Significant Events in Psychotherapy from the Viewpoint of Transgender Clients

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Abstract

This study examined the hindering and helpful events that transgender and gender-nonconforming Ontarians experienced in therapy. To explore descriptive accounts of these experiences, we employed a systematic and rigorous investigation using the significant events framework and thematic analysis to interpret findings. Eleven participants underwent semi-structured interviews, providing rich accounts of their recent therapy experiences alongside their contexts and impacts. From these interview transcripts, we constructed eight major themes relevant to the research question: (1) Helpful and Hindering Relational Gestures; (2) Expectations about the Therapist's Role; (3) Therapist's Perception of Transness; (4) Topics in Therapy; (5) Significant Relational-Emotional Experiences; (6) Significant Event Impacts on the Client; (7) Client Processes in Understanding Significant Therapy Events; and (8) Contexts. Implications for therapeutic work are discussed.

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Introduction

Transgender and Gender-Nonconforming (TGNC) people are those whose gender identity differs from that which they were assigned at birth (APA, 2015). In comparison, a cisgender person is someone whose gender identity aligns with their assigned sex at birth (APA, 2015). According to the most recent data available from the Survey of Safety in Public and Private Spaces (SSPPS) in 2018, approximately 75,000 Canadians over the age of 15 are transgender, representing 0.24% of the population (Jaffray, 2020). This group, while relatively small, faces unique stigmatization, violence, and disenfranchisement in Canadian society (Bauer & Scheim, 2015; Peter et al., 2021; Temple-Newhook, Benson et al., 2018). Stigma contributes to negative health, especially mental health. Indeed, TGNC Ontarians report histories of mental illness and suicidality at higher rates than cisgender people (Bauer & Scheim, 2015). Additionally, some TGNC people choose to access medical transition services such as hormones or surgeries, requiring more contact with healthcare systems than the general population.

Given their unique position in society, and especially within healthcare, researchers have begun to explore how TGNC people experience healthcare. Supportive, affirmative treatment for trans people can improve their mental and physical health significantly (Reisner, Poteat, et al., 2016; Valentine & Shipherd, 2018). However, many TGNC people face bias and even hostility in healthcare settings (Bauer & Scheim, 2015; Kcomt, 2019). Clinicians also express a lack of knowledge when working with TGNC people (Poteat et al., 2013). Healthcare thus represents a potentially life-saving support for TGNC people, but also a considerable risk.

In psychotherapeutic contexts, scholars have identified both positive and negative themes around TGNC people's experiences. For example, some have identified microaggressions (Morris et al., 2020) or microaffirmations (Anzani et al., 2019) from therapists. Others point to helpful

aspects of the therapeutic relationship such as empathy (Bess & Stabb, 2009), or unhelpful experiences such as pathologizing statements (Mizock & Lundquist, 2016). Despite these valuable contributions to understanding TGNC experiences of therapy, there is a dearth of rigorous investigation into specifically helpful or hindering events with this population. Only one study (T. Israel et al., 2008) has taken an explicit significant events research standpoint with TGNC people. However, while this investigation included TGNC people in its participant base, they were integrated into an exploration of LGBT experiences. There is still a gap in the literature regarding TGNC people's specific experiences of significant therapeutic events.

The significant events research framework is a type of Change Process Research (CPR) which identifies, describes, tracks, sequences, and links important moments with change processes within the therapeutic process (Elliott, 2010). This allows for a deeper understanding of what occurs in therapy, how participants experience therapeutic procedures, and how specific events in therapy impact both client and therapist. Significant events research often takes on a specific focus through harmful and hindering events research (Lilienfeld, 2007; Timulak, 2010). There is clear potential for experiencing both harmful and helpful events research among TGNC people in therapy. In fact, many of the broader investigations of TGNC experiences in therapy have uncovered events which researchers categorized as affirmative (Benson, 2013), healing (Elder, 2016), appreciated (Hunt, 2014), unhelpful (Benson, 2013), and negative (Elder, 2016; Hunt, 2014). The present study aims to further examine the experiences of TGNC clients using a significant events framework to systematically explore the specific contexts of why a given event was helpful or unhelpful (Elliott, 1983, 2010).

In addition, it is important to note geographic and cultural considerations. Much of the exploration of TGNC perspectives in therapy has been from an American perspective. Given that

different aspects of trans healthcare are highly dependent on the procedural and organizational standards set by each healthcare system (Coleman et al., 2012), the present study focuses on TGNC experiences within the Ontarian mental healthcare system. More specifically, different healthcare systems pose challenges to both therapists and clients as they navigate both funding for and access to gender-affirming medical procedures. Indeed, much of the literature has shown that clients feel gatekept by therapists while seeking support within the privatized American healthcare system (Elder, 2016; Joy, 2008; Mizock & Lundquist, 2016; Morris et al., 2020; Rachlin, 2002).

Support (or lack thereof) for medical transition can affect many aspects of the therapeutic dynamic. For example, clients report feeling power imbalances (Joy, 2008), disconnection (Mizock & Lundquist, 2016), and even coercion from their therapists. We also wished to explore how these dynamics might affect therapy within the provincially controlled Canadian healthcare systems. TGNC Ontarians may receive partial funding from the Ontario Health Insurance Plan (OHIP), but require a diagnosis of gender dysphoria as well as letters of support from healthcare professionals (Government of Ontario, 2023; G. Hunt & Pelz, 2016). Some clients receive these letters directly from their therapists, while others seek therapist support while navigating the transition process. The present study therefore investigates the intersection of therapy and access to medical transition care within the Ontarian healthcare context.

The present study aims to address gaps in the literature through a systematic and rigorous qualitative investigation of the hindering and helpful events that TGNC Ontarians experience in therapy. Understanding the experiences of this population through significant events research can inform practitioners in this area with a deeper understanding of this population's specific needs and concerns.

Relevant Context

Terminology

Trans identities are complex and variable. There are many terms associated with TGNC identities, and an even greater number of interpretations of those terms. This necessitates some flexibility in acknowledging what is and is not a TGNC identity. Susan Stryker (2008) writes that transgenderism has less to do with some concrete destination and more to do with "movement across a socially imposed boundary away from an unchosen starting place" (p. 1). This movement looks and feels different for each individual, yet they share a 'transness' which subverts typical ideas of gender. It would be impossible to comprehensively define each TGNC-related word in a way that encompasses every meaning and excludes any misunderstanding. That said, a glossary of TGNC and gender-related terminology is included in appendix A to help unfamiliar readers navigate the complex ideas involved in discussions of TGNC identity. There are also culturally-specific terms – such as the Indian hijra, or Indigenous ideas of two-spirit roles – that have been used flexibly throughout the world and throughout history (Levitt & Ippolito, 2014; Stryker, 2008). Discussion of culturally specific gender terminology is beyond the scope of the present paper, but it is worth noting the multitudinous ways that TGNC people have and continue to define themselves.

When speaking on TGNC issues, it is important to deconstