching as an essential multicultural competency is also salient for TGNC clients. Therapists may avoid discussing cultural factors altogether, or take on an active identity as agents of social change for their culturally marginalised clients. Clients may likewise feel varying degrees of comfort and interest in centering their identities in therapy. Media may provide an accessible tool for broaching culture between therapists and TGNC clients. Where research suggests therapists feel their training to be inadequate (O'Hara et al., 2013), hesitant therapists may use media as a bridge of understanding between their limited experiences and their gender diverse clients; in turn, clients may reference media as a bridge between their therapists' limited training and their own aims to represent themselves and their experiences. This broaching might range from more passive media references to direct engagement with a particular media text as a therapeutic tool (Schulenberg, 2003). Simultaneously, therapists with limited training and experience may feel hesitant to broach culture through the lens of media, potentially missing opportunities to relate to clients and explore the ways that media has impacted their identity development or experience of self. These speculations have yet to be interrogated in the therapy and counselling literature, and form the basis for the present study.

The research question I posed in my study was: What are TGNC clients' experiences of therapy and their gender identity as it relates to media that focuses on TGNC identities?

Chapter Three

Methodology

Conceptual/Theoretical Framework

My primary aim in this study was an exploratory look at the phenomenon of TGNC-centred media in TGNC clients' therapy. As I have outlined thus far, there is no existing literature that considers the links between TGNC therapy experiences and the changing media landscape for TGNC representation. Exploratory work demands a consideration of lived experience, an attention to the "intentions and perspectives of those involved in social interactions" (Agee, 2008, p. 432), that is endemic to qualitative work. In short, I wanted to see what media representing TGNC narratives, identities, and histories looks like in the therapeutic space, as dictated by those who have experience with this phenomenon.

Affirmative TGNC healthcare is a young field; invasive, pathologising, and dehumanising projects that centred researcher assumptions and desires for knowledge were the norm for the greater part of the 20th century (Barker, 2019). My motives for pursuing this research project are rooted in a belief that the therapy and counselling profession can and should do better for our TGNC clientele, and that a richer understanding of TGNC folks' experiences in therapy can improve the ways in which we enact change toward this goal. The literature supports the idea that our perceptions of TGNC individuals are informed by their representations in media, and it follows that these perceptions in turn influence therapy/counselling for TGNC clients. What does this influence look like?

I aimed to conduct qualitative work from a non-positivist stance (Laverty, 2003) that, rather than seeking to uncover or illuminate some 'hidden' phenomenon, allows participants to speak to their experiences and the meaning those experiences hold – in both their relationship with mental healthcare and in their broader lives. I used semi-structured interviews for this purpose, a method supported by Hesse-Biber (2007) as appropriate for exploratory work that seeks to get at specific aspects of a phenomenon. My interviewing techniques and approach to the data were informed by feminist standpoint theory (Harding, 2004) and hermeneutic phenomenology (Laverty, 2003) as theoretical framework and methodological guide respectively. These bodies of theoretical knowledge are entrenched in a social constructivist paradigm, which recognises that reality is rooted in local knowledge and that all research is

informed by the values and cultural positionality of the researcher, research participant, and the existing body of literature (Laverty, 2003).

Feminist Standpoint Theory

The current study is based in feminist standpoint theory. Feminist standpoint theory was founded with the intention of bringing women's lived experiences into academic research, enriching the prevailing research base as well as promoting feminist social change (Brooks, 2011). The history of academic work has privileged the voices of (white, middle- or upper-class, educated, cisgender) men, while simultaneously taking their experiences and perspectives as objective reality (Brooks, 2011; Harding, 2004). As feminist standpoint theory moves us toward understanding society through women's eyes, these claims to objectivity are challenged, as are the structures that limit women's experiences and the valuing of their perspectives (Brooks, 2011).

This theoretical framework has expanded since its inception in the 1960s to consider the standpoints of diverse groups of women as well as other marginalised groups. A standpoint focus permits insight into power dynamics and how we understand them regardless of specific identity (Rouse, 2009), and Harding (2004) highlights the applicability of standpoint theory to queer social justice movements in particular. I am applying feminist standpoint theory to my proposed study for two central reasons: one, I am valuing the experiences of participants who experience gender marginalisation; two, I believe that these perspectives may be applied toward social change, namely more affirmative and responsive mental health services for TGNC clients. Mainstream feminism has not always been welcoming toward those who were not designated as 'women' from birth or who seek feminist justice outside the gender binary (Brooks, 2011), and this exclusion continues to be enforced by many institutionally powerful 'feminists' today (Krell, 2017). A feminist consideration of the experiences of gender diverse individuals is arguably all the more essential, as the feminist research field must remain committed to valuing the standpoints of our TGNC siblings and ensuring their care and safety.

Sprague's (2005) text on feminist qualitative research methods offers guidelines by which feminist standpoint theory can be applied to methodological choices within research. She describes four concerns that traditional qualitative research has typically ignored, namely power dynamics within the research relationship, the objectification/Othering of research participants, the role of power in who can access participation in research, and assumptions in interpretation

of the data guided entirely by researcher pre-understandings. Feminist qualitative researchers have attempted to mitigate these challenges in multiple ways, such as by fostering a more reciprocal researcher-participant relationship, involving participants in the analysis, and creating a more collaborative research process. As Sprague (2005) documents, these critical approaches do not always succeed in prioritising the research agenda or even participants' best interests; for example, aiming for reciprocity and collaboration but instead violating a participant's boundaries, or asking them to take time to review themes when they may already have limited resources. Feminist research must instead operate from the standpoint of marginalised voices, base interpretations in participants' own descriptions of their interests and experience, recognise power relationships and collaborate with the viewpoints of other researchers, and centre an empowering social justice agenda in how participants' experiences are represented (Sprague, 2005).

Research Methodology

Hermeneutic Phenomenology

van Manen defines methodology as the "theory behind the method, including the study of what method one should follow and why" (1997, pp. 27-28). Phenomenology at its core draws from the philosophy of Husserl, who critiqued the application of traditional scientific methods to human subjects and emphasised a study of the phenomena of lived experience (Laverty, 2003). Heidegger expanded on these ideas and argued for considering human experiences within sociocultural and historical contexts; the field of hermeneutics is therefore an attempt at understanding the meanings of personal experience as rooted in these contexts (Laverty, 2003). Both Heidegger and his student, Gadamer, refuted the notion that experience could be considered neutrally by an external observer, challenging dominant scientific paradigms of objectivity and positivism (Turner, 2003; Vandermause & Fleming, 2011). Indeed, in this branch of phenomenology, researcher pre-understandings and assumptions are seen as a tool intrinsic to the interpretive process. Hermeneutic phenomenology does not therefore aim to uncover a universal experience of a particular phenomenon, but rather a person's specific experience of a phenomenon and its meaning, as interpreted by the researcher (Vandermause & Fleming, 2011; van Manen, 1997).

An essential concept in Gadamerian hermeneutic phenomenology is that of the fusion of horizons (Alsaigh & Coyne, 2021; Barak, 2022). In recognising the inseparability of the

researcher's pre-understandings to the interpretation of the text, Gadamer emphasises that encounters between the researcher's knowledge and the text co-construct each other. The fusion of horizons is the point at which the researcher's pre-understandings encounter the meanings within the text, and both the researcher's knowledge and the meaning of the text are expanded (Alsaigh & Coyne, 2021). The researcher's pre-understandings and the text are in repeated dialogue throughout the research process, from the development of research questions, to transcription of interviews, to representation of participants in the written thesis. In Gadamerian hermeneutics, the purpose is not to uncover an existing reality that exists somewhere 'out there' waiting to be documented, but to generate new meanings through the conversation between researcher and text (Barak, 2022). Nor is the purpose to give voice to a one true and conclusive interpretation; it is recognised that infinite worldviews are possible and that our interpretation represents but one snapshot of a phenomenon, described by particular people, at a particular time, albeit a valuable and important interpretation (Alsaigh & Coyne, 2021).

Barak (2022) suggests that cultural references, such as popular media, are an additional horizon which becomes fused with that of the researcher and the text. All objects, concepts, and experiences are understood in the context of one's own culturally based resonances; "the linguistic process of understanding always contains cultural resonances within it" (Barak, 2022, p. 773). In the case of my study, I am deliberately eliciting these cultural resonances from participants. Participants have a contextual relationship with the media they discuss with their therapists or counsellors, and subsequently with me. These references are fused between our horizons in multiple ways – for example, this creation of a new horizon is markedly different if they are referencing a TV show I also know and love, than one I have heard critiqued in passing. It is essential to acknowledge that the participants in my study and I are likely to share culturally based media resonances relevant to queer and TGNC communities, as we share an (overarching) in-group identity. Barak (2022) notes, however, that this fusion of my cultural resonances as researcher with those of participants in my study does not negate the need for cultural humility, and to take care to not impose one's perspective as the researcher onto the context and experiences of participants.

van Manen's Hermeneutic Phenomenology. van Manen's (1997) text *Researching Lived Experience: Human Science for an Action Sensitive Pedagogy* served as a guide throughout the processes of preparation, data collection, and data analysis. Though approaching

hermeneutics from a focus on education and the experiences of children, van Manen offers a profound rationale for the importance of phenomenological work and insights on what is to be prioritised in such a project. He describes phenomenology as "want[ing] to know what contributes to the good of [a] person" (1997, p. 6), a "philosophy of the personal" (p. 7) that emphasises the uniqueness of *what it is like to* experience a particular phenomenon. Simultaneously, phenomenology should be legible to those who interact with it, living into participants' experiences while remaining within our own sphere of experience; it is essentially intersubjective. Participants are speaking experiences into being, into which we speak our own experience as researchers as we repeatedly dialogue with the text. This speaking (recollecting, sharing, recording, transcribing, re-encountering) is our proxy for interaction with the original experience, and this transformation of the experience must be made explicit within the process of data collection and analysis.

The application of this way of thinking in the current study is outlined further in the Method section below.

Rationale For Hermeneutic Phenomenology. A hermeneutic methodology is appropriate to the consideration of subjective experiences in my study, as I aim to privilege the individual voices of TGNC therapy/counselling clients and interpret the meanings of their experience within the sociocultural context of TGNC mental healthcare. My pre-understandings are essential to this research process (Appendix H), and I engaged in analysis of my own assumptions throughout. Beginning with the personal prelude in this proposal, I followed the hermeneutic tradition in making research from my desire for a more just system of TGNC mental healthcare. My pre-understandings on this topic are many, and following hermeneutic phenomenology, they served to enrich both the research process and the current thesis writeup.

My rationale for employing a hermeneutic phenomenological methodology is manifold. At its core, hermeneutic phenomenology offers a pathway for interpreting participant experiences according to their own language and idiosyncrasies. Following Turner (2003), we encounter a fusion of horizons with our participants as we see our pre-understandings reflected in varied ways in their testimonies, or sometimes not at all. Hermeneutic phenomenology is adaptive in this way, and alters the perspectives of researcher, participant, and reader in profound ways with each textual encounter (Turner, 2003). This methodological choice also bolsters my interest in interviewing TGNC clients as opposed to their therapists. As the voices of medical

and academic professionals have been privileged in the history of TGNC healthcare, a shift of privilege opens doors toward interpretive meanings yet unspoken in the literature.

I do not mean to suggest that I am somehow offering a ground-breaking (or even unique) gateway to meaning expression for participants in my study. A sense of cultural humility (Danso, 2018) requires a checking-in around power differentials between researcher and participant, particularly the privilege given to academic sources over the lived experiences of TGNC individuals who may lack institutional backing. Simultaneously, however, it is important that the therapy and counselling literature be saturated with the voices of those who are not currently being served by mainstream psychological services. Mook (2010) writes that a "good interpretation [in psychotherapy] is attuned to the concrete specific circumstances of a particular client" (p. 219). This research orients the therapy and counselling literature toward the specific experiences of participants, in an aim to model a more affirmative orientation of therapists toward their TGNC clients.

Hermeneutic Phenomenology and Feminist Standpoint Theory

I have chosen to consider feminist standpoint theory as my theoretical framework as it informs my orientation to this project, particularly the social justice emphasis in my work. Hermeneutic phenomenology likewise informs my orientation to this research but offers a more precise guide as to methodology and data analysis. These two knowledge bases interact in the process of my study, and I draw on significant parallels that exist between them.

The concept of the hermeneutic circle describes the interrelationship between researcher, participant, text, and the multiple and ever-changing readings that encompass the process of hermeneutic research (Debesay et al., 2008). Understanding of the text (i.e., the interview transcript) becomes more complex through repeated re-engagement with it, and the researcher's pre-understandings (see Appendix H) challenged and expanded as a result. This core process of hermeneutic phenomenological research is well-aligned with feminist standpoint theory, where the perspectives derived from lived experience of participants are deliberately presented to challenge the existing biases and assumptions of researcher and research audience (Brooks, 2007). A feminist hermeneutic circle would be intentionally focused toward a more just future for feminist subjects; in the case of my study, for trans clients in the mental healthcare system. This future is not informed solely by the intentions of the researcher, nor by the testimony of

research participants, but rather co-constructed, re-read, re-considered, in the process of phenomenological meaning making.

I also advocate for a theoretical basis in feminist standpoint theory as a response to the aspects of hermeneutic phenomenology that I believe would be enhanced by this lens. The move toward understanding and challenging of pre-understandings that is inherent to hermeneutic phenomenology is valuable to my proposed research (Turner, 2003), though I desire the additional push toward social justice that is ensured by establishing roots in feminist qualitative research (Brooks, 2007). I work far from the plane of 'true' phenomenology, which craves a total absence of the researcher (Laverty, 2003); I allow my (feminist, critical, justice-oriented) pre-understandings to guide the research process, and approach my encounters with participants from the hermeneutic principle of openness and fusion with the perspectives of others (Turner, 2003).

Method

Participants and Recruitment

My approach to sampling in this study was guided by qualitative principles that value the subjectivity of individual participants (Morrow, 2007), as well as the centering of the relationship between participant and researcher that is essential to both hermeneutic phenomenological and standpoint theory (Brooks, 2011; Turner, 2003). Emphasis was placed on choosing participants with lived experience who were interested in discussing their encounter with the studied phenomenon, and whose experiences were dissimilar enough from one another to promote a rich and diverse overall picture of the phenomenon (Laverty, 2003). My sample size was limited by resources and time available for this study at the Master's level; I recruited four participants, which is in line with typical practice in phenomenological research (Starks & Trinidad, 2007). Participants provided rich and nuanced testimony of their lived experiences, diverse perspectives on current practice within mental healthcare for TGNC communities, and insightful ways of imagining the future of this care.

Sampling was conducted purposively, as is common in much qualitative and phenomenological work (Morrow, 2007) as well as feminist research (Hesse-Biber, 2007). This included both convenience and snowball sampling. Convenience sampling was conducted online through contacting community organisations and resource centres across Canada that catered to TGNC communities, seeking participants who met the inclusion criteria: a) identifying as a gender other than that assigned at birth (including identifying as Two-Spirit, trans, non-binary,

genderqueer, genderfluid, bigender, agender, etc.); b) being 18 or older; c) being able to meet virtually; d) having participated in individual therapy or counselling for at least one session; e) not currently participating in therapy; f) having disclosed their gender identity to their therapist or counsellor; and g) being able to share about experiences of therapy and TGNC identity as it relates to media. The decision not to include participants who were in ongoing psychotherapy was driven by the ethical consideration of minimising harm, as interviewing about ongoing therapy risked impacting existing therapeutic work and client-therapist relationships (Patino & Ferreira, 2018). Snowball sampling consisted of inviting prospective and actual participants to share the recruitment text (Appendix A) with others they thought may be interested in participating.

Instruments

The instruments I used for data collection included the demographic questionnaire (Appendix E), semi-structured interview guide (Appendix F), and myself as researcher.

Demographic Questionnaire. The purpose of the demographic questionnaire (Appendix E) was to gather relevant information about participants' background that informed my interpretation of what participants offered in the interviews (e.g., I assumed that certain themes may have been reflected more in some contexts over others as related to, for example, setting of therapy or age of participants). It included a blank text box for participants' gender identity and pronouns. This was a deliberate choice in line with the principles of my study, as I hoped to communicate an expansive view of gender identity and expression to participants in my study. Qualitative work allows for such diversity of experience and identity, as the need for ultimate quantification is absent; the researcher can, with intentionality, counter the dominant research paradigm that seeks to categorise and limit the characteristics of the gendered other (Singh & dickey, 2016). Participants could include as many gender signifiers and pronouns as they chose to disclose. Other sections of the questionnaire referred to experiences in therapy or counselling, as well as other demographic variables.

Interview Guide. The semi-structured interview guide (Appendix F) drew on principles in both hermeneutic phenomenology and feminist research. Hesse-Biber (2007) recommends employing an interview guide when a specific agenda is sought in the research process – in this case, a particular phenomenon – though advises that an interview that is too highly structured risks centering the research agenda above participant experiences. This goes against the

phenomenological emphasis on openness and participant-driven work (Laverty, 2003), and I therefore aimed to keep the interview guide as informal as possible while including those questions essential to my study. My project, as a preliminary look at media references in therapeutic experiences for TGNC clients, was based in my own inferences from what limited research has been conducted previously. It was thus particularly important that I question my own pre-understandings, propensity toward asking leading questions, and desire for specific findings or themes in the data.

The overarching theme of media in therapy/counselling served as the primary prompt, with more specific domains being TGNC-centred media (e.g., "Do you engage with any of this media personally?"), overall perspectives on therapy/counselling ("What is your sense of mental healthcare services and access for TGNC people?"), and the experience of therapy ("How did you respond to the media references that impacted the therapy process?") and of identity ("Was there a lasting impact on your sense of gender?") related to this media. Questions (Appendix F) were designed with the aim of generating rich descriptions of participants' experiences as relevant to the research question. They were also based in domains of interest that arose from the literature review, such as media as a tool for identity development (e.g., Cavalcante, 2017; McInroy & Craig, 2015). Participant responses directed the rest of the interview, with opportunity for them to expand their responses in each domain. Follow-up questions arose as appropriate (and were added to the interview guide as I gained preliminary data), but I remained committed to learning from participants first and foremost and allowing them to highlight the aspects of their experience they felt were most important.

van Manen (1997) asks us as researchers to stay as close to participants' experiences as possible. This emphasis was reflected in my interview approach, though adapted to accommodate multiple aspects of what I hoped to learn in this research. For example, I asked participants to reflect on the state of TGNC mental healthcare more broadly, what van Manen may not consider to be experience-close testimony. Integrating feminist standpoint theory here, I would argue that the experience of politics, of discourse, of how one's identity and care are defined in the broader public, are inseparable from 'experience-close' descriptions such as a specific dialogue exchange between a participant and their therapist.

Interview questions were piloted with a friend who identifies as nonbinary approximately one week before the start of interviews, and feedback was provided. The guide was well-received

by my friend and we met for about an hour to share ideas about the research project more broadly. This conversation was used to help gain clarity on what sort of testimony I was hoping to elicit with my chosen questions, and we built on our discussion to further refine the order of questions, pilot the flow of hypothetical interview responses, and consider more specific follow-up prompts. The guide was not altered significantly beyond the organisation of questions, though the ideas from our discussion stayed with me and helped inform later changes, such as including a specific prompt about participants' views on whether therapists could use media as a tool of learning.

Researcher as Instrument. Qualitative research necessitates a consideration of the presence of the researcher within the research. Both hermeneutic phenomenology and feminist standpoint theory further emphasise this role, and I recognise that my research is informed by my pre-understandings (Appendix H), depth of reflexivity, and existing skills and interests. I made my positionality explicit to participants, as outlined in the Introduction section of the interview guide. I was mindful of accessibility of terminology, and sought to use participants' own language both within the interview and in my final narrative. As the project progressed, I engaged in reflexivity about my own experience of the research, keeping research notes describing reflections, decision-making, and assumptions and understandings that inevitably arose as I conducted my interviews. I engaged with these notes within the final thesis, contributing to a hermeneutic circle (Turner, 2003) between the self as researcher, participants and their experiences, and my-self as it has changed throughout the interview process.

The parallels between therapy/counselling practice and qualitative interview techniques are many (Binder et al., 2012; Morrow, 2007), and I aimed to bring my counselling education into these interviews. As a social justice-focused, narrative-inclined practitioner, this research reflects the type of psychotherapist that I hope to be. My interviews necessitated empathic presence, a recognition of pre-understandings, and entering into relationship with an as yet unknown person (Binder et al., 2012), skills which are fundamental for therapists as well as researchers in the qualitative tradition. In this way, I was motivated to privilege the voices of participants and make space for their experiences in the literature on TGNC mental healthcare.

Procedures

Recruitment. Ethics approval was obtained from the University of Ottawa Research Ethics Board (Appendix I). Following approval, I shared a recruitment poster (Appendix A) and

study description (Appendix B) with queer and TGNC-centred resource centres and community organisations across Canada, using my own local knowledge of relevant organisations in Ottawa and St. John's, as well as search engines and internet databases to ensure thorough coverage of Canadian provinces and territories. At least one organisation was contacted in each province and territory. I also shared the recruitment message and poster with personal contacts who have connections to TGNC community organisations. This initial message was accompanied by a recruitment letter (Appendix C) inviting relevant contacts within organisations to disseminate the recruitment text by email or social media. Interested participants contacted me via email to express their interest. I then provided the study description (Appendix B), and if participants replied with continued interest, I arranged a meeting with them to conduct the interview via Zoom. A total of 13 participants expressed interest in the study, and once inclusion criteria were reviewed, four remained eligible. All eligible participants were interviewed. A copy of the consent form (Appendix D) was then forwarded to them. They were given the option of signing and returning it via email or providing verbal consent at the start of our interview (Greensmith & Giwa, 2013). At participants' discretion, the interview guide (Appendix F) was also shared with them at this time (three of the four participants requested to see the interview guide in advance).

Data Collection. Participants were sent a scheduled Zoom link a few days prior to their interview, which could only be accessed with either the direct link or a password.

Interviews began with an introduction as well as an overview of the study aims and my background as a researcher. Informed consent for participation was reviewed (regardless of whether the consent form was signed previously) and any questions or concerns participants had were addressed. Consent for recording audio and video was obtained, with the understanding that only the audio recording would be retained but that both would be recorded because of limitations using Zoom. The audio and video recording then began. We filled out the demographic questionnaire collaboratively. Before moving to the interview guide, I opened the discussion with participants on how they were feeling about attending the interview, as well as the differentials between myself as a cisgender-passing researcher and themselves (Hesse-Biber, 2007), in an effort to address researcher-participant relationship hierarchies and allow them to highlight concerns with the impact of power on the sharing of their experiences.

Next, I introduced the interview guide. The order of questions reflected an intention to start broadly, with experiences that may feel less personal for participants, and move

progressively to therapy/counselling-focused experiences. This order was amended following the first two interviews to improve the flow of the interview. Other questions were introduced to the interview as appropriate, with an aim to cover most of the interview guide either directly or as the interview progresses naturally, "going where [the participants] want to go, but keeping an overall topic in mind" (Hesse-Biber, 2007, p. 5). As appropriate throughout, I checked in with participants regarding their experience of being interviewed. At the end of my formal questions, they were given the opportunity to add in or expand on anything they felt was important to their experience, and not sufficiently covered in the interview thus far. Many of the richest descriptions of experience arose during this portion of the interview.

Recorded interviews lasted between 40 and 60 minutes, as needed relative to the discussion, coverage of the interview guide, and participants' sense of having adequately communicated their experience. The interview finished with a debriefing (Vandermause & Fleming, 2011), and they were provided a list of relevant support resources (Appendix G). Participants were sent a $20 digital gift card to a store of their choice, regardless of whether they withdrew from the study partway through or afterwards, though no participants withdrew following the start of their interview. Participants had the opportunity to review their transcripts following the interview, with a period of two weeks given to return the transcript by email with any comments or changes. They were also asked specific questions about identifying information where relevant (e.g., if they had mentioned healthcare services in a specific province, they were asked if they would like that information removed from the transcript, identified more broadly by general region, or retained verbatim).

Following each interview, Zoom converted the audio and video recording to a file on my computer. The video recording was permanently deleted, and the audio recording was immediately transferred to an encrypted USB drive. The file was checked for any issues or errors, and the original file on my computer was permanently deleted. Files were then renamed with either the participant's chosen pseudonym, or interview number if they had not yet provided a pseudonym (e.g., Interview 3). The encrypted USB drive was then locked in a safe in my home. Saved data did not include any references to participants' real names or contact information.

Data Analysis. Data analysis commenced with my verbatim transcription of interview recordings using Sonix, an encrypted, automated AI-based transcription software. Audio files

were uploaded from the encrypted USB drive to the Sonix platform. Sonix offered a rough transcription of the interviews, which I followed by reading through the transcription while listening to the recordings in real-time. Errors in transcription were then corrected, and identifying information was removed or modified. The opportunity to listen along to interviews while providing surface-level edits permitted an in-depth first encounter with the interview text, as I was able to concentrate on content over process while remaining focused on individual words, expressions, and tone. Once transcriptions were cleaned, they were downloaded as a Word document directly onto the USB drive and were further protected with a password. Preliminary notes on content that appeared relevant to the research question were created throughout this initial transcription cleaning process and recorded in a separate document on the encrypted USB drive. If participants provided edits in the two weeks following their interview, this file was saved directly to the USB drive and was password protected.

The phenomenological hermeneutic tradition emphasises the individual meanings the phenomenon in question holds for each participant (Robertson-Malt, 1999), while qualitative analysis overall necessitates an amalgamation of themes that intersect with each data set. Hermeneutics provides a blueprint for integrating these two approaches, as the researcher continually cycles between a view of the parts and the whole of collected data; a fusion of horizons therefore occurs not only between researcher and participant, but between the participants themselves (Turner, 2003).

An initial read-through of the interview transcripts was initiated with the aim of noticing participant excerpts that stood out to me, commonalities and differences between and within interviews, memories of my experience of the initial interviews, and reflections on my pre-understandings and how they were influencing this process of 'reading-through'. This re-reading was repeated several times as the interviews were read in succession. I then oriented myself to van Manen's stepwise research activities in hermeneutic phenomenology, as described in *Researching Lived Experience* (1997) and further elaborated in Robertson-Malt (1999). These steps include 1) turning to the nature of the lived experiences; 2) investigating experience as we live it rather than as we conceptualise it; 3) reflecting on the essential themes which characterise the phenomenon; 4) describing the phenomenon through the art of writing and rewriting; 5) maintaining a strong and oriented relation to the phenomenon; and 6) balancing the research context by considering parts and wholes. Data analysis was also influenced by Alsaigh and

Coyne's (2021) translation of Gadamer's philosophical work into concrete methodological steps for qualitative researchers, particularly steps 4 and 5. These steps include 1) developing the research question; 2) outlining researcher pre-understandings; 3) gaining understanding through dialogue with participants (the interview process); 4) gaining understanding through dialogue with texts (data analysis); and 5) establishing trustworthiness. Though relevant from the very first steps of research inquiry and design, this final step will be elaborated at the end of the results section, where I will return to a consideration of my pre-understandings and my process of working with participants' testimonies.

Statements or phrases that were of particular relevance to the research question were pulled from each transcript and coded with a key phrase (e.g., "education," "media in therapy"). This was done initially within each individual transcript, and then after a re-read of each transcript, codes that were similar across multiple transcripts were identified. For example, one transcript described a counsellor asking invasive questions about gender (Amy), which was then connected with an overlapping experience in another transcript (Sally). Codes were pared down into higher-order categories (e.g., codes for 'invasive questioning' and 'lack of therapist education' were recoded as 'negative experiences in therapy'), through a process of re-reading transcripts, further analysing my research notes, and a continued orientation to the phenomenon at hand ("holding the identified theme… against the overall context of the story(s) being told" [Robertson-Malt, 1999, p. 295]). The intention of paring down codes in this way was to develop an overview of the interview texts, with the aim of later re-expanding them into themes and subthemes that more accurately spoke to the specifics of participants' experiences. In short, I aimed to use coding to develop a more generalised view of the text as a whole, and as a guide to later 'zoom in' on the individual testimony of each interview and ensure my analysis remained experience close.

After codes were finalised, excerpts from each interview that related to each code were highlighted. These excerpts were then paraphrased, with the intent of developing a view of the parts as well as the whole of the interview text (Alsaigh & Coyne, 2021) and identifying commonalities or differences between each of the interviews. Each interview, now annotated with paraphrases of prominent excerpts, was then revisited in succession. I made note of points where experiences and perspectives reflected within the annotated version of the transcript were similar in nature or spoke to a common idea. For example, one transcript described social media

as a generally unsafe space for TGNC people (Jane) while another spoke to how it was essential in developing a better understanding of the affirming mental health services they deserved (Amy); these were noted as expressing differing perspectives on the common idea of social media in the lives of TGNC people.

Codes, paraphrases, and related notes were used to generate subthemes, of which there were 18 in total. Subthemes were sorted into six theme headings, described in the following chapter ("Results"). I aimed to stay as close to participants' experiences as possible in developing these subthemes, considering the subthemes that make the phenomenon what it is, and without which the phenomenon could not be what it is (van Manen, 1997). Simultaneously, I aimed to maintain an awareness of my pre-understandings and how they may influence the process of generating subthemes and grouping themes. This "[dialogue] with text" (Alsaigh & Coyne, 2021, p. 5) enabled a fusion of horizons between participants' testimony, my in-the-moment experience when reviewing the text, existing testimony from the literature transmuted through my previous work on the research proposal, and insights from my supervisor Dr. Audet as she reviewed the transcripts and my developing comments alongside them.

van Manen emphasises staying close to the identified phenomenon throughout the research process. Though my previous experience in qualitative work is limited, I am familiar with the delicate balance between imposing one's own agenda as research onto participants' experiences, and allowing the initial focus to be subsumed by particularly interesting descriptions and wordings that come out of each interview. I was mindful of this balance while conducting interviews and beginning thematic coding, guided by van Manen's comprehensive theory of what it is we are trying to do in hermeneutic work. Acknowledging the impossibility of objectivity and embeddedness of the researcher in the phenomenological text, I was fascinated by the participant statements that I was drawn to or that I passed quickly over, as well as those that I found myself wishing were more 'relevant' to *my* 'chosen' phenomenon because of their richness. As I will expand upon more in the discussion section, I returned to van Manen's theory as a home base of cultural humility (Danso, 2018) from where to allow the phenomenon to be spoken into being in ways yet unexpected, and to watch my relationship with the phenomenon evolve.

Trustworthiness

Credibility

The criterion of credibility represents "confidence to the truth of the data and its interpretation" (Alsaigh & Coyne, 2021, p. 6). In van Manen's (1997) hermeneutic phenomenology, credibility is primarily established through staying close to participants' words, a principle that I emphasised throughout data collection and analysis. I used direct quotes from participants in the Results and Discussion chapters as appropriate, and aimed to represent participants' words within the context they were shared in the interview. Participants were also given the opportunity to review their transcripts and make edits or additions as they felt necessary. One participant expanded on several parts of their testimony with more specific examples from their experiences (Lee), and another edited their transcript for clarity (Jane). Participants' edited transcripts were those used in the final analysis.

Towards the end of the interview, once I had finished working through the formal sections of the interview guide, all participants were given the opportunity to reflect on whether they felt their experiences had been represented in the interview, and if there was anything they would like to add. Jane used this opportunity to advocate for more representation of trans parents in media. The other three participants reported being satisfied with what they had shared and felt their experiences and perspectives were adequately represented.

I also emphasised methodological coherence in my data collection and analysis (Alsaigh & Coyne, 2021), consistently moving back and forth between the data and methodological texts such as van Manen (1997) and Robertson-Malt (1999), as well as Sprague (2005). This ensured that, though texts in hermeneutic phenomenology or feminist standpoint theory do not offer a concrete, definite method for carrying out research, I was mindful of the principles endemic to each body of literature as I interviewed participants and developed a fusion of horizons with participants' experiences.

My interpretation of data was necessarily informed by my social location on the gender spectrum, something that was disclosed to participants at the beginning of each interview. I prioritised self-reflexivity throughout the research process and the written thesis, including transparency with how the research process was carried out (see Procedures section). In conversations with my supervisor, Dr. Audet, she stressed the importance of this transparency, and I was able to expand on my representations of the research process to ensure readers could follow along with each step.

Dependability

The criterion of dependability represents "the stability of data over time and conditions" (Alsaigh & Coyne, 2021, p. 6). A fusion of horizons following Gadamerian hermeneutic phenomenology means that a 'final interpretation' is never possible, as one could endlessly move back and forth between the researcher's horizon and that of participants. However, interview data can be dependable within the time and space of the interviews for participants, and data analysis within the time and space of my work on the thesis. I therefore did not aim to collect and represent data that was "stabl[e]" across time and space, but rather data that was representative of participants' understandings at the time of interviews, and of my own understandings informed by interviews and the literature at the time of data analysis.

This is particularly relevant as we (myself and participants) were discussing a particular media moment, one that is constantly changing with media trends and new releases, and intersecting with political realities for TGNC people. As mentioned by Kosenko et al. (2018), there is a need for research that considers media released following the boom of TGNC representation in the early-to-mid 2010s, and this thesis is one contribution to that update in the literature. However, the media discussed in interviews will inevitably be 'dated' by the time the thesis is completed.

Confirmability

The criterion of confirmability represents "the objectivity of the data" (Alsaigh & Coyne, 2021, p. 6). In hermeneutic phenomenology, true objectivity is not the aim, and researcher's pre-understandings are endemic to the research process. However, transparency with pre-understandings and interpretations during the research process can help ensure an "open[ness] to the study text" (Alsaigh & Coyne, 2021, p. 6) that parallels the principle of objectivity.

I maintained notes on transcripts from the initial read-through post-interview, notes which were conserved in individual drafts of the thesis saved on my laptop. I consulted with Dr. Audet throughout; as Alsaigh & Coyne (2021) note, "experts" can help to deepen understandings of the data and elaborate on findings, particularly when those consulted have extensive experience in qualitative work. Dr. Audet's experience and strong emphasis on self-reflexivity and transparency helped ensure I remained oriented to the text, and was mindful of where my pre-understandings or interpretive lens were moving into space where participants' testimony should be represented more authentically. She provided relevant articles from her own

experience in qualitative research and supervision of other qualitative theses, which allowed me to build on existing literature and ‘check myself’ on my biases and expectations.

Chapter Four

Results

Participant Contexts

Amy (they/them)

Amy is nonbinary and attended a university counselling clinic initially for anxiety and depression. They had between biweekly and monthly sessions within the last five years. They saw three counsellors during this time, two of whom were cisgender women and one of whom was a cisgender man. Their counsellors had all had received an M.Ed. in counselling psychology, though Amy is unsure of their years of experience. Cognitive behavioural therapy (CBT) was the modality practiced by each. Amy identifies as Caucasian, and is between ages 18 and 25.

Amy approaches media mindfully, engaging when it is beneficial and avoiding when it is negative. They primarily engage with social media, and have found online community essential in feeling validated for their challenges around mental health and counselling. They took an advocacy stance against the quality of counselling they received, and has been able to integrate their experiences into their current job creating better access to services. Amy is autistic and they describe their sense of gender as being informed by "how [they] experience the world." They have a strong connection with the joyful experiences of gender expansiveness, both as they experience it and see it in others.

Jane (she/her)

Jane is a trans woman and attended therapy at a private practice for gender dysphoria, depression, and anxiety. She had approximately 5-6 sessions during a span of a year. Her therapist was a cisgender woman with a degree in social work, who had five years' practice experience. Jane believes CBT was the modality used. Jane identifies as white Western European, and is between ages 25 and 35.

Jane has a longstanding relationship with TGNC representation in media, and had a critical view on both older, stereotyped representations and newer, less regulated social media spaces. She had overall positive experiences with her therapist, and though gender was not a primary focus of their work, they processed impacts of stereotypical representations and how Jane could counter these representations with friends and family members. Jane enjoys engaging in academic literature about gender and having theory-based conversations with her partner. Jane

is a parent and sees a lack of media representation of parents who transition or come out as TGNC before their child is born.

Lee (they/them)

Lee is nonbinary and attended therapy at various settings over a span of twelve years. Lee was a minor for the majority of this timespan, and they would sometimes attend sessions 3x/week. Their primary therapist was a psychiatric nurse, who was a cisgender woman. Lee is unsure of their therapists' years of experience, but they did not seem to be early career clinicians. CBT was the modality practiced by each. Lee identifies as brown, and is between ages 25 and 35.

Media is an essential part of Lee's life and informs both their personal and professional interests. In their interview, they brought complexity and nuance to contemporary TGNC-centred media as well as representations in the media they grew up with. They had a range of therapy and counselling experiences. Safety and trust were a challenge for Lee in all of their therapy experiences, as they were primarily in therapy as a minor and never felt that what they shared would stay private. Media nonetheless formed a significant part of Lee's work in therapy, and offered a conduit for discussing more challenging emotions or broaching gender more safely.

Sally (they/them)

Sally is nonbinary and attended therapy at various settings within the last five years for anxiety. They had sessions every two or three weeks, initially at a university counselling clinic, and most recently in private practice. Both their therapists had degrees in social work, with between 5 and 10 years of experience. Sally believes they were both cisgender women. Sally initially received CBT, and more recently internal family systems therapy (IFS), acceptance and commitment therapy (ACT), and brainspotting therapy. Sally identifies as Indigenous Mexican and white, and is between ages 18 and 25.

Sally deliberately seeks out queer and TGNC representations in media, and sees how media has changed in recent years while still remaining limited in terms of complexity. They believe in media as a source of recognition for TGNC kids, and experienced that recognition themselves, growing up in a Mexican family where gender identity was not discussed. Social media could be an informative space though at times a triggering one, where news of transphobic attacks is ubiquitous. Sally had a profound experience with their therapist, who shared a TV show representing queer Latinx experiences. This came after several years of non-affirming

therapy experiences, where Sally struggled to feel heard, understood, or safe to be fully themselves.

Results

The following six themes were developed from the interview texts: 1) *media outside of therapy;* 2) *media, mental health, and identity outside the therapy room;* 3) *media in the therapy room;* 4) *non-affirming moments in therapy;* 5) *processing impacts of non-affirming care;* and 6) *perceptions of change and hopes for the future.*

Themes 1 to 3 are those which are most closely related to my initial research question, *What are TGNC clients' experiences of therapy and their gender identity as it relates to media that focuses on TGNC identities?* They touch on participants' relationships with TGNC-centred media generally, the impacts of TGNC-centred media on their mental health and sense of identity, and their experiences with media as part of therapy. Themes 4 to 5 focus on participants' experiences of non-affirming care as TGNC clients, which often related to media either directly or indirectly. Theme 6 amalgamates participants' perceptions of the changing state of TGNC mental healthcare, as well as recommendations for how media could inform more gender-affirming practices in therapy.

Table 1
Themes and Subthemes

Theme	Subtheme	Sample Excerpt
1. Media outside of therapy	1a. Perceptions of representation in traditional media: Change and continued challenges	"I think there's a concerted effort from people in the community to really tell the story… It's just nice to see different stories being told." (Jane)
	1b. Complexities of 'good' / 'bad' media	"I believe [the Seed of Chucky] was the first time I came across gender non-conforming dialogue. I felt both repulsed and drawn/obsessed to this concept." (Lee)

2. Media, mental health, and identity outside the therapy room	2a. Gender identity development	"You wouldn't get that conversation… you wouldn't get that epiphany without the media." (Jane)
	2b. Resourcing information	"…on one hand it's like, 'Oh my god, this is happening everywhere. That sucks and I hate the world.' But on the other hand, it's kind of like, 'It's not just me.'" (Amy)
	2c. Sense of community	"Seeing someone, even though we can't talk about it, but seeing someone have similar experiences on, in the media… it does have a big impact on yourself when you're not really surrounded and having that opportunity like every single day." (Sally)
3. Media in the therapy room	3a. Overview of experiences	"And she was like, 'You should check it out, like, I've been watching it, it's been great.' And it was like, I watched it and I was like crying. I was like, 'This is amazing.'" (Sally)
	3b. Barriers to bringing media fully into therapy	"I didn't really feel safe bringing up [knowledge gained from media] in that context." (Amy)
4. Non-affirming moments in therapy	4a. Therapists' lack of education on gender diversity	"There's trans counsellors and mental health workers in spite of the system, and not because of the system." (Jane)
	4b. Community care burden	"But then when that help isn't available or isn't affirming or it isn't good, then it's kind of like, 'Where do you turn?'" (Amy)

	4c. Identity exploration separated from therapy	"I kind of really separated that from my, from my counseling." (Amy)
	4d. Differing impacts of media and therapy on identity	"I think it like stunted my own realization of like myself and my own identity for maybe longer than it might have." (Lee)
5. Processing impacts of non-affirming care	5a. Feeling rejection and blame	"I remember taking that as like a lot of rejection as that kind of like happened. I was like, wow, no one wants me." (Lee)
	5b. Identifying quality of care	"…it took me a little while to pick up on it [the counsellor's lack of knowledge/understanding]." (Amy)
	5c. Resigning to less affirming care	"So even if they are experiencing that transphobia, they're like, 'This is all I've got.' So, I'm just going to have to sit here and tolerate it so I can try and get help for all the other things." (Amy)
6. Perceptions of change and hopes for the future	6a. Changes in accessing affirming care	"I find I've been hearing a lot that that's really positive." (Lee)
	6b. Deserving more from therapy	"The stuff that I'm seeing now [on TikTok], I think is kind of just further confirming that, I'm like, 'It's so important to have a counsellor with lived experience.' And I think I'd kind of figured that out without having it in the proper words." (Amy)

	6c. Media as a tool for therapists	"If you meet people where they are and if they're on new media or if they're watching you know traditional media, you're better able to relate to how they think about things." (Jane)

Terminology

Participants either used the terms 'therapy' or 'counselling' depending on their experience (e.g., private practice therapist vs. university counsellor). This was also the case with the terms 'TGNC' and 'trans'. I have maintained participants' chosen terminology and they can be read as interchangeable and equivalent.

I used the term "TGNC-identified therapist/counsellor" or "TGNC therapist/counsellor" to indicate a professional who is themselves gender diverse. "TGNC-allied" or "TGNC-specialised" is used for therapists who according to participants appeared to be cisgender.

"Traditional media" here refers to forms of mass communication such as television and film that are transmitted one way from creators to consumers. "Social media" refers to online media where viewers or consumers can interact with content and creators, and participate in creating their own content.

1. Media Outside of Therapy

This theme outlines participants' relationships with TGNC-centred media . Participants had varied perspectives on the current state of TGNC-centred media and their relationships with TGNC representation had each changed over time. This theme includes the subthemes 1a) *perceptions of representation in traditional media: change and continued challenges,* and 1b) *complexities of 'good' / 'bad' media.*

1a. Perceptions of Representation in Traditional Media: Change and Continued Challenges. All participants identified a stark change in representations of TGNC identities in traditional media in recent years, with descriptions of the change ranging from media having "come a long way" (Jane) to an "explosion" of TGNC representation on-screen (Lee). Jane noted that "there was nothing" in terms of representation when they were young. Lee, who is in the same age range as Jane, discussed negative media representations they experienced as a young

person, rather than an absence of representation at all. They defined negative media representations as those that "make you [as a TGNC person] feel worse" in a way that is done deliberately by media creators. Though negative representations continue today, mixed messages about what it means to be TGNC were more common in the time when they were growing up.

Jane discussed generational differences in terms of the TGNC-centred media that was available for older generations. Jane saw it propagate the stereotype that living as TGNC ensured a dangerous life characterised by a constant fight to survive (which Jane noted was not necessarily far removed from TGNC experiences at the time), or reduce TGNC identities to "cross-dressing" as on *M*A*S*H* (1972-1983) or to victims of violent crime on police procedural dramas. These portrayals were not only sensationalist, but "a theatric," an exaggeration of behaviour and identity. Jane discussed how it has taken a long time to see changes in media, and that often what you are exposed to is still "not the reality."

Jane felt that media representation paralleled the growing overall visibility of TGNC identities, in that the general public has become more aware of gender diverse identities over the past number of years, and political attention to TGNC issues has increased. She saw how media has not only disrupted ignorance of TGNC identities and experiences, but has encouraged viewers (both cis and TGNC) to "discuss it and face it" with accountability. Lee specifically noted the change in representation in more popular or 'big budget' TV shows and movies, such as *Yellowjackets* (2021-) or *House of the Dragon* (2022-). *Orange is the New Black* (2013-2019) was mentioned by several participants as initiating the change in representation seen over the past decade. More recent shows such as *Sort Of* (2021-) and *Queer as Folk* (2022) were viewed more positively than those of this earlier 2010s-era of TGNC representation. Sally and Lee deliberately sought out media that represents TGNC or queer identities, and Sally and Amy described selecting which media they interact with based on how positive or negative they perceive the representation to be.

Jane saw how popular media continues to be exclusionary to TGNC people of colour, and that those who are "white and pretty" get more media attention. She saw herself as privileged in this respect, and believes media should focus on more underrepresented stories. Simultaneously, she has not seen her own experience as a parent reflected in media, particularly as her child is growing up with a parent who is already out as trans. "Seeing trans people as parents kind of

humanises people more," and representation should not be limited to parents who come out after their kids have grown up.

Lee and other participants noted the common depiction of gender as exclusively binary, "masc/fem, that's it." Amy described how media most often presents nonbinary identities in limiting ways, and that gender is much more expansive than what is shown in traditional media. Both Lee and Amy aimed to nuance these limiting understandings in how they relate to gender more privately, and how they have come to express and share their gender identity with others.

1b. Complexities of 'Good' / 'Bad' Media. Though all participants shared a view that media representation had expanded in recent years, participants' individual relationships with media were more diverse and complex, especially with social media. Engagement with media varied, ranging from primarily using social media platforms like TikTok and Instagram as tools of identity exploration, to a more abstract engagement with the history of TGNC media and media theory.

Amy described social media as both a safe space essential to "finding and forming" their identity, and a sphere where harmful transphobic views can propagate. Jane shared the view that social media is "more fractured" than traditional media, and can be equally as limiting and "reductive" as traditional media representations. They view social media platforms on the whole as intentionally driving conflict and permitting more intense forms of transphobic discourse and action, such as sites like Kiwi Farms dedicated to harassing and doxing[1] TGNC social media users seemingly at random. Regarding Jane's own relationship with social media, "you never fully feel at ease because you always know there's going to be one person in a room of 100 that's going to be horrible."

Sally and Jane both felt impacts of witnessing cis people engaging with TGNC-centred media. Knowledge of entertainment and social media could "come off as performative" for Jane, even if cis viewers' intentions are otherwise – "it's like I Googled it and then I talked about it." Jane called for more educational TGNC-focused media, and described entertainment media as "very surface level" and primarily useful for those of an older generation who may be less familiar or comfortable with gender diversity. She cited the YouTube channel Philosophy Tube, hosted by trans creator Abigail Thorne, as an example of positive educational media. For Jane,

[1] "To publicly identify or publish private information about (someone) especially as a form of punishment or revenge." (Merriam-Webster, n.d.)

the strength of the channel is Thorne's ability to translate academic concepts of gender theory to a wider audience. Sally spoke to the triggering aspects of seeing cis people engage with TGNC news on social media, specifically reposting and discussing news about transphobic attacks. They saw that this may be well-intentioned, but that cis audiences lack lived experience and true understanding – "it feels a little insensitive because like they're coming at it from a position of privilege."

For Lee, older representations like *Degrassi* (2001-2015, with trans character Adam appearing 2010-2013) were "of [their] era," but were not as damaging as some other representations. Increased mainstream visibility of TGNC identities over the past two decades did not, for Lee, automatically correspond with increased humanisation or invitations towards identity development. More publicly acclaimed media depictions of TGNC identity like *Transparent* (2014-2019), *Boys Don't Cry* (1999), *The Danish Girl* (2015), *Dallas Buyers Club* (2013), *A Girl Like Me* (2006), and *Tomboy* (2011) "showcased how unsafe, scary, fearful… it is to be trans." These representations were dominant during the time Lee was in therapy, but "didn't feel representative."

By contrast, representations of TGNC identities in the horror genre were more influential for Lee. Horror films like *The Seed of Chucky* (2004), *The Crying Game* (1992), *The Silence of the Lambs* (1991), or *Sleepaway Camp* (1983), and exploitation drama *Glen or Glenda* (1953) were some of Lee's first exposures to TGNC people, and initiated a feeling that Lee related to Julia Kristeva's concept of abjection[2]. In therapy sessions, Lee discussed media where cis actors played TGNC characters, such as Denise on *Twin Peaks* (1990-1991), a representation they found "surprisingly… not as abhorrent" as some of the mainstream TGNC representations mentioned above like *Dallas Buyers Club* (2013).

The sum of these earlier portrayals featured TGNC characters played for fear or comedy (or were at least received that way by mainstream audiences), yet these representations were those most often encountered by Lee growing up. The abject – parts of oneself that have become liminal, that are unconsciously rejected and excluded, as they are deemed deviant to the social

[2] Lee did not provide a definition of abjection. A relevant excerpt in Kristeva's words: "A massive and sudden emergence of uncanniness, which, familiar as it might have been in an opaque and forgotten life, now harries me as radically separate, loathsome. Not me. Not that. But not nothing, either. A "something" that I do not recognize as a thing. A weight of meaninglessness, about which there is nothing insignificant, and which crushes me. On the edge of nonexistence and hallucination, of a reality that, if I acknowledge it, annihilates me. There, abject and abjection are my safeguards. The primers of my culture." (Kristeva, 1982, p. 2).

order – came into view for Lee in consuming these depictions of TGNC identity. 'Good' representations (more recently released, Oscar-nominated, critically acclaimed, big budget) representations were received by Lee as fear-inducing and shut down identity exploration, while 'bad' (older, intentionally horrifying, sensationalised, comedic) representations contributed to their identity development.

2. Media, Mental Health, and Identity Outside the Therapy Room

Participants experienced media as a factor in their mental health and sense of identity. This theme expands on perspectives outlined in theme 1 and describes how participant engagement with TGNC-centred media impacted their 2a) *gender identity development,* 2b) *resourcing information,* and 2c) *sense of community.*

2a. Gender Identity Development. Participants reported that media strongly informed the development of their relationship with gender identity. Growing up sheltered from knowledge of gender diversity, Sally cited media as the "number one influencer in… helping me understand my identity better," though they were unlikely to see their Mexican and nonbinary identities represented intersectionally. Media as a first encounter with gender diversity was relevant for Lee and Jane. For example, Lee recalls learning about using a binder from the character Adam on *Degrassi* (2001-2015). Both cited media as foundational to their becoming comfortable with their gender identity, especially after seeing more dynamic, realistic representations emerge over time.

First encounters with gender diversity through media were not always straightforward and affirming. Jane described an initial desire to shut down the part of herself that was interested in TGNC media. As she engaged with this media more, it helped her realise that "it's not something to be ashamed of." She felt that she or anyone "wouldn't get that conversation… wouldn't get that epiphany without the media," and that it allowed her to learn about transition options in a way that would be otherwise inaccessible or delayed.

Experiences with media could also have a negative impact on exploration and acceptance of gender identity. For Lee, watching media featuring TGNC characters as a young person was an opportunity to discern the reactions of their peers. It was "an interesting time to see what other people kind of thought about something that you're kind of privately grappling with." Lee's peers were "kind of like showing their ass, if you will… and I think that like… just makes you feel ways." Jane discussed the limitations of who gets to be represented in popular media, those

who are "genetically…lucky" or in the "one percent" of attractiveness. Though she knows "most people don't look like that," she felt that these representations can nonetheless "cause more dysphoria, more self-esteem issues." Jane described how limited representations can also impact gender expression for audiences, and echoed Lee and Amy on the pressure to embody the masculine/feminine binary that is typically shown in media.

For Amy, gender identity development through media felt like "defining yourself rather than [other] people defining you." They described "feeling like yourself in your body" through media exploration. Similarly for Lee, who described media as a "kind giver," media was a tool for seeking understanding and connection based on their day-to-day experiences. Watching *Sort Of* (2021-) had a strong recent impact for Lee, allowing them to better understand their gender identity as a brown nonbinary person and "finally [being] able and comfortable to articulate my gender identity and feelings. It felt fulfilling to have that and I saw it as a sign in a way." Gaining understanding of the self also went beyond traditional fictional representation for Lee. They noted figures such as Joan of Arc, Marilyn Monroe, or Princess Diana who have informed their identity as nonbinary:

> Joan, to me, is similar to how Marilyn or Princess Di have become mouldable figures for people in that they are essentially fictional. So I think Joan is applicable to talk about as a nonbinary character who allowed me to understand that about myself.

2b. Resourcing Information. Media was cited as a key source of information about gender identity, therapy, and how to find resources. Following their negative experience in counselling, it was extremely affirming for Amy "seeing autistic trans people talking about stuff, like how CBT can feel really invalidating sometimes and then just talking about problems in the healthcare system." Social media helped confirm for them that lived experience in a counsellor is essential, and gave words to that need while helping them make decisions in finding a new counsellor. There was a sense that "maybe they [others on social media with shared experience] know what to do." Amy "experience[s] the world in so many other ways" than how gender is typically defined, and they found "media has been really, really helpful to kind of help unpack that and also just be exposed to other people who do belong to that community." This then translated into the world "outside of [media]," where for Amy "gender is such a like ongoing,

ever in-flux like thing. And it's influenced by everything I experience," not just media or therapy.

The validation of "see[ing] people like you represented" was accompanied by conflicting feelings for Amy, particularly in the area of mental health experiences, as "…on one hand it's like, 'Oh my god, this is happening everywhere. That sucks and I hate the world.' But on the other hand, it's kind of like, 'It's not just me'." Amy acknowledged the limitations of seeking therapeutic advice on social media, while they simultaneously permitted themselves to enjoy the positive feelings that come from that validation: "I know that I can't get therapy from like following some people on social media, but at the same time, it's really nice to have kind of a positive messaging being given to you all the time." This was a "validation that I wasn't getting from counselling," and was described as a "placeholder" while "on a waitlist for like 84 years" to see an affirming counsellor.

Sally followed a few Instagram accounts that focused on TGNC issues, finding them informative. They felt it was especially important for immigrant kids to be able to access TGNC-affirming media, as it "provide[d] some support and counter sort of stuff you've grown up hearing in your family." However, they can also be "at times…a little triggering" because of news stories about violence against TGNC people, such as the Club Q shooting in Colorado in November 2022. The work of information gathering was paired with a hesitation to expose themselves to reminders of the dangerous experiences TGNC face, something that was difficult to control on social media in particular.

2c. Sense of Community. Media represented a source of community for participants, and they related media to feelings of validation and a desire for shared lived experience. For Sally, who until recently did not have many queer or TGNC friends, let alone any who identified as Latinx, the TV show recommended by their therapist provided them a feeling of common experience. "Even though we can't talk about it," in that traditional media is not interactional, Sally felt that seeing this representation was essential especially when in-person community was not present. They felt it would be "damaging to not have any sort of representation or like involvement and just seeing things that don't represent me in the media." Amy was impacted by seeing experiences of gender affirmation on social media, "seeing stuff like people who start a physical transition and they're so happy and they're so excited. Like, trans joy is also just so different than, than other joys."

Jane described the experience of "stay[ing] online more early on" when "you come out as trans… You're online a lot because, I mean, you know, the rate of trans people is not very high in any given area… You're trying to figure yourself out." This is particularly relevant for communities with few other TGNC people, as was the case in Jane's area of Atlantic Canada. As her gender exploration evolved, Jane saw how social media was more often an unsafe space for TGNC people; they "tend[ed] to keep my online presence minimal… I don't interact online because I know I don't want to expose myself to the [risk of harassment]." She would:

> be a lot more open to it… if there would be more protection [from harassment], like there would be less worry and less anxiety about interacting online in that sense with strangers, because you can have positive groups and communities.

She spoke to how "you need community, as much as it's a personal journey" and the ways that was challenged during the pandemic, as social media was often a hostile space and yet the only method of connecting with other TGNC people.

3. Media in the Therapy Room

This theme describes participants' experiences with media as it was present within therapy. It includes the subthemes 3a) *overview of experiences,* and 3b) *barriers to bringing media fully into therapy*.

3a. Overview of Experiences. Participants had diverse experiences with the presence of media in the therapy room, and the ways those experiences influenced the course of therapy and their relationship with the therapist. Sally's and Lee's experiences involved direct use of media in-session, whereas Amy's and Jane's experiences were informed by media more indirectly.

Media formed an integral part of Lee's therapy process. They recalled consuming TGNC-centred media around the time they were in therapy and brought all kinds of media into the therapy space each week. Therapy was in large part Lee "speaking on what I watch"; they would introduce a piece of media that had impacted their thoughts and feelings, and their therapist would ask related questions. It was rare that they "talked about anything that wasn't…a piece of media I like consumed for that week." For Lee, "…it allowed me a sense of autonomy and I think it let me kind of like maybe talk maybe, like now when I look back, like maybe talk about things without really talking about them…" This contrasted directly with Lee's past relationships

with mental healthcare teams, where Lee had lacked a sense of authority or autonomy in their therapy. Lee's experiences in therapy were mandated by the foster care system, where "something you think is like a private moment" was in fact an instance where "everyone [social workers, child and youth workers, foster parents, etc.] knows everything." "Get[ting] to speak for an hour about anything I want," especially media, offered a reprieve from the typical constraints of mandated therapy.

As we spoke during the interview, Lee became aware that it was (and continues to be) difficult for them to discuss thoughts and feelings without using media as a conduit. Lee's impression was that their therapist enjoyed using media in this way, and she would provide Lee recommendations and encourage them to expand on particular themes in their media consumption. Lee benefited in other ways as well, such as "really being able to you know, I think, hone my skill of like discussing media," a skill and interest that guided Lee's academic and professional decisions and remained important in their personal and professional life.

Sally also shared positive experiences with media in therapy. During the time they were in therapy, they were thinking on the intersection of their identity of being Mexican and an immigrant and being queer and nonbinary. Their therapist recommended a TV show with a queer Latina character. Watching the show had a strong emotional impact on Sally: "I watched it, and I was like crying. I was like, this is amazing." They reported that having their therapist bring that forward, having "thought of me when she watched it" and going "out of her way" to recommend it, deepened the therapeutic relationship.

Amy brought up media to the third counsellor they saw "when I came out as nonbinary to them and we talked about how I figured that out." Discussing gender was not a goal of counselling, but Amy talked during counselling "about how, like I guess [gender] interacted with media to kind of help me figure out what that meant" and "seeing examples [in media] to help me kind of unpack my own thoughts about gender." For Jane, it was important to "show the reality contrary to the [media] stereotype people have in their head" of what it means to be TGNC. She used her lived experience to counter negative media representations, particularly with older family members, a process that she problem solved with her therapist. Jane's therapist was affirming and did not endorse these media stereotypes, and helped her figure out how to "break" those stereotypes with others while simultaneously unpacking the media that propagates limiting stereotypes in the first place.

3b. Barriers to Bringing Media Fully into Therapy. Two participants described experiences of discomfort with bringing a discussion of media and gender identity into the therapy room. Experiences of non-TGNC-affirming care, as well as invalidation of their presenting mental health concerns more generally, dissuaded them from discussing the ways that TGNC-centred media impacted their sense of identity.

Media had a strong influence on Amy's sense of their gender, and they learned from social media new ways to approach their therapy. As they had experienced previous invalidation when sharing what was not working for them in therapy as well as non-affirmation of their nonbinary identity, they "didn't really feel safe bringing up [knowledge gained from media] in that context." Amy has since reflected on how negative social media discourse from "people that will never see me how I see me… that are putting you into their own boxes of gender" has impacted them, and how it "would have probably been good to talk about [that] somewhere" if they had felt comfortable doing so with their counsellor.

Affirming use of media ensured that barrier was able to be overcome for one participant. Sally noted that they had thought a lot about TGNC representation, both in media and in their social circles, and that they "hadn't really found the time and place or how to really approach it" in therapy. TGNC representation had not been introduced into the therapy until their therapist suggested a TV show centering experiences similar to Sally's own. It rendered accessible within the therapy space a conversation about representation, "open[ing] the door to one of the final things that I was still hesitant about." They shared:

> Just having that sort of trust of a certain subject also influences trust in general and trust in other things that could be brought up, for example, like… issues with race or different things like that that maybe she wouldn't understand. Now I'm like, maybe she can't empathise with it, but I can definitely see the sympathy and that understanding and the sort of openness to discussing it, which makes me a lot more comfortable.

Sally described how, prior to their therapist sharing this TV show, "there'd be that sort of barrier that I could never really cross. And I think that was sort of preventing me from reaching a certain level of success in therapy." After this point, "I can, and I have, sort of gone, like, felt so much

better about therapy and just like in my life in general and have kind of been closer to that point of quote unquote success."

4. Non-Affirming Moments in Therapy

Most participants had firsthand experience with non-affirming therapy related to their gender identity. All spoke to general inadequacies in gender diverse mental healthcare, and the following subthemes represent the impacts that these current gaps in care had on participants. These subthemes are 4a) *therapists' lack of education on gender diversity,* 4b) *community care burden,* 4c) *identity exploration separated from therapy*, and 4d) *differing impacts of media and therapy on identity.*

4a. Therapists' Lack of Education on Gender Diversity. A dominant theme throughout each interview was therapists' lack of education on gender diversity, and the overall low numbers of TGNC-specialised or -identified therapists. Lee spoke to the issue of how "it's hard to find someone like specialised to like kind of be able to like, equipped to kind of [work with gender] and deal with that, especially when you're like a minor still." Limitation on services was also relevant for Jane, living in an Atlantic Canadian province where she could count only four WPATH-certified practitioners[3] in her city, all with "huge waitlists." In Jane's words, "there's trans counsellors and mental health workers in spite of the system, and not because of the system."

Amy's experience of their counsellor's lack of education was direct, and caused them to reflect on what it means to be queer- or TGNC-allied within mental healthcare. Their counsellor was "outwardly supportive" and happy that Amy disclosed their gender identity in counselling, but failed to use Amy's pronouns or correct name. Their counsellor often "brushed over" their nonbinary identity and seemed to have only a basic understanding of what the term meant; "whenever I said anything to do with it, it was like she was learning it for the first time." They later added, "that's not right in this dynamic. And that means that, that means I have more knowledge about [gender] than you. So if I wanted to learn about it, this isn't the place I can do that." They did not feel it was appropriate to be in the role of a teacher as the client, and [didn't] "think that counsellors like to be in that position [of having to be taught]… at the same time, if

[3] Some provinces require mental healthcare providers to complete the 50-hour WPATH certification program in order to offer letters of support for hormone therapy, gender-affirming surgeries, and other gender-affirming healthcare. WPATH certification may also signal to a client that a provider has training in working with TGNC clients and that they have committed to providing gender-affirming care.

you don't know something, it's really just better to, to admit to that." Amy distinguished between being an affirming practitioner "on paper" and actually having the lived experience of working with other TGNC clients.

Sally described the "strange feeling" of not knowing whether they should bring up an experience of homophobia with a high school counsellor because this previous counsellor had never brought up sexual orientation herself and Sally was "worried that maybe she would judge me." This was despite the fact that they were "pretty close" and had established trust in other areas. For them, mandated therapist education and training could counter this barrier of hesitation and fear of judgement. Amy shared this view, and did not feel that TGNC-affirming education is "something that is focused on" in counsellors' training. They questioned who is given the power to determine the 'truth' of a client's gender identity in counselling. For Amy, "it still feels optional for counsellors to be respectful of you or not." Amy spoke to the risks involved with challenging a counsellor on their lack of education when "they can just drop you as a client and move on and like, who's gonna fight that, especially someone who's mentally vulnerable."

They related inadequate education to counsellors'/therapists' gatekeeping access to resources and particular definitions of gender – counsellors may have pre-existing and limited ideas about what "make[s] you trans," such as "incomplete transness without [physical transition]." For Amy, the reality of their identity is much more expansive than how it is understood by the general population "just the classic like line of masculine, androgyny, feminine. That's like one thing. And then my gender is like everything else around it as well."

4b. Community Care Burden. A particularly notable experience of Amy's spoke to the broader impacts when mental healthcare for TGNC people is inadequate or inaccessible. Amy outlined the burden on TGNC communities that arises when TGNC clients cannot access affirming therapists or counsellors:

> …everybody in your life too is like, "Please go and like, seek help." And it's like, "Yeah, that makes sense. That's a very logical response." But then when that help isn't available or isn't affirming or it isn't good, then it's kind of like, "Where do you turn?" But it's also like, "What, what do your support systems do then too?"

TGNC communities step in to ensure community members are getting needed mental health support when professional support is either difficult to find or insufficiently affirming. Amy sees how community care "really comes into play" where professional affirming care is lacking, and how communities must decide "who's doing the worst this week?" in prioritising the support they provide. They have seen this "really, really common" pattern in gender diverse as well as autistic spaces. For Amy, community care "does a better job" than existing counselling services for TGNC communities, but "it's basically just a big mess of people just helping each other out… it really gets dark."

Community care also extends to developing networks of knowledge of the counsellors or clinics that do practice affirming care, with the burden of system navigation again falling to community networks. Amy experienced that this network is often supported by social media. They described "finding your community and finding support" where "it's lacking in every other direction" and local in-person resources may be limited. Jane echoed this theme of community care, but emphasised that local, word-of-mouth knowledge "has more impact on your day-to-day" in areas with limited access to resources, as "system navigation is a big thing here because it's not clear. And I think, I always say local has more impact… than worldwide or national."

4c. Identity Exploration Separated from Therapy. Partly as a result of therapists' lack of knowledge or limited access to TGNC-specialised practitioners, participants' explorations of gender primarily happened outside the therapy context. They did have experiences within therapy that impacted their relationship with gender, but none sought out therapy or counselling solely to explore gender or address related challenges. For Jane, understanding her gender identity occurred primarily within her close circle, though she did come to "feel more sure" of her gender identity in therapy and engaged in exploration work like journaling. Gender was welcome within the therapy space, and the therapist was open to bringing in discussions of media in ways appropriate to the depth and focus of the therapy. Simultaneously, gender was not the central focus of her presenting concerns in therapy, because she had already done so much identity exploration on her own – "I'm somebody the therapy doesn't work great on because, because I go off and read Judith Butler. There's not much my therapist can add on top of that." She conceptualised therapy not as a revolutionary process of insight, but described how:

> People nowadays are working to see therapy as like, doing like kind of house cleaning, if that makes sense, versus like a crisis all the time. So that's how I kind of saw it was more just like sorting things out, working through kind of that early gender identity, like, where do I fall, what feels right.

Other participants' experiences of identity exploration were also primarily rooted outside the therapy context, but differed in that they were dissuaded from bringing gender into the therapy space because of their negative experiences and the non-affirming behaviour of their therapists. Counselling helped give Amy more energy to "be generally thinking about myself more," but did not contribute to identity exploration directly. They intentionally "separated [my sense of gender identity] from my, from my counselling." The process of gender identity exploration for Amy was "very personal," and feeling "dehumanis[ed]" in therapy for not being "called their name properly" ensured therapy was not a safe space for this exploration – "Like, aren't you [as the counsellor] supposed to be someone who supports and helps me?" Lee's identity exploration was discouraged in therapy, as their therapist explained their interest in exploring gender diversity in pathological ways, rather than centering Lee's experience: "I think it was often like alluded to like, well, like the like the answers in a way would kind of be like, 'Oh, well, maybe this could be like linked to like, like sexual abuse stuff or self-esteem, like low self-esteem.'" Lee came to accept their therapist's perspective over their own, describing their reaction at the time as "Oh, okay," and "I feel like it was often like, 'Oh well, it must be like this.'"

4d. Differing Impacts of Media and Therapy on Identity. Participants described the impacts of media and therapy on their gender identity in distinct ways. There was a sense that media had contributed to accelerating identity development in several cases, while therapy had been less impactful or even damaging to identity development. The media experiences that occurred outside the therapy space were generally described as more impactful than those that related directly to therapy.

Sally emphasised the positive impacts of media more strongly than those of therapy, though both were experienced positively. Sally's therapist used media effectively and in affirming ways, which contributed to the overall affirming nature of Sally's therapy experience. Describing whether discussions about media in therapy had an impact on their sense of gender,

they shared "I think maybe not in the therapy space, but as a cause of the therapy space. So I don't think in therapy I've been like, 'Oh, that's a good insight on my identity' or anything like that." Their relationship with gender deepened through increased connections with queer and TGNC communities, and with TGNC-centred media. For them, "[media] has taken me from probably… like not growing up, but probably going like another ten years closeted with internalised transphobia to like being partially out, and way more comfortable with my identity," a comfort they anticipated will "continue to get better" mostly due to "the positive influences I have in the media" and also after having "reached out and hav[ing] some queer friends and stuff."

Two participants contrasted the positive impacts of media with their negative experiences in therapy. At the intersection of media and therapy, Amy felt that "seeing [on social media] the side of people talking about their [negative] experiences with counselling is, is helpful because in a way I'm like, maybe I could have avoided that invalidation." Media was used as a tool of resource gathering that provided hope for potential alternatives to the counselling they received. Their counsellor did not take up discussions of media as part of counselling, and was overall non-affirming.

While Lee's therapist was very much open to using media to inform the therapy, her ability to work with gender was highly limited and ultimately harmful to Lee's gender identity development. Lee's therapist suggested that Lee's interest in exploring gender, and potential desire to pursue surgery, could be linked to low self-esteem or trauma, or of being a "tomboy," They elaborated, "It's something that [the therapist] was just not specialised in. And I think that did make some of that difficult, especially now when I kind of look back." They felt that therapy "stunted my own realisation of like myself and my own identity for maybe longer than it might have" had they not pursued therapy. Lee's experiences with their therapist attributing a desire to explore gender to trauma or low self-esteem ensured that they "pushed down…a lot of like feelings, that like… and still sometimes, some of those things like not really like grappling with or dealing with", and they repeated that "it's stunted [my sense of gender identity]."

5. Processing Impacts of Non-Affirming Care

This theme focuses in on the emotional and psychological impacts of experiences when therapy was non-affirming. Some participants shared experiences that were directly connected to media, while others shared experiences that linked contextually to media or had no apparent link

to media; these experiences nonetheless related to how they made sense of therapy or of themselves and their identities within therapy. Subthemes include 5a) *feeling rejection and blame;* 5b) *identifying quality of care;* and 5c) *resigning to less affirming care.*

5a. Feeling Rejection and Self-Blame. The experience of being referred out, or being told by a therapist that their presentation was beyond the therapist's scope of knowledge, intersected with participants' understandings of themselves as gender diverse and of their mental health. Participants experienced invalidation and out-referrals as rejections, and this led to self-blame. Lee and Amy were both told by their therapists that they would need to seek services elsewhere in order to receive the help they were seeking for their mental health concerns. Though their presenting concerns did not centre gender specifically, both Lee and Amy had experienced invalidating responses to discussing gender with these same therapists. Their therapists spoke about the limitations on their practice in terms of interventions or therapy styles – Amy's counsellor stating "Well, I don't do that" about dialectical behaviour therapy (DBT), or Lee's therapist saying "I don't think I'm a good fit for you," for example – but were not explicit about their lack of experience working with gender diversity.

Regardless of whether they as the client agreed that another therapist might be a better fit, they described feeling that "no one wants me" (Lee) or "feeling kind of invalidated and kind of alone because there isn't anyone I can actually go to about this on a professional level" (Amy). Lee recalled "taking that as like a lot of rejection as that kind of like happened." Amy's sense of "hopelessness" toward receiving the support they were seeking intersected with their symptoms of depression, as they were prone to "thought spirals," something of which their counsellor was well-informed. They felt that their counsellor could have made the effort to tailor their services to Amy's needs rather than referring out, particularly after Amy brought up DBT skills like distress tolerance as a possible path forward in their counselling. "DBT is kind of a branch of CBT, so surely there's like something you could do even if it's not DBT. Like you have knowledge of DBT, you probably have resources to learn about it like, something." They remember asking themselves, "Am I too much? Am I ever gonna get better? Or am I ever, am I ever going to be able to be treated by anyone?" This resulting feeling of hopelessness was like a "slap in the face." Amy was able to offer themselves empathy, saying it is "pretty normal to feel that way when you keep getting rejected," but also sometimes blamed themselves.

5b. Identifying Quality of Care. Two participants spoke to the process of having to determine whether therapy was helpful for them, discerning which aspects were not helpful or even harmful, and processing the resulting emotions on their own. In all cases, participants' therapists or counsellors never openly disclosed or acknowledged their lack of education or experience in the area of gender diversity.

Sally described the "strange" feeling of being pushed to talk about gender and sexuality with their community therapists, which paralleled their earlier experiences of hesitating to bring up gender with a school counsellor. They were not given the opportunity to discuss gender on their own terms, and Sally's experience with having "felt very like, almost like they were… attacking me" ended with them "somehow chang[ing] topics… and I don't think I went back after." As a "people pleaser," Sally felt uncomfortable asserting what was not working, which led to another community therapist determining "Okay, you don't need my help." The burden then remained on Sally to seek out gender-affirming services in future. When looking for a new therapist, they asked outright whether the therapist was LGBTQ+ allied, "which I think, if anything, it was a little nerve-wracking for me to ask." They felt that TGNC youth specifically would hesitate to ask these screening questions, and that "it shouldn't be like something you need to ask someone."

For Amy, insights into how they felt treatment could best serve them were not well-received by their counsellor. When they began therapy, they "didn't know I had ADHD. I didn't know I was autistic," and their counsellor focused instead on treating depression and anxiety symptoms. Amy received "all this great feedback where it was like, 'Oh, you applied this skill really well,'" but Amy did not feel the counselling was "work[ing] for me." Amy got the sense that their counsellor wondered "Why are you not magically better?".

> They were like, "You're doing all of these amazing things, that I taught you how to do." And I was like, "Cool, I still feel like shit." And I was like, "I'm glad I'm doing all of this so well, but like, I don't feel good."

Amy described the burden of having to figure out that these counselling strategies were not suited to their concerns and goals, and of problem solving potential alternatives alone: "…it took me a little while to pick up on it [the counsellor's lack of knowledge/understanding]," both

because of the counsellor's lack of transparency around their scope of practice, and because "if you're leaving it to me to pick up on social cues… that's not something I'm very good at." Though they felt they benefitted somewhat from the therapy, when looking back they could see that their anxiety was a product of "overstimulation and overexertion," and that they did not have the "right knowledge of my brain" at the time they were in counselling. Amy also noted how TGNC people "tend to be lower, doing lower on the socioeconomic ladder because of all these systemic barriers that they're facing already," which poses additional complications around "insurance and accessibility" when "most [affirming counselling] are also through private clinics."

Sally and Amy both described cognitive behavioural therapy (CBT) as the default (or sole) approach they were offered, and spoke to how this did not fit well with their needs. Amy struggled to recall specific CBT techniques they used at the time, and noted that those techniques were only of benefit when they were having a "decent energy day. Then I can sit down and reframe my thought. But I was like, most of my days… are really low energy days, and I can't make that happen in my brain." They unsuccessfully sought suggestions from their counsellor for techniques to help them increase their energy levels to be able to use CBT techniques: "So I was like, 'What can I do instead to get myself to a point when I can do that?' And that's where they were like, 'I don't know!'" Through researching online, Amy determined that DBT would likely be helpful for them; this was later echoed by the counsellor, but Amy was told they would have to seek services elsewhere to receive DBT. Sally was aware that "CBT obviously wasn't working for me" with past therapists, and that feeling "fully comfortable" with their more recent therapist was informed by a change in modalities to acceptance and commitment therapy (ACT), internal family systems (IFS), and brainspotting. Sally eventually got the experience of being listened to by their therapist and having therapy tailored to their needs and expectations – feeling they were "going alongside" their therapist instead of "just being given advice and not really being allowed to express myself" – something that Amy had yet to experience at the time of the interview.

5c. Resigning to Less Affirming Care. In describing the inadequacies within the care they received, participants communicated a certain level of acceptance of, or resignation to, this reality. Amy and Jane recognised that finding a therapist with lived experience or more education on gender-affirming care was unlikely, as they simultaneously recognised the

limitations of seeing a therapist who did not have lived experience. Amy described her therapist as "trying to be a good, a good ally, but [she] just didn't really know how and didn't really have the education behind how to do that," and concluded "her heart's in the right place and she doesn't really know what she's doing." Still yet, Jane shared "I guess if I felt like I could relate to the therapist, it would have been a better fit in that way… I wasn't expecting that kind of experience."

For Jane in Atlantic Canada, care by TGNC-identified or -specialised therapists is limited to those who have coverage under their employment insurance benefits, and "even then, that depends on the province." Jane also noted that because demand is high, even if a client has those resources, they are often assigned to a long waitlist. She added, "it's better than it was, but it very much is a room of privileged old men who are deciding" what aspects of TGNC mental and physical healthcare will be covered by provincial health plans or private insurance – "it's very reductive and it's very lacking." Though Jane believed that the therapy likely would have benefitted from working with a TGNC practitioner, she carried the expectation that she would inevitably be disappointed in trying to find one because of low numbers and long waitlists.

Sally and Amy hesitated to place blame on therapists themselves for the lack of diversity in the field or their lack of appropriate education on gender diversity. Sally questioned whether having a therapist with lived experience would have impacted the therapeutic process, and their ability to discuss gender within sessions:

> But I do still think there's times where maybe [gender] doesn't get really understood as well as I would like it to be, just like, I don't bring it up too much, but just sometimes when I do bring up issues that come up with it… She's obviously great. I love her as my therapist, but sometimes it's, it wouldn't be the same. And sometimes I'm like, if I had a trans therapist, would it be different? Would they have a better sense of understanding?... Which isn't her fault, obviously…

Sally spoke early in the interview about representation in the recent film *Enola Holmes* (2022) where a TGNC character was briefly shown putting on a dress, "it could have been more, but you know, I'll take it." Later in the interview, they wondered whether a therapist who was themselves TGNC-identified would be better equipped to provide affirming care, while "tak[ing]

it" in a similar way. Amy shared in this questioning, but communicated a feeling of resignation to the standard of care that currently exists:

> Like it's really hard. And for some people that's their only option. So even if they are experiencing that transphobia, they're like, "This is all I've got. So, I'm just going to have to sit here and tolerate it so I can try and get help for all the other things."

Though Lee did not speak to resigning to less gender-affirming care specifically, they shared similar feelings around being told by their therapist that they were not a "good fit" and would be referred somewhere else. Reflecting on their feelings at the time, Lee described how "I have a lot of things just happening… it's hard to find someone like specialised," and that "in that moment… I was like… 'Okay, I understand.'"

In sum, participants identified limitations in their therapy with cisgender therapists who are not educated about working with gender diversity, considered whether seeing a TGNC-identified therapist would allow for more comfort in discussing gender in therapy, and accepted that they must "tolerate" non-affirming therapy in order to get at least some of their mental health needs met.

6. Perceptions of Change and Hopes for the Future

Participants drew on their experiences to identify changes in therapeutic care for TGNC clients over the past number of years. They shared hopes and expectations for what more affirming care could look like, and how their experiences could inform this future. These expectations included recommendations for how media could be used as an educational tool for therapists, and as a therapeutic tool directly with clients. Subthemes include 6a) *changes in accessing affirming care*, 6b) *deserving more from therapy*, and 6c) *media as a tool for therapists.*

6a. Changes in Accessing Affirming Care. Some participants described positive changes in terms of therapy and counselling for TGNC clients in recent years, or ways that system navigation toward affirming care has become more accessible. Through Amy's use of social media to explore experiences of other TGNC and autistic clients in counselling, Amy could "honour my feelings while also focusing on what I can do now instead." Amy was also able to see that, while many social media users shared their negative experiences, many had

successfully navigated the system toward care that was actually therapeutic: “if there are people who get this, then maybe they figured stuff out and maybe, maybe they know what to do.”

Lee, as the participant with the longest history in therapy, had seen distinct changes over the past number of years in terms of access to affirming care. They noted the option to “filter someone who is like, specialised in like trans and gender nonconforming like… LGBTQ+ care. And like somebody who is themselves also like, like either nonbinary or trans.” Lee does not remember that option being available “even… a few years ago.” They felt this to be important not just for seeking TGNC-affirming care generally, but for choosing therapists with an intersectional, gender diverse view of other presenting concerns like eating disorders or bipolar disorder. They have not yet sought out therapy using this feature, but have “been hearing a lot that that’s really positive,” speaking to friends whose experiences “have been more positive, even in group therapy.”

Lee had also heard from social workers they worked with in the past that they are now receiving more training on TGNC- and queer-affirming therapy for minors. They are “getting more training on where to send [their] kids who are like, who are queer and trans for like therapy” and “finding… like external context to have like on the go” for these children, “something that… was definitely not in place” when Lee was receiving services as a minor.

6b. Deserving More from Therapy. Participants hoped for better TGNC healthcare, and shared ideas about what ‘better’ could look like. They were able to identify what they wanted and needed from their own care and for the future of broader TGNC care throughout each interview, informed and driven by their own experiences. An argument was commonly made for more mental health professionals who were themselves queer or TGNC and possessed lived community experience, or had received extensive education and direct experience with TGNC clients. For Lee, they once believed that a practitioner would themselves have to be TGNC to offer truly affirming care, but they now feel that “no, actually, like cis people can care about [TGNC people], you know, and still like…it is the crux of…community care in a way.” Lee emphasised how “there’s still shitty like therapy no matter, no matter what, and no matter the lens.”

Nevertheless, most participants agreed that lived experience, really “knowing” (Lee) the experience from the inside, could offer a “much better level of support” (Amy) than a practitioner outside the community. For Jane, “it’s when the understanding the therapist has is a

conceptual one and experience with other clients, then it's different than if the person has lived experience in that regard." Media informed Amy's view that lived experience was essential for them in a counsellor:

> The stuff that I'm seeing now [on TikTok], I think is kind of just further confirming that, I'm like, "It's so important to have a counsellor with lived experience." And I think I'd kind of figured that out without having it in the proper words.

Amy developed an increased understanding of their mental health needs following their negative experiences at a university counselling centre. In their words, "I deserved better, and this is what I need [now]." Amy saw current counselling services for TGNC clients as "really not good enough," especially for TGNC communities where lack of access to resources can be significant. They cited the need to address barriers of wait times, fees, and insurance coverage, and felt that "more people do [need gender-affirming counselling] than, than I think universities think and they're like, 'Oh, this person is an ally. That's perfect.'" Reflecting on their own counsellor who made Amy feel like their "teacher," Amy argued "it's really just better to, to admit to" the limits of one's clinical knowledge about gender diversity. Though they wanted to see more counsellors with lived experience working in accessible settings, "logically…it is really hard to find someone like that and…we deserve better than that." They were at the time of the interview working in a field where they helped others access resources and affirming care, and therefore changing the system from an in-group standpoint.

6c. Media as a Tool for Therapists. Participants shared perspectives on therapists using media as a tool for learning, both for therapists independently and to inform the therapy process in collaboration with clients. Sally felt that therapists should "be educating themselves on issues that they don't really know too much about that their clients will probably be experiencing," including gender, and that they could use media as one tool in this education. Further, Sally felt that media could be used as a tool in therapy to "share with clients," as was the case with their therapist, in a more cinematherapy-type approach. Sally felt that care must be taken in choosing sources and taking information into therapy, and it should be done from a place of "mak[ing] sure that everyone feels included and safe" rather than "just doing it because it's like the 'woke'

thing to do." Sally added that TGNC voices must be prioritised in seeking out particular media, centering lived experience while "not sort of tak[ing] everything from one source."

Lee was a strong proponent of using media in therapy. They outlined the skill their therapist demonstrated of relating media to ongoing therapy work, drawing connections and integrating it with presenting concerns. They felt it was important what specific media was chosen: "I'm not going to be like, 'Go watch *Boys Don't Cry*, therapist.'" Lee specifically recommended an episode of *Euphoria* (2019-) where a trans character, Jules, attends a session with her new therapist. They also spoke to the benefits of integrating media in therapy generally, and how for them it "made things kind of fun" and demonstrated that the therapist was making an effort to "[meet] me on my level." Jane echoed the idea that the use of media could allow clients to feel "more safe and not guarded" in therapy.

Amy felt that media could be used by therapists "to an extent. I think it would need to be like a combination of formal training and, and media." Amy felt media provides an opportunity to "[listen] to people's lived experiences," and stated "we all know we learn better when there's a personal connection to it." They noted how it is "really easy to exist within your, your lived experience and your privilege" but that following social media accounts from outside a counsellor's experience can lead to more "well-rounded and informed" counselling. Jane shared the view that media can provide that personal connection that "humanises people," and bridge the gap between "propaganda and buzzwords" and "a story that [they] can relate to." Jane also felt that media could signal an authentic view of their therapist's depth of knowledge of TGNC communities.

> Someone understanding the references to media means that they know the subject beyond just the clinical textbook sense… like, okay, like there's some meat behind this, you know, these clinical words. That's not just them going, okay, the two trans clients I have out of my hundreds.

For Jane, an understanding of TGNC-focused media demonstrates that the therapist has deliberately gone beyond a cursory understanding. Clients could use media as a yardstick of a therapist's TGNC community knowledge. The use of media must happen on the client's level – "meet[ing] people where they are", keeping current with a "cultural understanding" of the

client's generation, especially for younger clients. Having a therapist "that knows the media like that back of their hand… it's rare," but when present it can signal a therapist's commitment to meeting their client on their cultural level. Jane also stressed an intersectional view of media representation – "the impact should go" to perspectives of TGNC people of colour rather than those who are white or have social capital like an established career or a partner and children. Jane saw herself reflected in these stories of privilege, and while she felt her story was "interesting," it was not "super rare" or "going to change hearts or anything."

Chapter Five

Summary and Discussion

The discussion section will include a summary of the research question and results, a revisiting of my pre-understandings and methodology as they applied to the results and discussion sections, and an interpretation of each theme in relation to existing research in the field. I will then consider this study's implications for therapy and counselling practice, limitations of the project, future recommendations for research and interviewing, and offer a short conclusion.

I approached this research from the standpoint of the clear consensus in the therapy and counselling literature that mental health services for TGNC clients are inadequate (Benson, 2013; Hunt, 2014; White & Fontenot, 2019). TGNC clients have different mental health needs from their cis counterparts, and experience more severe symptomatology (Anzani et al., 2019; Parr & Howe, 2019). These are data intended to demand attention from readers, and to orient us all to care more about what is happening in the field for our TGNC clients. They are also an extremely limited part of the stories of TGNC peoples' lives, and my study aimed to bring more direct attention to these lives and how TGNC people make sense of themselves through therapy and media. I aimed to reflect each element of my research question, *What are TGNC clients' experiences of therapy and their gender identity as it relates to media that focuses on TGNC identities?* throughout my interview process, data analysis, and further explorations of the literature as relevant to participants' testimony. Essential to me was platforming TGNC clients' voices over those of therapists, the latter being more often represented in the literature. I also prioritised participants' words as transcribed directly (Sprague, 2005), and while fusing horizons with participants in defining and organising themes, I aimed to keep my interpretation of their words as close to what was spoken as possible. The following discussion section will move further into a fusion of horizons, connecting participants' words with other findings in the literature and aiming to add richness to descriptions which were confined to the single hour we had to conduct each interview.

Participants clearly reported ways in which use of media in therapy and experiences with media outside of therapy impacted their experiences of the care they received – how they were often failed by this care while also actively and creatively envisioning a better future of TGNC mental healthcare. Though the shortcomings of the field were not a core priority for this project,

it quickly became evident that participants' experiences could not be understood outside of this broader context of inadequate and non-affirming care. It was frankly also clear that participants really wanted to speak to their experiences and perceptions of the issue, even when their own experiences were predominantly positive. My 'agenda' of seeking out the intersection of TGNC media and therapy was therefore expanded especially as interviews progressed and I saw this emphasis on inadequate care grow. What grew alongside inadequacies were participants' insightful and unwavering visions for what the field should be doing instead, which is where media sometimes re-entered the conversation. The implications section of the thesis will therefore be guided primarily by participants' own suggestions, as much of the current state of the field can be attributed to a failure to listen to the voices we should be prioritising most.

Revisiting Methodology

My Pre-Understandings

In revisiting my pre-understandings (Appendix H) following data analysis, it was fascinating to see significant overlaps in my perspectives on and those of participants, as well as topics where my expectations diverged from participant testimony. I had originally drafted my pre-understandings for the research proposal and had not revisited them until data collection was complete. These pre-understandings informed the entire research process, and as I reviewed transcripts, drafted codes and themes, organised themes and subthemes, and edited my results, I aimed to notice my own biases – e.g., What am I hoping to see in this description of experience? – and return to participants' direct testimony as closely as possible. Using van Manen (1997) and Alsaigh and Coyne (2021) as a guide, I do believe I have remained close to the phenomenon, while not negating my own reflections as part of a Gadamerian fusion of horizons.

In my pre-understandings, I described media as an outlet for emotion, a tool for education and analysis, and a method of connection with others. I emphasised the multifaceted nature of representation, and how increased visibility does not necessarily correspond with better quality of life for TGNC people. These views were echoed in participants' interviews, though in more complex ways than I described. I was honoured by participants' openness to discussing the challenges of representation, both through their immediate experience and more indirect impacts. I aimed to communicate a sense that I 'got' what they were talking about—that is, that I was myself steeped in TGNC-centred media, and I felt that this encouraged participants to share their

experiences without feeling the burden to over-explain the basics of what it means to feel represented.

I wrote in my pre-understandings that mental health services for TGNC folks have increased in recent years, but that the overall perception of these services is negative. I stressed the importance of community networks of knowledge to finding affirming care, and noted how this challenge is exacerbated in smaller cities or rural areas. These concerns were each relevant for participants in my study. In regards to media within therapy, I had anticipated that participants may be discussing news events and anti-TGNC legislation in therapy, as the rights of TGNC people are increasingly up for debate within news discourse and in courtrooms (most relevantly in the United States). This was not part of the experiences that participants shared, though Sally shared that encountering TGNC news stories on social media was a common stressor. It could be speculated that clients currently attending therapy may be bringing their experience of news and legislation into therapy, as legal attacks on TGNC human rights have grown exponentially since the beginning of 2023 (Trans Legislation Tracker, 2023), after my interviews were completed. Simultaneously, news stories and legislation have certainly been relevant to TGNC lives over the past number of years, and there may be other reasons that clients choose to keep their experiences of these events separate from therapy (see, for example, subtheme “Barriers to Bringing Media Fully into Therapy”).

Going into this work, I believed that current practices in therapy with TGNC clients were generally inadequate, but that media could enhance this work when used appropriately and carefully. In reflecting post-data analysis, I see that I was partly expecting participants to have predominantly negative experiences in therapy. This was not the case in the participant pool, though all participants had either experienced non-affirming therapy in the past, or had a sense that affirming services in general were rarely accessible. I do not believe this expectation came from a place of cynicism or looking for the worst; telling ‘hard truths’ comes with my academic lineage in gender studies, and a fusion of horizons between myself and participants’ experiences includes this attitude toward giving voice to these uncomfortable realities, especially when some participants’ experiences were actively harmful to their sense of gender identity and mental wellbeing. I was also informed by the conclusive demonstration in the literature that mental healthcare for TGNC clients is rarely affirming.

Approaching this work from an exploratory lens, I had very little foundation in the literature on what to expect from participant testimony on this topic. The open-endedness of this part of the research admittedly allowed for hope to move in, in favour of my belief in the potential of media in therapy when used carefully. I was glad to see that the use of media in therapy was experienced positively by all participants, and that all saw a continued role for media in therapy with TGNC clients to varying degrees.

The Interview Process

Experiences of media in therapy were explored by all participants, though this focus was maintained more strongly for those who had seen the interview guide in advance – Lee, Jane, and Sally. These three participants seemingly had specific experiences with media in therapy that they intended to discuss, and appeared more 'prepared' for the opening interview question on this topic – "Tell me about a time in therapy/counselling when TGNC media has come up in some way." Amy did not elect to see the interview guide in advance, and I experienced our interview as less structured. I felt that there were benefits to both having participants review the interview guide in advance and not seeing it in advance, as my interview with Amy allowed for more free movement between topics relevant to the research question, and more spontaneous ad hoc changes to the interview guide. They were guided by what was important to them in their experiences, and we spent more time during the interview discussing how they had been impacted by their counselling experiences, and how media (particularly social media) had impacted their understanding of their mental health. This led to rich discussions that ultimately informed the subthemes of "Feeling Rejection and Self-Blame" and "Community Care Burden", the latter of which was supported entirely by testimony from Amy.

With the three other participants, my sense as interviewer was that they were prepared for each section of the interview and had thought in advance about what experiences and perspectives they would like to share, particularly what experiences of media and media in therapy had been most impactful for them. Though these interviews did not feel formal in structure, the sense was more of 'checking the boxes' of the interview guide rather than spontaneously moving between topics. The richness of testimony was nonetheless maintained across all interviews, as participants were presumably able to approach the interview from whichever stance they were most comfortable with – more spontaneous discussion or pre-prepared answers. Interviews often blended the two approaches, with some participants sharing

that they had reflected in advance on how they would respond to the interview questions, but responses ultimately emerged organically as interviews progressed.

Structuring the Analysis

Data analysis was guided by van Manen's Gadamerian hermeneutic phenomenology, as outlined in his book *Researching Lived Experiences* (1997) and rendered more concrete by Alsaigh and Coyne (2021) and Robertson-Malt (1999). I also followed principles of feminist research, using Sprague (2005) as a guide. A core shared principle of Gadamerian hermeneutics and feminist research is to stay as close to the researched phenomenon as possible, a principle that I kept in mind throughout the research process (figuratively kept in mind, as well as literally on a Post-It on the side of my laptop – "stay experience close!"). As discussed previously, my pre-understandings necessarily influenced which follow-up questions I generated during each interview, which statements I was most drawn to in data analysis, and how themes were generated and organised. The work of hermeneutic phenomenology is in allowing my position as researcher to be present in the data collection and analysis, while maintaining this closeness to participants' testimony and to the phenomenon itself. Attempting to pare down participant testimony to that most relevant to the phenomenon was challenging – counselling training tells us to treat all clients' words as equally vital to understanding their experiences, and I felt drawn towards each and every response from participants during and after the interviews. As a result, there is little from any of the interviews that has not found its way into the results and discussion, and I believe that having four interviews allowed me to give space to each of them with a depth that may not have been possible with several more interviews.

van Manen's six research activities, as cited and elaborated in Robertson-Malt (1999), provided a guide for the complete research process – orienting myself to the phenomenon through an in-depth literature review, investigating the lived experience directly rather than an abstraction of the experience ("treating the people who are actually living the experience as experts," p. 294), reflecting on my chosen themes as one of many interpretations of the experiences described by participants, analysing with an aim to understand the different meanings experiences held for each participant, staying close to the phenomenon, and holding themes against the context of the whole. These were 'steps' of a kind that felt intuitive to the type of project I hoped to pursue, and it was exciting to see them develop and become more complex from the first moments of data collection. As a researcher, it was essential to

continuously recognise this work as one possible analysis of the phenomenon, both in order to embody cultural humility and reflect on power imbalances, and to mitigate the sense that I must provide *the* definitive perspective on participants' experiences.

Alsaigh and Coyne (2021) strongly emphasise this need for self-reflexivity in Gadamerian hermeneutic work. Their research steps mirror those outlined by Robertson-Malt (1999), and they provide an essential guide for the practical work involved in data analysis – how to immerse oneself in the data; develop codes, categories, and themes; link literature to themes; critique one's own analysis and identify limitations – while keeping self-reflexivity at the forefront. They also provide a clear illustration of how to link these steps with more abstract Gadamerian concepts, and use them to "complete" the hermeneutic circle through each section of the thesis. Their prompts for self-reflexivity were essential to considering the limitations of this study, which are included at the end of the discussion section.

Feminist Theory in the Analysis

Sprague (2005) argues that a researcher's standpoint, as either community insider or outsider, is necessarily influential on what testimony is transmitted during the interview. In short, power is present in the dialogue of the interview. Sprague is focusing on feminist interviewing between women, but her emphasis on "connect[ing] as women" is relevant with TGNC community research as well. Bridging Gadamerian hermeneutics and feminist standpoint theory, it is understood that a researcher cannot be removed from the research process. Sprague recommends bringing relevant personal disclosure into the research relationship, particularly when working with participants from marginalised groups. I opened each interview with a statement on my own relationship to gender diversity and on my 'insider-outsider' status within TGNC communities. I also sought to acknowledge the power dynamics at play between myself as cis passing and with limited experience coming out to others, and how participant experiences may (or may not) differ significantly from my own.

Sprague (2005) speaks as well to the hegemonic biases of positionality, and how this impacts what we find "interesting" about a particular text. Researchers may avoid sections of transcripts they deem boring, or include more quotes from participants they perceive as being more articulate or conforming to academic language. She emphasises that phenomenon-close research does not prevent us from taking up the biases of existing literature in our research area, and that researchers must repeatedly consider their potential for bias at every stage of the

research process. Developing a reciprocal research relationship, reflecting on emotional reactions during interviews, emphasising the personhood of participants, and listening for "inarticulateness" are all recommended as principles to consider and return to. This listening for what is unsaid, what is being created beyond verbal expression in response to the interview prompts, stayed with me during data collection and analysis. As Sprague (2005) writes, "verbal struggles can be indications of a lack of fit between one's knowledge of daily practices and struggles and the hegemonic worldview." This is particularly relevant in work with participants from marginalised groups, whose experiences and desires have often been literally dictated by those in the dominant group.

I attended to the potentially unarticulated in participant testimony throughout data collection and analysis, while simultaneously ensuring that I was not reading my own pre-understandings into participants' experiences. I noticed my desires to highlight particular sections of text, or interpretations that corresponded with my own experiences – for example, Jane's more 'academic' way of speaking in our interview, or her references to Judith Butler as a meaningful way of exploring and deconstructing gender identity. These are important parts of the interview texts, but were not prioritised over experiences more distant from my own. This involved working through what the automatic perfectionist part of me might say, for example, "This passage would sound great (clear, articulate, powerful) in my thesis, and therefore it's important!" I aimed to focus instead to those passages that were most representative of participants' experiences. Drawing on my counselling skills, I maintained an orientation to the interview as one brief moment in participants' lives, and one limited description of their personhood. I also allowed for my own emotional reactions within the interview space, particularly as participants discussed distressing past experiences, without moving the focus away from their testimony in the moment.

Interpretation by Theme

In the following section, I will consider implications of themes from the Results chapter in the context of existing literature in the field. Subthemes will be considered within their corresponding themes. The themes are as follows: 1) *media outside of therapy;* 2) *media, mental health, and identity outside the therapy room;* 3) *media in the therapy room;* 4) *non-affirming moments in therapy;* 5) *processing impacts of non-affirming care;* and 6) *perceptions of change and hopes for the future.*

Media Outside of Therapy

Participants each had chosen ways of interacting with TGNC-focused media, and perspectives on the changing state of that media. They saw increasing representation of TGNC people and stories in traditional media over the past several decades, though this increase in representation did not always correspond with more positive and dynamic portrayals of TGNC people. Social media was seen as a more divisive space though was not without its merits, and participants were aware of how cis engagement with TGNC content on social media occurred within a larger context of microaggressions and sensationalist portrayals of TGNC lives.

Much of the literature cites *Orange is the New Black* (2013-2019) as the "inaugur[al]" piece of traditional media that brought TGNC identities into the mainstream (Keegan, 2022). This view was echoed by some participants, though other representations were more impactful in their personal experience. Some participants supported a linear view of progression in representation, for example Jane who spoke of the journey from *M*A*S*H* (1972-1983) and "cross-dressing" to seeing TGNC parents represented positively. For others like Lee, their experience of representation had changed in more variable ways over the course of their life. They experienced mainstream, critically acclaimed representations as dehumanising and fear-inducing, whereas their closer relationship with horror media ensured greater identification with representations whose purported aim was to dehumanise and induce fear.

Lee's perspective runs counter to the experiences of Cavalcante's (2017) participants for whom *Boys Don't Cry* (1999) and *Transamerica* (2005) were formative depictions of TGNC identity that allowed them to learn about TGNC identities and see aspects of themselves reflected on screen, often for the first time. Media studies scholars have more closely aligned with Lee's perspective on these mainstream representations. Ford (2016, p. 64) describes the "stereotypical representation[s] of trans themes and images that do not fit contemporary gender-diverse communities," "clichéd narrative devices," and "the ongoing problematic of trans representation within mainstream cinematic texts" evident in films such as *Boys Don't Cry* (1999), *The Crying Game* (1992), and *Dallas Buyers Club* (2013), all of which were referenced by Lee as part of their exposure to a view of TGNC life as dangerous and despairing. Copier and Steinbock (2018), also writing on *Dallas Buyers Club* (2013), illustrate how increasing mainstream representation makes for "an uptake of trans presence that is… also an absence" (p. 924) in its failure to cast TGNC actors in these roles or include TGNC perspectives in the development of

these films. Keegan (2022, p. 29) defines these "bad" trans media representations (objects) as those

> …that refuse to fit neatly within the purportedly closed system of sexual difference, gesturing at the possibilities beyond deterministic, binary categorisations… The bad trans object threatens the very stability of sexual difference itself, and therefore must be ignored or erased.

Keegan critiques the "inclusion-based vision" (p. 29) of modern-day TGNC media discourse, where increased representation is unambiguously 'good', and 'good' representation increasingly means binary, white, conventionally attractive, neurotypical, bourgeois, and conforming with the laws of the state. The limitations of these 'good trans objects' were evident for Lee, as were the "catharsis and validation" of representations from the horror genre (Vena & Burgess, 2022, p. 189). In a dialogue on generational differences in perceptions of 'bad' representation, Vena and Burgess (2022) discuss the failure of increased representation to translate to real-world benefits for TGNC communities, especially for those who are less privileged in terms of race or class. Vena echoes Lee here: "To read or celebrate a bad object, one that was meant to frighten or intrigue cis audiences, is to recycle a piece of supposed cultural 'garbage' into a product of meaning and use for trans viewers" (p. 192). Jane and Lee both spoke to witnessing the influence of dominant TGNC-centred media on the attitudes of those close to them and, for Jane, the process of challenging the stereotypes that they had taken on from popular media. Close to 35% of respondents in the Trans Media Watch (2010) survey felt that TGNC-centred media had caused negative reactions from their cis loved ones, and 5% described ongoing family conflict or severed relationships as a result of media representations. For several of Cavalcante's (2017) participants, the release of mainstream TGNC-centred films provided a conduit for loved ones to speak to participants about TGNC identities. This was sometimes received as friends and family aiming to connect across differing experiences and participants getting to speak as an "ambassador" (p. 549) for the TGNC community, and other times as a "burden of representation" (p. 548) where they were expected to translate TGNC media representations into existing stereotyped understandings of gender diverse identities. Increasing representation as a talking point with loved ones was also echoed in Kosenko et al. (2018), where

participants used media to broach the topic of gender diversity with family members and romantic partners, and to gain a better understanding of their relationships.

Media, Mental Health, and Identity Outside the Therapy Room

The media that participants encountered informed the development of their gender identity, their ability to resource information and the form that resourcing took, and the sense of connection they felt with TGNC communities. Cavalcante's (2017) participants reflected on similar themes of media as "resource in… self-making" (p. 550) through identification with fictional characters in traditional media. Similarly, Kosenko et al.'s (2018) participants described "mak[ing] sense of their own identities" (p. 279) through both traditional and social media. Media informed their gender expression, and like Jane mentioned in our interview, used social media as a safe jumping off point early in transition. Kosenko et al.'s participants identified a sense of shared experience in books and online communities, including coming to understand shared language and transition options. This maps onto the subtheme of resourcing information for participants in my study. In contrast with my interviews, television was not as influential for community building or identity development for participants in Kosenko et al. The authors themselves note that their interviews were conducted prior to the dramatic increase in TGNC representation in television and film (around 2015), and it is therefore worth considering that participants' experiences with influential TV representations in the current study are speaking to the specific and more recent media moment when my interviews were recorded (late 2022).

Participants in Craig et al. (2015) and McInroy and Craig (2015) described the variety of online resources available for TGNC people, and the influence of these resources on identity development and sense of community – each theme here overlapping with those expressed in my interviews. Some of their participants felt positively about particular pieces or modes of media that were received negatively by others, which parallels the discussion of social media in my interviews. Jane, for example, saw social media as a generally unsafe space where transphobia could proliferate to the point of violence, whereas it was essential to Amy's developing understanding of their mental health needs and an escape from discrimination in the offline world. Craig et al. (2015) also reported participants identifying with particular media figures as role models, some of whom were queer or TGNC but many who were not. This echoes Lee's relationships with semi-fictionalised public figures who have informed their gender identity and expression.

Jane briefly described the experience of encountering TGNC identities in media, but not feeling she could let herself 'go there' with exploring gender diversity. Adrian in Cavalcante (2017) spoke to a similar experience, as he felt shared identity with the main character in *Boys Don't Cry* (1999) while feeling "powerfully uncomfortable and shameful" (p. 551) about this response. Though Jane did not define her experience in these terms, she shared with Adrian the "affective rupture" (p. 551) of seeing a part of herself embodied on-screen, but "shutting it off and putting it away" (p. 552) as she was not yet ready to embark on a journey of identification. Media was essential for both Jane and Adrian when they did return to the project of identity building.

I had been curious whether participants may be discussing anti-TGNC news stories in a therapy setting, as these events are highly distressing and potentially traumatic depending on a client's proximity to the event. Though participants did not raise instances of broaching news stories in therapy, or having their therapist do so, troubling news media did have an impact on participants' mental health. Sally described the "triggering" nature of seeing news stories posted and reposted, by accounts they had followed with the desire to seek affirming information and find community.

Amy, Jane, and Lee each identified the limiting binary nature of how gender is typically represented in media, where TGNC people must aim for either masculine or feminine gender expression and away from the ambiguous or nonbinary. This maps onto the privileging of TGNC people who "adhere to white, cisnormative[4] beauty standards" (Cavalcante, 2017, p. 552) in popular media, something that Jane stressed near the end of her interview. Krell's (2017) analysis of transmisogyny and racism in television media argues that the binary categories of 'transgender' and 'cisgender,' of 'masculine' and 'feminine,' are inherently dependent on the discursive work of normativity and whiteness, which seeks to establish rigid borders between identity categories.

In this discourse, intersections of identities are rendered Other, where for example the terms 'trans woman' and 'trans woman of colour' suggest that the former is by default white (Krell, 2017). These assumptions are reflected and constructed by media, and TGNC people who conform to standards of whiteness, beauty, and are most proximal to passing as cis are those with

[4] The assumption that cisgender identity is the norm and that all individuals do or should conform to standards of gender expression that align with binary cis identities.

the greatest access to representation. This was evident in Sally's and Lee's experiences as TGNC and racialised, where finding representations of themselves only became possible within the past year. Accessing these representations was profoundly impactful for both. It was paired with a sense of incredulity for Sally, and strong catharsis which was then processed in therapy. For Lee, the representation of *Sort Of* (2021-) was a sign that allowed them to lean into understanding and profound comfort in their identity.

Masanet et al. (2022) explore representation in the TV show *Euphoria* (2019-), which was also mentioned by Lee in their interview, and describe it in ways that overlap with Lee's and Sally's experiences. The authors identify how *Euphoria* supports its primary trans character, Jules, in moving beyond the "trans fact" (p. 146) narrative where the transition story is the central focus of their character development. Jules is also given value as a character as a "subject of love" in the first season, and she is portrayed as "likeable and complex" (p. 151). Jules also gets to experience spaces of protection and comfort, gaining a space away from "marginality, violence, and danger" (p. 152). This language of comfort and complexity echoes that used by Lee and Sally, as it showed up in their experiences of feeling seen by nuanced media representations that more closely fit their realities as TGNC people.

Notably, Jules is a white character, and Masanet et al.'s discussion of *Euphoria* therefore can only approximate Lee's and Sally's experiences with seeing racialised TGNC characters in traditional media. Lee's and Sally's testimony offers insight on how representation impacts identity, particularly for racialised TGNC people who rarely see themselves represented on-screen.

Media in the Therapy Room

Participants' experiences with the use of media within therapy varied, and manifested in ways that both aligned with and differed from the limited literature on media and therapy. Sally's experience is the one that most clearly aligns with Schulenberg's (2003) conceptualisation of cinematherapy, whereby a therapist recommends media that is then used to enhance emotional depth in therapy, which therefore strengthens the therapeutic relationship. Sally's therapist recommended them a TV show featuring a character whose identities as queer and Latinx overlapped with Sally's. The resulting emotional impact on Sally reflects Schulenberg's argument that media in therapy could help clients find a "growing sense of hope" (2003, p. 39). Sally also perceived this as an educational move on the part of the therapist, a way for her to

demonstrate her interest in genuinely knowing the experiences of identity groups to which she did not belong.

Lancaster and Terepka (2021) support such an intervention in their recommendations for cinematherapy with queer and TGNC clients, outlining that media can create a shared experience between client and therapist and deepen the therapeutic bond. Schulenberg (2003) suggests that therapist carefully consider their motivations for wanting to work with media in therapy, and though we do not know Sally's therapist's thought process, the impact suggests that such care was taken. The therapist watched the TV show prior to recommending it, clearly explained expectations, matched the media to Sally's demographic background, and actively debriefed with Sally following the recommendation, all of which are emphasised by Schulenberg (2003) and Lancaster and Terepka (2021).

Schulenberg's (2003) suggestion that media may help clients 'go there' with emotionally challenging experiences was most clearly the case for Lee, who also received media recommendations from their therapist. As both Lee and their therapist brought media into nearly all therapy sessions, Lee came to experience the difficulties in speaking about more emotional topics without using media as a conduit. Though this may be characterised as a limitation of relying on media for emotional depth, it also might be asked whether Lee would have introduced these topics at all had media not been so openly embraced as a therapeutic tool by their therapist. Lancaster and Terepka (2021) emphasise how media can help "[reveal] issues in a non-threatening way with the safety of distance" (p. 52), and that its use can be deepened by a therapist exploring emotional reactions to media and "mak[ing] meaning" between the media and the client's life experiences. This was the case for both Lee and Sally.

A benefit of cinematherapy that is not highlighted by Schulenberg, but is reflected in participant interviews, is of media as a tool for broaching culture. Day-Vines (2007) defines broaching culture as "…a consistent and ongoing attitude of openness with a genuine commitment by the counsellor to continually invite the client to explore issues of diversity." The use of media in Sally's therapy embodied this attitude of openness and commitment to understanding experiences outside of the therapist's own. This was experienced by Sally as an opportunity to bring in elements of their identity that they had previously been hesitant to discuss, due to uncertainty that their therapist would receive these topics in an informed way.

Jane used media in therapy to broach experiences of stereotyping, and to approach the conversation of how to challenge these (often negative) media stereotypes in the face of older relatives whose understandings of TGNC identities were founded on such stereotypes. The burden of "always hav[ing] to show the reality" contrary to the stereotype speaks to the relational labour that goes into having to explain one's identity to others, and to present it in ways that are comprehensible to the dominant cis majority. When media fails to present realistic portrayals of TGNC identities and experiences, Jane and other TGNC people are required to spend more time and energy educating (or re-educating) others in their lives in order to be better understood. Jane benefitted from her therapist's support through this work of being truly seen by her family.

Amy's experience with media in counselling was restricted to sharing that media contributed to understanding their gender. Their case represents the limitations of media use in the therapy – when the therapist is not ready to receive media as a therapeutic tool, and prevents the broaching of culture by dismissing its relevancy. When the dismissal is paired with an overall non-affirming approach toward gender in therapy, further use of media as a tool for connection and deepened understanding is prevented. Amy expressed that they would have liked to discuss limiting media representations and the harms of social media in their counselling; it had an impact on their sense of self and mental wellbeing, and was therefore relevant to counselling work. The counsellor's lack of education on how to safely broach both media and gender identity ensured these topics were not revisited in the therapeutic space. Owen et al. (2016) define moments like these as cultural missed opportunities, and found that therapists who missed these opportunities tended to have worse outcomes with their clients. This finding has clear relevance for Amy's experience, as the absence of media and gender in the counselling space were indicators for Amy about the inadequate quality of care they were receiving.

West's (1995) and Ashley's (2014) examinations of the role of stereotypes on mental wellbeing are also relevant for Amy's and Jane's interest in discussing stereotypes with their practitioners. West (1995) calls for therapists to recognise the influence that common media stereotypes have on their perceptions of clients, and provides guidelines on how to broach experiences of stereotyping with Black women clients. Building on West's (1995) conceptual approach, Ashley (2014) describes a case example wherein she was able to normalise her client's anger within the context of the angry Black woman stereotype, and to recognise how this stereotype has prevented emotional expression for this client throughout her life. Jane and her

therapist focused more on the interpersonal impacts of stereotyping, but she nevertheless worked alongside Jane to move through the landscape of limiting media representations. The therapy space did not afford Amy the experience of "allowing [the stereotype] to be present in the room" (Ashley, 2014, p. 33) or a similar level of sensitivity to identity in general. What remained was an impression for Amy that their concerns were not worth making the effort for, and that they would have to explore the impacts of limited media representations without professional support.

It is interesting to note that Jane and Sally, who had the more positive therapy experiences of the four, saw social workers for their therapy; Amy and Lee saw a Licensed Counselling Therapist and a psychiatric nurse respectively. Relevant literature cited in the current study, such as White and Fontenot (2019) or Applegarth and Nuttall (2016), do not specify professional qualifications of participants' therapists and counsellors; they rely on participants' self-reported identities as "consumers of mental health" or experiences in talking therapies, respectively. This was the approach taken in the current study, where participants could self-select for eligibility based on whether they could speak to experiences in counselling and/or psychotherapy.

Riggs and Bartholomaeus (2016) compared competencies and attitudes for 306 mental health professionals practicing in Australia, including mental health nurses, counsellors, psychologists, social workers, and psychiatrists. There was no statistically significant difference between mental health nurses, counsellors, psychologists, and social workers on clinical knowledge for working with TGNC clients, though psychiatrists had significantly lower levels of clinical knowledge than each of these groups. There were no differences in categories on comfort of interacting with TGNC people. Counsellors had significantly more confidence in working with TGNC clients than did mental health nurses, psychologists, and social workers, but not psychiatrists.

As this is the only comparative study on mental health professionals' competencies in working with TGNC clients published within the last 35 years, it is unclear whether particular categories of mental health professionals are better equipped to serve this population. Notably, participants in my study reported comparatively more positive experiences with social workers than other professionals (e.g., counsellors or psychiatrists), which prompts questions about whether training in the contextual and social nature of mental health plays a role in gender-

affirming therapy. Further research is needed to better understand the differences in service provision for TGNC clients between professional categories.

Non-Affirming Moments in Therapy

Whether or not media was included in the therapy dialogue, participants highlighted their therapists' lack of education around how to affirmingly approach gender identity, the burden on themselves and their communities of subsequently keeping identity work separate from therapy, and the ways that media supported their gender expression where therapy may have limited it. There was a sense for all participants that low education on gender should be assumed as default to avoid being harmed by disclosing too much and being misunderstood or rejected by their therapist.

Both Sally and Amy experienced therapists/counsellors who demonstrated entitlement to know about their gender identity and sexual orientation, broaching the topic in the first session with the expectation it would be received without hesitation. Amy's counsellor was "outwardly supportive" in their level of interest, but demonstrated this support in a solely tokenistic way as conveyed by failing to use Amy's correct name or pronouns. When Sally and Amy tried diverting the question or changing the subject, these professionals seemed unaware of (or uninterested in) the possible impact of forcing the issue. Lee's therapist, by contrast, was not interested in pursuing an exploration of gender identity with her client, but dismissed Lee's statements as evidence of past trauma or low self-esteem. Gender was therefore not broached in therapy safely again, though Lee continued to use media as a conduit for talking about gender, such as discussing a trans character in *Twin Peaks* (1990-1991) being played by a cis actor. Amy experienced the burden of acting as a teacher for their counsellor, something that was openly acknowledged by the counsellor. They felt that the counsellor did not make an effort to further educate herself outside of direct conversations with Amy, and that she did not like the feeling of knowing less than her client. This need to educate their counsellor was not merely frustrating, and Amy described the material risks of self-advocacy as a TGNC client – of being "drop[ped]" by the counsellor and failing to receive support at all, particularly with power dynamics of gender identity present in the room.

Each of these themes – the educational burden of teaching a mental health professional about your identity, the avoidance and pathologising of gender in session, and inflating gender to a higher importance in treatment than what is indicated by the client – are described by

participants in Mizock and Lundquist (2016). Other themes developed in the authors' analysis are of therapists' limited definitions of what it means to be TGNC, treating all TGNC people as if they share identical experiences of gender, and gatekeeping access to medical services. The first of these themes is reflected in a comment made by Amy about the perception that someone is not TGNC enough if they have not been judged to be completely committed to transitioning. This pressure is echoed by one of Applegarth and Nuttall's (2016, p. 70) participants, describing it in the context of therapy: "There is always that thing… that you need to look as female and glam as possible so they know you're really serious about it." TGNC clients are in a position of having to 'prove' their identity to their cis therapists in order to be taken seriously. As Ashley (2014) wrote in the context of therapy with Black women clients, "in a therapy setting, being or feeling silenced or dehumanised is counterintuitive to the therapeutic alliance and process, which may result in unsuccessful treatment outcomes" (p. 31). There is a potential intersection here of media representation and therapists' perceptions of what counts as, and who gets to legitimise, genuine gender expression. Though participants in my study did not reference media in this context, nor did participants in Applegarth and Nuttall (2016), it is worth considering where therapists are learning their ideas about what "makes [someone] trans," in Amy's words. As discussed in the previous theme of media, mental health, and identity, media representations of TGNC identities are typically confined to binary gender expressions and beauty standards that correspond with the cis majority. These common representations may inform how therapists understand their TGNC clients. Further, if therapists are in a role of providing recommendations for hormonal and surgical transition, these representations may (consciously or unconsciously) inform their decisions about TGNC clients' access to further care.

Sally's more recent experience and Jane's primary experience were characterised by many differences from those of Amy and Lee, but notably absent were these themes described by Mizock and Lundquist (2016): their therapists did not expect to be taught about gender by their clients, did not either overemphasise or overly de-emphasise gender in their therapeutic work, did not pathologise gender diversity or attempt to 'repair' it in their clients, did not assume all TGNC people had equivalent experiences, and did not gatekeep access to transition-related resources. These 'what-not-to-do' guidelines are useful for understanding why Sally's and Jane's experiences were much more positive in terms of how gender was handled in-session, as well as in terms of success in therapy generally and getting what they were looking for out of their

therapy. It was evident throughout the interviews that a non-affirming and invalidating view of gender pre-empted Amy's and Lee's being able to benefit from therapy and to continue to seek professional mental health treatment. Here, community care steps in to replace professional care, as described by Amy. Importantly, this was the case even though neither of them sought therapy for the purpose of addressing gender identity development. Invalidation of this core aspect of their identity was a rupture that spread well beyond its source.

Graham et al. (2009), in their study of cultural barriers faced by Muslim clients, echoed this issue of finding mental health services within one's community that embody culturally relevant practice. Their participants recommended that counselling agencies employ culturally diverse practitioners, and argued that more practitioners who are part of, or informed about, clients' cultural groups are needed. Though this study focused on working with Muslim clients, the authors note that these findings are important for counsellors and counselling agencies working with a variety of multicultural groups. A study by NeMoyer et al. (2020) looked at how these suggestions may be applied, conducting a quantitative analysis of the impacts of increased supply of mental health services by racial group for emerging adults, an age population that parallels the participants in my study. They found a significant interaction for increased supply of services and increased benefit for clients of colour, whereas effects were less pronounced for white clients. This finding built on similar results from Cook et al. (2013), whose data analysis determined that increased supply of mental health providers correlated with increased use of mental health services for Latinx and Black participants, but not for white participants.

Though each of these studies focused on service provision for clients of colour, there is potential that their findings would extend to other marginalised groups, such as TGNC people, and particularly TGNC people of colour. Following this possibility, it may be suggested that increased availability of services for TGNC communities would correlate with clients accessing these services, and deriving more benefit from the services they receive. These studies demonstrate benefits for racialised communities when access to services is increased overall. It is also worth considering how these impacts might be further bolstered by increased availability of mental health practitioners who are specifically part of a client's cultural group, or who are well-versed in how to work with a client's cultural group in an affirming way. As it currently stands, demand for TGNC practitioners exceeds supply, as Jane notes they enter the system only "despite" it, not "because" of it.

The idea that media was often a catalyst for identity development whereas therapy was more neutral or even harmful to this development is consistent with literature in both areas. Literature on media and gender diversity has highlighted participants' positive or mixed experiences, while missteps and insensitivity are the common themes in the counselling and therapy literature. Both represent institutions of power that determine what is important to the population they are meant to serve and define them without accountability to the communities represented. However, even when media representations were lacking or outright dehumanising, there remains something in seeing a part of oneself on the screen – perhaps an abject part – that is not replicated in therapy. No participants in my study had experiences with a therapist who was themselves TGNC, though all speculated on what difference it might have made had that been the case. A discourse of representation *in therapy* therefore operates in the unarticulated of participants' testimony, due to an absence of direct experience. What might it mean to see a part of oneself across the room in the therapy chair? TGNC clients must find ways of feeling represented despite this lack of representation in mental health practitioners. In participants' current realities, social media allowed them and other TGNC community members to construct their own relationships of shared experience, ways of being represented, and mental health supports and resources. As Amy emphasised, that online validation operated as a placeholder while in (seemingly endless) waitlist limbo for a TGNC counsellor.

Processing Impacts of Non-Affirming Care

As part of their experience with non-affirming mental healthcare, participants took on feelings of rejection and self-blame, were tasked with developing the skills to understand when the therapy could or could not meet their needs, and learned to accept less than what they desired.

I previously described experiences from Mizock and Lundquist (2016) as guidelines on what not to do as a therapist. Participants in that study were equipped to recognise the non-affirmations within their care, but it is worth considering how clients may come to understand their non-affirmative experiences when it is more difficult to assign responsibility to the therapist. For Amy, it was impossible to entirely divorce their perceptions of their own mental wellbeing from the judgements ascribed to them by their counsellor. Though they were at times able to recognise that these failures in treatment were not their responsibility, the nature of their depression led them to ruminating on anxious thoughts of not being good enough, or being

untreatable. Amy stated they did not have the "right knowledge of [their] brain" at the time of therapy, but was not supported by a counsellor who could help explore this knowledge collaboratively. The rejection of their needs based on their presenting mental health concerns overlapped with invalidating care related to gender identity. Importantly, Amy's counsellor was more comfortable disclosing their limited scope of practice around DBT than their lack of education on working with gender identity. The counsellor presumably did not feel that her limited knowledge of gender precluded beneficial counselling work with Amy, and she felt comfortable leaning on her client to gain that knowledge. By contrast, providing DBT as requested by her client was deemed outside of her scope, to the point of needing to refer out. For Amy's counsellor, gender identity was assessed as a flexible realm of knowledge that could be expanded with relative ease, whereas drawing on a different modality was placed outside a harder border of scope of practice. This assessment of scope did not ultimately prioritise Amy's needs as the client.

Lee was similarly not equipped to challenge their therapist's understandings of gender diversity at the time of therapy in feeling like their therapist must have some degree of expertise, they followed her conceptualisation of gender as a product of trauma and self-esteem. Both Lee and Amy reflected critically on these experiences during the interviews, but this critical understanding did not pre-empt affective damage from non-affirming care. Sally carried the burden of determining that their therapist could not meet their mental health needs in an affirming way, and risking the possible repercussions of disclosing their queer and nonbinary identities with their next therapist in ensuring the pattern was not reproduced. Participants were placed in a dual bind of hoping for more while accepting less, and holding on to the idea that they will get something out of treatment even when their identity is being "brushed over," minimised, or outright denied.

Furthermore, not all clients will have the means to look upon such experiences critically, either during the experience or afterwards. Ongoing non-affirmation can lead to dismissing one's own desire for more from their care, and even deliberately denying oneself a critical examination of therapeutic experiences. Sally, for example, had a predominantly positive experience with their recent therapist, but dismissed themselves when they briefly wondered whether a TGNC therapist would understand them better. Clients are of course entitled to focus on the positives of their therapy experiences, but for marginalised clients in particular, there may be a hesitation to

label inadequacies for what they are, and a sense of obligation to be grateful for the good care they did manage to receive. One participant's comment in Anzani et al. (2019, p. 264) was particularly revealing on this issue, and mirrored Sally's and Amy's sentiments: "Maybe I'm being ungrateful [by being critical of my therapist's failure to discuss gender with me], because there are some therapists who are outright rejecting."

All participants in Anzani et al. (2019, p. 262) were prompted to describe their therapists' "subtle positive or supportive messages to you based on your gender identity." Some examples of affirming care highlighted by participants include returning a phone call after a missed appointment, not discouraging them from transitioning, not being "outright rejecting," ending a nearly year-long gatekeeping of necessary letters, and focusing on the presenting problem (Anzani et al., 2019, p. 264). As mentioned in the literature review, these examples provided by participants suggest an absence of microaggressions rather than a presence of affirming care. This echoes the what-not-to-do nature of Mizock and Lundquist (2016) – Sally's and Jane's experiences were positive partly as a result of an absence of negative experiences. In a landscape where negative experiences in mental healthcare are so common as to become banal, "prior hostile or invalidating experiences… act as an anchoring point, lowering one's threshold for positivity" (Anzani et al., 2019, p. 265). As less is offered to TGNC clients, they not only come to accept and expect less, but to view even basic components of therapeutic care as TGNC-affirmative.

Perceptions of Change and Hopes for the Future

Participants shared perceptions of the changing quality of mental healthcare for TGNC clients. They witnessed this change in the experiences of close others or in professionals they had relationships with, and also advocated for this change within their own care. Though past negative therapy experiences were justifiably discouraging, they did not deter participants from hoping for better with future care, and for problem solving ways of seeking it out. This was evident for Sally, who had successfully sought affirming care by the time of our interview, and for Amy and Lee who both expressed hope that better was out there (even if not currently accessible). Jane had a balanced view of what therapy was able to offer her, using therapy as a "house cleaning" tool as needed. Though anecdotal from the experiences of four clients, change toward more affirming services was also suggested in the timeline of services received by each participant. Sally's positive experience occurred within the last year, while Amy's and Lee's

negative experiences began around four or more years prior to the interview. Jane's experience occurred in the middle of this timeline.

Media as a tool for therapist education had a role in these positive changes, whether changes directly experienced or anticipated. All participants saw merits in how media could be used by therapists to learn about TGNC identities, and as an intervention in the therapy room. Amy shared hesitations about relying on media exclusively, emphasising that media could be beneficial as a supplement to more formal professional development in working with TGNC populations. The role of personal connection in learning, and media as a conduit for personal connection, was highlighted by Jane and Amy. The idea of using media to "feel more safe and not guarded" as described by Jane resonates for Lee's and Sally's experiences of using media in therapy to approach otherwise difficult topics. Jane's description of media's role in humanising TGNC people speaks to a protective buffering offered by media, where audiences can no longer exclude or Other TGNC people as easily. This finding is supported by Miller et al. (2020) in their study of parasocial relationships with TGNC media figures. They argue that media encounters with outgroup members, which for cis audiences would include TGNC people, can help engender more positive attitudes towards the represented group.

Relationships with media figures can have similar impacts as in-person interactions, especially considering that only around 15% of Americans in 2017 reported personally knowing a TGNC person (Miller et al., 2020). Therapists may seek out training in working with TGNC clients, but Amy emphasised that the lived experiences of TGNC people transmitted in media have unique merit and cannot be replaced by a more abstract, professionally-trained view of TGNC people. Jane suggested that there are many different forms of knowledge of TGNC communities, spanning media, lived experience, academic sources, self-teaching drawn from voices in the community, and formal training. In her view, media could become a more beneficial source of knowledge by prioritising educational material, rather than entertainment value. As we are speaking of a mainstream media culture driven by algorithms and profit, and that therefore presents what is deemed most 'palatable' and 'passable' to cis majority audiences, a focus on educational impact meaningful to TGNC communities seems distant.

Miller et al. (2020) stressed the need to take popular media culture and celebrity figures seriously as political topics, as the public may be more familiar with celebrity culture than current political affairs and may therefore derive more knowledge of TGNC identities from

celebrity figures. I would extend this argument to work in mental health. It is evident in testimony from participants in my study that popular media culture has implications for TGNC mental health, implications that interact with political concerns as well as personal wellbeing. For TGNC people, whose existence is often politicised regardless of their own political awareness, it is essential that we "[meet] [them] on [their] level" (Lee) and understand media as a realm for counselling theory and application. It is also important for therapists to recognise their own relationships with TGNC media, and to understand these relationships as political ones.

Participants' views on the use of media in therapy will be expanded in the following implications section, as I aim to transmit participants' recommendations with close attention to their own words. I offer implications that are based in participants' words, but that are informed by my own understanding of the counselling and therapy literature and experiences as a psychotherapist. I here aim for a fusion of horizons with participants, while privileging their experiences as TGNC clients over my own as a practitioner and researcher.

Implications for Therapy

The implications provided below assume a default audience of cis therapists and counsellors, who make up the majority of practitioners in the field. These implications are not solely relevant to cis practitioners, however, and offer ways for all practitioners to deepen their practice with TGNC clients and employ media in their work.

This study also presents implications for media itself – e.g., Jane's call for media that interrogates its privileging of whiteness and cisnormative beauty standards. The current study is focused on drawing implications from participant interviews to improve mental healthcare practice with TGNC clients; future research could explore the implications for the field of media studies or recommendations for content creators/network writers/etc.

Making Safe Spaces for TGNC Clients

The overall consensus for how to improve therapy and counselling for TGNC clients is the need for increased and better-informed education on working with this population. Therapists must make clear that gender is a welcome topic in the therapy space, without asking invasive questions or feeling entitled to information about a client's gender identity and expression. Themes discussed by Mizock and Lundquist (2016), and echoed by participants in this study, offer a starting point on what types of behaviour to avoid: expecting clients to be teachers about

gender diversity; therapists either overemphasising or de-emphasising gender in therapeutic conversations based on their own assumptions or level of knowledge; pathologising gender diversity or attempting to repair it; assuming all TGNC people have equivalent experiences; and gatekeeping access to transition-related resources like letters of recommendation for affirmative surgery. All of these behaviours are grounded in a prioritisation of client-centred care, and require therapists to be aware of the limitations of their TGNC cultural knowledge and the ways that discomfort can disrupt a client-centred approach. In the literature review of this research, I critiqued the limitations of 'do's' and 'don'ts' as insufficient for developing TGNC-affirmative care, a point also made by Spencer et al. (2021). Though this type of guideline seemed cursory to me at the outset of the study, the testimony of participants in my study made clear that the field of therapy and counselling is not yet at the point where it can be assumed most therapists are meeting these basics of affirmative care.

There is considerable importance here for recognising privilege and becoming comfortable with moments of discomfort and often knowing less than clients. Cis practitioners must recognise that a TGNC therapist will always be more equipped to work with TGNC clients, but that due to the demographic makeup of the field, clients will very rarely be able to access therapeutic services with TGNC practitioners. Following Graham et al. (2009) in their discussion of working with Muslim clients, cis therapists may seek out consultation with or aim to work alongside TGNC therapists. Therapists should also recognise that they may play less of a role in clients' understandings or development of gender identity than expected; as evidenced in this study, participants were much more likely to be influenced by community, close loved ones, and media than by their therapist or work done in therapy. TGNC clients may be particularly likely to come in with previous negative experiences in therapy, and therapists should become comfortable asking about these past experiences and working collaboratively to learn from what went wrong, all while centering the client's experience. Clients may feel uncomfortable asserting their needs with a cis therapist who holds significantly more social power, and therapists should reflect on whether their TGNC clients are tolerating 'good enough' care because they are unsure that better care is available or worth the effort in pursuing.

Therapists likely have modalities that they are loyal to and committed to working with, and it is important to research whether these modalities have been validated or adapted for work with TGNC populations. Therapists can also seek formal training, such as the WPATH

certification program, or participate in more informal education such as a psychology reading group focused on TGNC mental healthcare. However, this work must go beyond education 'on paper,' and practitioners should make genuine efforts to connect with the TGNC community in their area, and be a part of positive change – for example, by making oneself known as a TGNC-affirmative option for those seeking therapy services, or offering a sliding scale for TGNC clients.

Furthermore, in aiming to offer more TGNC-affirmative care, practitioners must be transparent about their level of training and experience in working with TGNC clients, and seek out supervision or refer out when relevant. As in Amy's and Lee's experiences, out-referrals can be experienced as rejections and lead to emotional harms that are experienced as reflections on oneself and one's identity. It is therefore essential that referrals are handled with care and transparency from therapists, ensuring a clear understanding of why the referral is being made and collaborating with clients to find a better fit. It is also important to clarify clients' purpose for seeking care at the beginning of therapy. For example, participants may be wanting to complete the minimum number of sessions required to receive a letter supporting surgical transition. If a practitioner is not comfortable with such an arrangement, this must be communicated from the start (Anzani et al., 2019). This will help alleviate the burden on TGNC clients of trying to determine whether their needs will be met in their work with the therapist.

Use of Media

Media can be an asset in therapy with TGNC clients. Participants had positive views of recommending media based on client identity, whether gender identity or otherwise, as a tool of broaching culture. Media can also be used as a conduit for clients' difficult emotions and to ease into discussions of gender identity, and media that a client brings into the therapy room should be explored for its salience to the client and integrated within other areas of focus in therapy. If using TGNC-focused media as a tool of education, therapists must choose their sources carefully, prioritising TGNC voices within media. They should seek out multiple, diverse sources of media and learn from a genuine interest in fostering safety and affirmation for their clients, rather than seeking to check a box of 'multicultural' awareness. Some specific suggestions made by participants include the Jules episode (Special Episode Part 2, 2021) of *Euphoria* (2019-) and CBC's *Sort Of* (2021-). Media does not necessarily have to be queer- or TGNC-focused to be impactful for clients, and therapists can consider which elements of a

client's experience or identity (e.g., racial discrimination) may be reflected in a particular piece of media. Social media can also be a tool for building informational resources for cis therapists, similarly to how it may build community for their TGNC clients. Perhaps most importantly, media should not be viewed as a replacement for more formal training or experience working with TGNC clients, and therapists should attend to issues of privilege and performativity when discussing media outside one's experience and community.

Therapists should also be aware of the salience of media in the lives of their clients. They should be informed about issues in media relevant to TGNC clients, as discussed by West (1995) and Ashley (2014) – the history of TGNC identities represented sensationally and played for laughs or horror, binary representations of gender as either masculine or feminine, power dynamics in who is typically represented and the privileging of those who most closely pass as cis, and the prevalence of cis writers, directors, and actors defining mainstream TGNC media. They can also explore how media representation is often complex for people of marginalised identities, who rarely see themselves represented at all. A cis therapist's instinctual labelling of a piece of media as 'bad' or dehumanising may carry significantly different connotations for their TGNC client. Following the results in this study and in the literature, therapists should recognise the meaningful role media may have for their TGNC clients – traditional media is often the first place TGNC people encounter diverse gender expressions, it may function as a source of information, and can help them form community. Social media can be a space to find resources and build identity within community, while also exposing TGNC people to harassment and threats to safety. Therapists can support clients in safely navigating the complexities of social media, and processing the emotional and potentially traumatic impacts of experiencing harm online. Therapists should be open to exploring both traditional and social media as a resourcing tool, collaborating with their clients on accessing relevant information online, and especially if early in transition or encountering isolation, problem solving how social media can help build connections with others.

Limitations

There are several demographic limitations to this study, including 1) all participants being between 18 and 35 years old; 2) limited representation of racialised people; 3) no representation of trans men, Two-Spirit people, or other gender identities; 4) geographical location of participants being limited to Ontario and the Atlantic provinces; 5) exclusion of

clients currently in therapy; 6) interviews being conducted virtually; and 7) heterogeneity of professional title of participants' therapists and counsellors. Sprague (2005) speaks to the distortion of research samples in the direction of privilege, an ongoing systemic issue within psychotherapy and counselling research. Young people are more likely to be able to conduct an interview via Zoom and to encounter recruitment messaging that is predominantly conducted online. I did reach out to several TGNC seniors' groups, but recruitment could have been further emphasised ensuring greater age diversity in the sample. Community organisations and counselling services were contacted in each Canadian province and territory, though contact was generally limited to urban centres as more rural communities often do not have TGNC-focused organisations.

Notably, the vast majority of prospective participants who expressed interest were currently in therapy. Though this exclusion criterion was designed to prevent impacts on participants' current therapy process and therapeutic relationship, it may have been useful to adapt this criterion. Many current therapy clients wanted to contribute to this project and were interested in sharing their experiences. This issue raises questions of whether excluding current therapy clients penalises TGNC people who have successfully found and accessed therapy, evidently no small feat.

Most participants differed in the professional designation of their primary therapist or counsellor. Though my focus was on participants' experiences in counselling and therapy, their therapy was provided by a diverse array of professionals, including mental health counsellors, social workers, and psychiatric nurses. My focus on 'counselling and psychotherapy' is therefore complicated, as is what participants said about practices in mental healthcare. Because the practice of counselling and/or psychotherapy is regulated in heterogeneous ways across Canada, it is difficult to define what specifically counts as the practice of counselling and psychotherapy. Participant experiences and results for this study may have differed had all participants seen psychotherapists, counsellors, psychiatrists, etc., as professional backgrounds and values espoused by each profession differ. These differences may impact the experiences of TGNC clients who encounter each profession. The role of professional designation therefore could have been considered more explicitly in recruitment material, and incorporated into interview questions for participants who had seen professionals from multiple professional designations.

The absence of trans men in this work is concerning but unsurprising, considering the well-documented challenge of recruiting men to participate in research. There are also documented ways to (somewhat) improve recruitment of men in health research (Ryan et al., 2019), though it is unclear whether these findings extend to trans men, or whether they apply to research in psychotherapy. McInroy and Craig's (2015) participants discussed the general lack of visibility for trans men in comparison with trans women. This point was made in reference to media representation, but also extends to visibility within research. As Vincent (2018) highlights, trans women, trans men, and nonbinary people each have unique experiences and knowledge that are not necessarily transferable between identity categories. I had hoped to recruit from across diverse gender identities, and ultimately accepted all interested participants who met inclusion criteria.

The perspectives of Two-Spirit clients are notably absent from this research, and this absence speaks to the limitations of attempting to include Two-Spirit identities into the settler colonial framework of trans and gender nonconforming identities, and homogenising Indigenous gender diversity under an umbrella term. Simultaneously, an inclusion of Two-Spirit perspectives without disrupting other settler colonial aspects of the research process and TGNC and queer identity frameworks "masks the ongoing settler-colonial violence required for modern queer formations to exist" (Greensmith & Giwa, 2013, p. 130). Two-Spirit knowledges have been displaced both by dominant binary understandings of gender and by white understandings of gender diversity, and while I aim to disrupt the former in this project, my research does little to unsettle the latter. Two-Spirit people are already rendered invisible in mainstream LGTBQ+ discourse (Greensmith & Giwa, 2013); white settler researchers like myself must enact anticolonial research practices while not appropriating Two-Spirit identities and "desir[ing] a bit of the Other to escape the blank landscape of Whiteness" (bell hooks, quoted in Greensmith & Giwa, 2013, p. 142). "Instead, non-Indigenous queers must take seriously their settler privilege and/or complicity… as reifying settler colonialism" (Greensmith & Giwa, 2013, p. 142).

It is important that my data analysis be considered within its context of trans women (one of four) and nonbinary (three of four) participants, and that these results and implications may not represent the experiences and desires of trans men, Two-Spirit people, or people with other gender identities in therapy.

Delimitations

Several elements of the research included by design contributed to the richness of data, notably 1) sample size; 2) phrasing of recruitment materials; 3) exploratory nature of the research and flexibility of the interview guide; and 4) participant opportunity to provide comments and edits post-interview.

My sample size of four participants allowed for depth to participant interviews and to my subsequent engagement with interview texts. Most, if not all, parts of participants' interviews are present in the written thesis, in a way that would likely not have been possible with a large sample size. Participants spoke to their experiences within their own contexts, with their individual experiences, interests, and thoughts valued; I was able to engage with their experiences and contexts without the pressure of rendering them generalisable. On a practical level, my sample size permitted me to compensate participants for their time, a principle that is essential to my ethical stance as a researcher and based in an understanding of the intersections of socioeconomic status and gender diversity.

In recruitment materials, I maintained a deliberately open stance in describing what participant experiences I was seeking for the study. Participants were recruited based on *any* experiences with media, therapy, and the intersections of the two. This allowed for a diversity of experiences and a meaningful fusion of horizons with participants, expanding my own pre-understandings and adding complexity to the existing literature on TGNC relationships with mental healthcare and media.

Because this topic had not been addressed directly in previous literature, I approached the research from an exploratory stance. A framework of curiosity, re-emphasised throughout the research process, helped ensure the data represented in the thesis speaks to what is most important to participants. The gaps in the literature were a strength in this way, as I did not have previous academic work against which to compare participants' experiences. I experienced the interview guide as a useful signpost to direct the interviews, while also building on aspects of participants' testimony in the moment. Counselling skills were useful here, as I have countless experiences of finding my session 'agenda' rendered obsolete by clients' expectations and priorities. For TGNC people, who are often defined rather than truly listened to, it was particularly important that interviews did not reproduce power dynamics where their experiences are constrained by the agendas of others.

This priority extended to participants' opportunities to provide edits and comments post-interview. One participant, Lee, felt that they struggled to speak fully to their experiences of media during the interview, and they provided extensive comments after the interview on their relationship with specific pieces of media. This specificity added richness to the text, and ensured that final themes depict not a generalised version of their experiences, but one that is experience-close and idiosyncratic.

Recommendations for Future Research

Future research can expand on the current study in several ways. First, research on the intersections of media and therapy with TGNC clients can be deepened, as this study is the first to analyse this phenomenon directly. This research should also include a focused attempt to recruit trans men, Two-Spirit people, and people with other gender identities and to understand their relationship to this phenomenon. Age and geographic diversity should be considered, as well as greater representation of racialised participants – how does this experience show up for older TGNC adults, for adolescents, for those in rural communities, for BIPOC TGNC people?

Though participants in this study presented a clear picture of the specific pieces of media that have been most significant for them, future work could deepen this understanding of media as applied in therapy and mental health. More work in this area could contribute to developing guidelines for working with media with TGNC clients, and ideally offer trials or case studies of this work as in Ashley (2014). As this area bridges several academic fields, it is important to encourage interdisciplinary work between media studies, psychology and psychotherapy, gender/feminist studies, sociology, and other relevant domains. Much of the baseline research that informed my research question was made possible by moving beyond disciplinary borders. Media studies are already rich with analyses of TGNC representation and meaning-making in media, and could take up the implications of participants in this study (and others in future research) in order to supplement academic theory with the grounded experiences of TGNC people outside the academy.

A notable experience shared by participants is that of media as a more salient space of identity construction than the therapy space. This is not an experience currently reflected in the literature, as the intersections of media and therapy for TGNC people have not been directly examined. As future research deepens our understanding of this intersection, it will be important to expand on this connection, and its implications for mental health systems broadly. When

therapy is not an adequately safe space in which to introduce identity development, are clients pushed to seek other forms of support? Connections with media representations are often the earliest relationships clients have with gender diversity – how does this influence the identity work that clients are later able to engage with in therapy? More abstractly, what might be lost when the relationship between media and identity is not welcomed and understood within the therapy space? The present research has begun to address the speculative questions on media and therapy that I set out with, while also pointing towards the parts of this experience that remain unaddressed and unrepresented in the therapy and counselling literature.

Another experience shared by several participants was that of receiving out-referrals by therapists and counsellors as a source of rejection. There is a strong emphasis in the field on the ethical duties therapists have to refer out when they are not sufficiently trained or experienced in working with particular client concerns. This ethical imperative may not, however, be evident to clients, and the resulting sense of rejection can have deep consequences for their sense of themselves, their gender identity, and their presenting mental health concerns. Future research could examine these impacts more directly, and work to gain a better understanding of how therapists can approach the issue of recognising limits to cultural competence while simultaneously avoiding doing harm with gender diverse clients.

There is little research generally on TGNC clients' access to mental health services, and retention rates over the long term. Do those negative experiences described by participants influence retention rates or likelihood of using mental health services in future? Furthermore, though several studies have begun to examine what kinds of training or experience are most impactful for clinicians working with TGNC clients (Kanamori & Cornelius-White, 2017; O'Hara et al., 2013; Stroumsa et al., 2019), more grounded research is undeniably needed to enact a TGNC-affirming field of practice. Does having a TGNC therapist make a difference to experience of care, therapy outcomes, identity development? Is there more uptake of mental healthcare services if more community-insider practitioners are available, and structural diversity is improved? We have several sets of guidelines and frameworks that are informed by thoughtful and important research, but it is necessary to go beyond theory and see how these ideas impact the actual TGNC clients in our therapy rooms.

A related suggestion is for more comparative research on participant experiences with different professional categories within mental healthcare (e.g., experiences with M.Ed. level

counsellors vs. psychologists vs. social workers). TGNC clients are likely to encounter several health professionals as they seek services for mental health needs, hormone therapy, and gender-affirming surgery. As the incidence of negative experiences with mental health providers is high, they may also be more likely to seek out multiple mental healthcare providers before finding one who is affirming (this was the case for three of four participants in the current study, two of which had yet to find an affirming practitioner). While it is in line with previous work in the field (Riggs and Bartholomaeus [2016] being the exception), amalgamating data from experiences with social workers, a counsellor, and a psychiatric nurse, does little to help differentiate levels of training and competence between professional categories. Future work could compare experiences between clients, as well as within clients' experiences if they have seen practitioners from multiple professional categories.

I believe that a significant contribution of the present study was its focus on client perspectives, as the literature has predominantly focused on practitioners, and has developed guidelines without explicit reference to client testimony. I suggest continued focus on TGNC clients in this research area, though it may be supplemented by qualitative interviews with therapists who work with this population.

Specifically regarding interview practice when working with TGNC participants in this area of study, I believe future research would benefit from more collaboration between participants, and between participants and researcher. As the interviews progressed, I saw how each was supplemented by the testimony of previous participants that was still fresh in my mind. A focus group would be an alternate way to approach this project, and something I would prioritise myself if able to extend the project. Other studies focused on TGNC experiences in therapy have used focus groups (e.g., Parr & Howe, 2019). Researchers experienced in grounded theory could explore a community-based project in this area, or conduct a discourse analysis that integrated the media mentioned by participants, or therapist training materials, more directly. A more specific suggestion for either individual interviews or focus groups, I would be interested in asking participants where they think their therapists/counsellors are learning about TGNC identities or working with TGNC clients, in order to cultivate insight into how TGNC clients receive the knowledge (or lack thereof) communicated by their practitioners.

Conclusion

The aim of this study was to deepen understandings of the impact that media has on TGNC clients' experiences of therapy, and of their gender identity. This work was conducted in the context of generally inadequate mental health services for TGNC people, and the finding that many therapists feel unequipped to work with TGNC clients. Overall, media had a strong presence in participants' development of their gender identity, as well as their experiences of finding resources and building community. Media also had a presence in the therapy room for participants, and while that media was sometimes TGNC-focused and sometimes not, their experiences in this domain were predominantly positive. Experiences of gender affirmation in therapy were mixed, though media was sometimes a conduit for greater affirmation of gender diversity. Participants reported diverse ways that they felt their identities pathologised in therapy, and how they became aware of their cis therapists' limited training or experience in working with TGNC clients. This study contributes to a growing literature on working with TGNC clients in therapy, bringing in the factor of relationships with media which are often highly significant for TGNC people. Research in this area is important to developing affirmative practices in therapy with TGNC clients, and ensuring that the mental health and identity needs of our TGNC clients are being met on their terms. It can also help us as practitioners reflect on where we receive our knowledge of TGNC identities, and to use media more carefully as a tool for expanding our work and relationships with TGNC communities.

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Appendix A: Recruitment Text

Do you identify as transgender or gender nonconforming (TGNC)? Have you been in therapy or counselling?

I am seeking to hear from TGNC folks about their experiences of therapy and TGNC identity as it relates to media that focus on TGNC identity (e.g., social media, blogs, news, movies, TV shows), regardless of whether media was discussed directly in therapy. I hope to conduct interviews with TGNC folks that centre their perspectives and lived experience, with the aim of better understanding mental healthcare for TGNC clients.

To participate in this study, you must:

- Identify as a gender other than that assigned at birth (e.g., trans, gender nonconforming, Two-Spirit, nonbinary, genderqueer, genderfluid, bigender, agender, or otherwise gender diverse)
- Be 18 or older
- Be able to meet virtually
- Have attended individual therapy or counselling for at least one full session
- Not currently be in therapy
- Have disclosed your gender identity to your therapist or counsellor
- Be able to share about experiences of therapy and TGNC identity as it relates to media

Participation will involve an audio-recorded interview of approximately 1 hour, and participants will receive a $20 gift card for their time and participation. Participation will be first-come, first-served with consideration given to ensuring diversity within participant recruitment.

Interviews will take place virtually. What you choose to share will be completely confidential, and you will have the right to withdraw interview data during the research process.

If you are interested in this study, please contact me, Julia Clarke (she/they).

I am a Master's student in Counselling Psychology at the University of Ottawa. This research has been approved by the University of Ottawa Research Ethics Board and is supervised by Dr. Cristelle Audet.

Appendix B: Study Description

My name is Julia Clarke, and I am a Master's student in Counselling Psychology at the University of Ottawa. I am working under the supervision of Dr. Cristelle Audet. I am currently recruiting participants for my Master's thesis research, which seeks to document the lived experiences of transgender and gender nonconforming (TGNC) people in therapy as they relate to TGNC identities represented in popular media. Specifically, I am seeking to hear from TGNC folks who have felt that their therapy experience was impacted by media (whether or not it was discussed directly in therapy) featuring TGNC narratives, characters, or histories, whether that be a news story, TV episode, ad in a podcast, or any other media.

Study purpose

This study is situated within a long history of non-affirming practice with TGNC folks in psychology and mental healthcare. Research shows that TGNC clients are still often underserved in therapy, and that therapists and counsellors feel undertrained to discuss gender diversity with their clients. At the same time that training remains inadequate, representations of TGNC in popular media have grown exponentially over the past decade. My study therefore seeks to investigate the ways this media representation has impacted the therapy room, with a focus on TGNC clients' experiences. The aim is to add to the body of knowledge that suggests best practice for work with TGNC clients; provide better and more informed mental healthcare services to TGNC folks; and highlight the experiences of TGNC clients as the experts of what this change should look like.

Participation criteria

To participate in this study, you must a) identify as a gender other than that assigned at birth (e.g., Two-Spirit, trans, non-binary, genderqueer, agender, or otherwise gender diverse), b) be 18 or older, c) be able to meet virtually, d) have participated in individual therapy or counselling for at least one session, e) not currently be in therapy, f) have disclosed your gender identity to your therapist or counsellor, and g) be able to share about experiences of therapy and TGNC identity as it relates to media.

Interview process

If you choose to participate in this study, you will take part in a one-on-one interview that will last for approximately 1 hour. You will also complete a demographic questionnaire at the beginning of the interview. The interview would entail getting a sense of your experiences in therapy/counselling, and the ways that media relate to those experiences and your sense of identity, from your perspective. Interview questions will follow from your experiences and could include themes such as your view of therapy/counselling, your experiences with media representations of TGNC identities, and the ways media and therapy have intersected for you.

You are welcome to see my interview guide ahead of the interview if you think this would be helpful.

The interview would be conducted via a secure online video platform. A time would be arranged that is convenient for us both, where we could speak uninterrupted for approximately 1 hour. The interview would be audio recorded with your consent, after which I would create a verbatim transcript. You would be given a $20 gift card for your time and participation, regardless of whether you decide to withdraw your interview data partway through, or following, the interview.

Your participation would be anonymous and confidential, and you would have the opportunity to choose a pseudonym (made-up name) for the transcript and to withhold or retract any identifying details about yourself. You have the right to ask any questions about the research process, and to decline any questions that I would ask during the interview. You would have the opportunity to review your verbatim interview transcript following the interview, and add further comments or retract parts of the interview. You would be given two weeks to review your transcript.

Throughout the research process, you would also have the right to withdraw your consent to participate and have any existing data destroyed, with no negative consequences. However, after I submit my thesis or other publications for dissemination, I will be unable to remove any data.

Risks of participation

This study has the potential to bring up challenging or triggering memories, relating to experiences in therapy/counselling and your mental health. You would be given the opportunity to receive the interview questions in advance, if you would like, and to decide to proceed or withdraw from the study accordingly. You would have the right to pause or stop the interview at any time if you felt distressed, and to re-orient the interview discussion (including declining questions) as needed for your comfort. I would also provide each participant with a list of local mental health resources at the end of the interview, or at any other time as requested.

Benefits of participation

Your participation in this study would allow you to speak freely on your experiences in therapy/counselling, and to contribute to a growing literature on how TGNC folks are experiencing mental healthcare. The intent is to better understand your experiences in therapy, through sharing your perspective on TGNC-centred media in the therapy room.

Privacy and confidentiality

As mentioned above, participation in this study is completely confidential and results will be anonymized as much as possible. Any written research data, whether in print or digital, would not contain your name or contact information. Confidential interview data, including the audio

recording and interview transcript, will be stored on an encrypted USB drive in a safe at my home for a period of five years. A copy of the audio recording and transcript will be stored on an encrypted USB drive in the locked office of my supervisor, Dr. Cristelle Audet.

If you wish to contact me with any questions or express interest in being a part of this project, please send me an email.

My supervisor, Dr. Cristelle Audet, can likewise be contacted.

Thank you for your consideration and take care,
Julia Clarke (she/they)

Appendix C: Recruitment Message

Hello [contact name],

I am a graduate student of the Counselling Psychology program at the University of Ottawa, currently completing my Master's thesis supervised by Dr. Cristelle Audet and which has received ethics approval (certificate attached). My work focuses on the experiences of trans and gender nonconforming (TGNC) folks in therapy/counselling, and specifically the relevancy of media to these experiences, of which I hope to gain a better understanding. This knowledge may help inform therapy practice and improve therapists' work with this population.

Individuals must (a) identify as transgender or gender nonconforming, (b) have been in therapy or counselling in the past, (c) have disclosed their gender identity to their therapist, and (d) be able to share about experiences of therapy and TGNC identity as it relates to media. They must be at least 18 years of age. Participation comprises an interview conducted virtually that will last approximately 1 hour along with a token compensation of a $20 gift card.

I would greatly appreciate your assistance in passing on the attached recruitment poster to [service users at your organisation/your staff/your social media pages or listserv/etc.]. I have also attached a more in-depth study description. Interested participants could then contact me at the email provided.

I appreciate your time and consideration, and please let me know if you have any questions or would like further information about my study.

Thank you and take care,
Julia Clarke

Appendix D: Informed Consent Form

University of Ottawa
Informed Consent Form

Title of the study: Trans and gender nonconforming (TGNC) clients' experiences of therapy and their gender identity as it relates to media that focuses on TGNC identities

Université d'Ottawa

Faculté d'éducation

University of Ottawa

Faculty of Education

Names of researchers and contact information

Julia Clarke (she/they)
Master's student
Faculty of Education
University of Ottawa
Email:

Dr. Cristelle Audet (she/her)
Thesis supervisor
Faculty of Education
University of Ottawa
Email:

Invitation to Participate: I have been invited to participate in a research project conducted by Julia Clarke, under the supervision of Dr. Cristelle Audet, as part of her Master's thesis in Counselling Psychology.

Purpose of the Study: The purpose of the study is to document the experiences of transgender and gender nonconforming (TGNC) clients in therapy/counselling as they relate to media representations of TGNC identity.

Participation: My participation will consist of participating in an interview about my experiences. The time needed for this is approximately 1 hour. The interview will be scheduled for a mutually agreed upon time and date and will take place as a virtual meeting that Julia will audio-record for future transcription. I will have the opportunity to review my interview transcript following the interview, and add to or retract from it.

Assessment of risks: My participation in this study entails the potential for distress when discussing therapy/counselling experiences and my mental health. However, if I experience any discomfort, Julia has assured me that I may decide to stop the interview or decline questions at any time. I will have the opportunity to review the interview protocol prior to the interview if I wish, and my interview transcript following the interview. Each participant will also be provided a list of support resources.

Benefits: By participating, I will have the opportunity to share my experiences in therapy/counselling and to contribute to more supportive and effective therapy/counselling for TGNC clients.

Confidentiality, anonymity, and security: I have received assurance from Julia that the information I share will remain strictly confidential. I understand that my interview and transcript will be viewed only by the researcher and their supervisor, Dr. Cristelle Audet, will be used only for the purpose of the study, and that my confidentiality will be protected through safe, secure, and password-protected measures.

My identity will be protected; I have been given the opportunity to select a pseudonym and choose how I would like my gender identity and pronouns to be represented in the finalised narrative.

I understand that security of the video interview can only be guaranteed via Microsoft Teams, and that other platforms such as Zoom or Facetime do not offer back-to-back encryption. Reasonable measures will be undertaken to minimise any security compromise as well as my confidentiality and anonymity (such as a meeting room limit of only two individuals and use of a personalised meeting link).

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Ottawa ON K1N 6N5

Canada

www.uOttawa.ca

Conservation of data: All data will be stored electronically. Stored data will include digitally signed consent forms, audio recordings of interviews (including demographic questionnaire responses), and interview transcripts. Data will be transferred from the principal investigator's computer immediately following each interview, to an encrypted USB drive stored in a locked safe at the principal investigator's home. This original data will be conserved for a period of five years following the interview date. A backup copy of the electronic data will be made onto an encrypted USB key which will be securely stored in a locked cabinet inside the thesis supervisor's locked office. The backup copy will be destroyed at the completion of the thesis.

Voluntary Participation: I am under no obligation to participate and if I choose to participate, I can withdraw from the study at any time and/or refuse to answer any questions, without suffering any negative consequences. If I choose to withdraw, all data gathered until the time of withdrawal will be destroyed, unless already published or disseminated.

Acceptance: I, _____ [*Name of participant*], agree to participate in the above research study conducted by Julia Clarke as part of their Master's thesis in Counselling Psychology at the University of Ottawa under the supervision of Dr. Cristelle Audet. My consent will be audio recorded by the researcher. I will receive a copy of the consent form for my records.

If I have any questions about the study, I may contact Julia Clarke or Dr. Cristelle Audet.

If I have any ethical concerns regarding my participation in this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, 550 Cumberland Street, Room 154, (613) 562-5387 or ethics@uottawa.ca.

Participant's name Date:

Julia Clarke

Researcher's name Date:

Appendix E: Demographic Questionnaire

Chosen pseudonym (first name): _____

How do you currently define your gender identity?

How would you like your gender identity defined for the written part of this research?

What are your pronouns?

What pronouns would you like us to use during the interview?

What pronouns would you like used for the written part of this research?

What is your age range? 18-25, 25-35, 35-45, 45-55, 55-65, 65-75, 75+

How would you describe your racial identity?

The following questions pertain to your experiences in therapy/counselling. You can skip any questions you would prefer not to answer. If you have had multiple therapy/counselling experiences, feel free to describe each of them.

What brought you to therapy/counselling?

When did you start therapy/counselling and for how long did you attend?

Around how many sessions did you have, and how frequently did you meet?

What was your therapist/counsellor's gender identity (if known)?

Where did you receive therapy/counselling? (e.g., private clinic, community centre, shelter, etc.)

What were your therapist/counsellor's professional qualifications (if known)? (e.g., registered psychotherapist, registered social worker, etc., and # of years in practice)

What approach did your therapist/counsellor generally use (if known)? (e.g., cognitive-behavioural therapy, narrative therapy, etc.)

Appendix F: Interview Guide

Introduction

- Overview of study and study aims
- My background as a researcher
- Rights of participants
- Demographic questionnaire
- Informed consent and consent to audio record

Introducing the interview

- How are you feeling about attending this interview?
- Power differentials
- Participant role and follow-up (right to withdraw data, review transcript)

Impressions of media

- How do you feel about popular media that features TGNC identities, narrative, characters, histories?
- Do you engage with any of this media personally? What are its impacts, if any, in your life?

References to media

- Tell me about a time in therapy/counselling when TGNC media has come up in some way.
- Tell me about a time in therapy/counselling when TGNC media has failed to come up when you felt it should.

Experiences in therapy/counselling

- What was your overall experience in therapy/counselling?
- What was your relationship like with your therapist/counsellor?
- What is your sense of mental healthcare services and access for TGNC people?

Experience of the therapy process in relation to TGNC-centred media

- In what ways, if any, did the references to media influence (or lack thereof) how you experienced:
    - The therapist?
    - The therapeutic relationship?
    - The process of therapy?
    - The outcome(s) of therapy?
- How did you respond?

Sense of identity in therapy in relation to TGNC-centred media

- How did the references (or lack thereof) influence how you experienced your sense of identity, if at all?
- How did you respond?
- Was there a lasting impact on your sense of your gender within the therapy/counselling space?
- Was there a lasting impact in your life more generally?

Check-in

- What was it like for you to be in this interview?
- Is there anything you feel is important to add to what we've discussed?
- Do you have a sense that your experience has been adequately represented here? Is there anything you would change or want to emphasise?
- Based on what we've discussed today, do you have any ideas for how the inclusion of media in therapy/counselling could be improved?

Debrief

- Summary of interview
- What happens now – where the data goes, my contact with them, etc.
- Resource guide (share that this is provided to all participants)

Appendix G: Resource Guides

Ottawa

Mental health and emergency services

Ottawa Distress Centre: 613-238-3311
Mental Health Crisis Line: 613-722-6914
Mental Health Mobile Crisis Unit, Ottawa Hospital: 613-722-6914
Royal Ottawa Mental Health Centre: 613-722-6521
Hope for Wellness Line for First Nations and Inuit communities: 1-855-242-3310
E-Mental Health: ementalhealth.ca

TGNC-specific and other community services

Trans Lifeline: 1-877-330-6366
Kind Space: 613-902-7527 (text only)
LGBT Youthline: 647-694-4275 (text only)
Black Youth Helpline: 1-833-294-8650
Trans Wellness Ontario: https://www.transwellness.ca/
Talk 4 Healing for Indigenous women: 1-855-554-HEAL (call or text)
Trans Health Programs at Centretown Community Health Centre: https://www.centretownchc.org/programs-services/lgbtq-trans-health-program/
Youth Services Bureau Spectrum LGBTQ Community Youth Group: https://www.ysb.ca/for-youth/youth-engagement/spectrum-lgbtq-community-youth-group/
First Nations and Inuit Hope for Wellness Help Line: 1-855-242-3310

Toronto

Mental health and emergency services

Toronto Distress Centres: 416-408-4357 or 408-HELP
Gerstein Centre Crisis Line: 416-929-5200
Toronto Rape Crisis Centre: 416-597-8808
Warden Woods Community Support Line: 647-327-0206
Hope for Wellness Line for First Nations and Inuit communities: 1-855-242-3310
E-Mental Health: ementalhealth.ca

TGNC-specific and other community services

Trans Lifeline: 1-877-330-6366
The 519: https://www.the519.org/programs/category/trans-specific
Trans Wellness Ontario: https://www.transwellness.ca/
LGBT Youthline: 647-694-4275 (text only)
Black Youth Helpline: 416-285-9944

Talk 4 Healing for Indigenous women: 1-855-554-HEAL (call or text)
First Nations and Inuit Hope for Wellness Help Line: 1-855-242-3310

St. John's

Mental health and emergency services

Mental Health Mobile Crisis Unit: 709-737-4668
Doorways Walk-In Counselling: 709-752-4903
Hope for Wellness Line for First Nations and Inuit communities: 1-855-242-3310
E-Mental Health: ementalhealth.ca

TGNC-specific and other community services

Trans Lifeline: 1-877-330-6366
Planned Parenthood 2SLGBTQ+ Warm Line: 1-866-230-8041 (call or text)
Black Youth Helpline: 1-833-294-8650
Talk 4 Healing for Indigenous women: 1-855-554-HEAL (call or text)
Trans Support NL: https://tsnl.org/
First Light: https://firstlightnl.ca/
St. John's Women's Centre: https://sjwomenscentre.ca/

Maritimes

Mental health and emergency services

Mental Health Crisis Line NS: 1-888-429-8167
Crisis Text Line NS: text NSSTRONG to 741741
Mental Health Mobile Crisis Team Halifax: 1-888-429-8167
Mobile Crisis Unit NB: https://horizonnb.ca/services/addictions-mental-health/adult-services/mobile-crisis-unit/
Chimo Help Line NB: 1-800-667-5005
Mental Health and Addictions Line PEI: 1-833-553-6983
Island Helpline PEI: 1-800-218-2885
Mobile Mental Health Response Service PEI: 1-833-553-6983
E-Mental Health: ementalhealth.ca
Hope for Wellness Line for First Nations and Inuit communities: 1-855-242-3310

TGNC-specific and other community services

Trans Lifeline: 1-877-330-6366
All Genders Helpline NS: 1-855-466-4994
Black Youth Helpline: 1-833-294-8650

Talk 4 Healing for Indigenous women: 1-855-554-HEAL (call or text)
South House Halifax Peer Support: https://southhousehalifax.org/peersupport
Nova Scotia Rainbow Action Project: https://nsrap.ca/
FLY Halifax Peer Support: https://www.transhfx.com/about-us
Transgender Health Network NB: https://www.facebook.com/transhealthnetworknb/
Chroma NB: https://chromanb.ca/
Our Landing Place PEI: https://www.ourlandingplace.com/our-team
PEERS Alliance PEI: https://www.peersalliance.ca/

Appendix H: Pre-Understandings

My understandings of healthcare, and specifically mental healthcare for TGNC folks, have primarily been informed by the experiences of close friends and co-workers, and notably by experiences shared by TGNC folks through the media – magazine articles, podcast episodes, news stories, or social media posts. Media is primarily the way I connect with how other TGNC folks experience the mental healthcare services they interact with; this includes friends and acquaintances, as it can often feel more comfortable for them to share a social media post about a microaggression experienced in therapy, than to disclose it to a friend in an emotional conversation. My view of media is thus as a tool for driving discourse, providing an outlet for processing emotionally challenging experiences, and connecting with others with shared experiences. This is of course not limited to the TGNC community, but through both my own life and the research I have seen as it relates to media and TGNC community building, I perceive media (particularly social media) to be essential to the gender exploration of many TGNC folks, as well as to their sense of connection with others with shared lived experiences.

Simultaneously, media can distort conversations about TGNC identities. TGNC folks have been historically misrepresented in media, which perpetuates the violence they experience. Though improving in recent years, TGNC-centred media often continues to present one-dimensional storylines of TGNC characters, misgender both victims and survivors of gender-based violence, and discount the experiences especially of younger TGNC folks as a phase or even proof of indoctrination through 'progressive' social media content (there is a reason that many news articles discussing TGNC identity now have the comments section turned off). There is real harm here, at the same time that there is opportunity for community building and identity exploration – media for TGNC folks is complex, and my interest in understanding how this complexity is perceived is part of what motivates my research.

Mental health services for TGNC folks have likewise become more prevalent in recent years, as it has become apparent that mental health practitioners have a responsibility to offer informed care for TGNC clients. It is difficult to underestimate what a considerable shift this is, and how much is still left unexamined. We may not diagnose clients as having gender identity disorder, but gender dysphoria is still classified in the DSM as maladaptive – while we practice in a world where transphobia is legally enforceable. My discussions with friends, and education through lived experiences shared via social media, has demonstrated that TGNC folks feel the mental healthcare they receive is inadequate and uninformed. Particularly in smaller cities and towns, there may be a handful of practitioners who have been given the 'green light' in terms of their responsiveness and education on TGNC identities. Communication about who is a 'safe' practitioner is limited to those with community membership, which often excludes recent immigrants or refugees, those who are not publicly out as TGNC, and those who live in more rural areas. While it can be useful to offer a public database of practitioners who are trained to work with TGNC populations, this information should not be gatekept by the profession, nor should it be limited to those who have more social connections within the community. I would

also argue that ultimately, all practitioners within mental healthcare should be trained to work with TGNC clients.

The topics of media and mental healthcare for TGNC intersect, for me, in conversations I have had with my cisgender friends and family members. Many of them had first encounters with TGNC identities through media, and media representations have been the catalyst for nearly all conversations I have had around gender identity. Even for those with personal knowledge of TGNC identity, there is much they do not know and do not feel it is necessarily appropriate to ask close others, such as questions about the medical transition process, or how sexual orientation is impacted by transition. They go online for these questions – social media, short articles, blog posts – or learn more indirectly as these experiences are portrayed through film and TV. Media is also a more impersonal space for learning, where we are more able to educate ourselves without burdening TGNC people. Considering an example in my own learning, I can follow the experiences of friends seeking hormone therapy because of the information I've sought out online, without needing to burden them with potentially invasive questions. Media as a tool for learning is a significant part of my rationale for this study, and I am interested to consider that therapists and counsellors may also be using media similarly.

Many pieces of media representing TGNC narratives, histories, and political actualities are dear to me, and have informed my understanding of my own gender identity and how I am in relationship with my TGNC siblings. These representations are also limiting, and often normalise experiences of violence and invalidation at the expense of experiences of joy and affirmation. I do not believe that mainstream representation will ever do enough to support the daily lives of TGNC individuals, but it nonetheless carries a heavy burden in the process by which the general public relates to the TGNC folks in their communities and elsewhere. I believe as therapists/counsellors who are part of the general public—despite our attempts to counter the many biases that we have been raised with—we will provide inadequate care when we misunderstand our clients, when we are ignorant, when we fail to recognise our ignorance, when we claim authority, and, importantly, when we mean well. Media is one way through which we might better understand our TGNC clients, and we do them a disservice when we fail to respond to what is media-relevant in their lives. A TGNC client who brings to therapy a news story about anti-TGNC legislation in Florida, or wishes to discuss a nonbinary character in a new Netflix show, is sharing something meaningful with us, and it is our responsibility to know how to respond in identity-affirming ways. Simultaneously, therapists must learn how to use media to broach culture with their TGNC clients, in order to avoid pathologising aspects of TGNC identities or re-traumatising their clients. As a result of effective references to media in the therapy room, clients may feel their experience of therapy enhanced, the therapeutic relationship strengthened, and their interest in exploring identity with their therapist expanded; the opposite may well occur when media is not presented or responded to with intentionality and cultural sensitivity.

I expect that some participant experiences will centre times when a therapist has mentioned a piece of media in a careless way, or has attempted to engage clients in a discussion

of media that a client is uncomfortable. Other experiences will centre clients hoping that a therapist will be aware of a piece of media without having to explain it to them, or seeing a therapist try to learn about what media is important to the client. There is a nearly unlimited range of experiences that intersect with and diverge from these examples, which is where qualitative research becomes particularly essential for this topic. Current literature gives us a very limited perspective of what is actually happening in the therapy room in terms of TGNC-centred media's presence or absence, and I anticipate the insights from my interviews to shed some light on what media-relevant microaggressions or affirmations might look like. I want better, well-researched, client-centred, trauma-informed, standpoint-grounded mental healthcare services for TGNC folks; services that are simultaneously prolific, accessible, and realistic regarding where the majority of therapists currently stand. Gaining a more informed picture of TGNC mental healthcare, through the lens of media, is my small contribution to what I hope is an emerging field that serves rather than pathologises our TGNC client community.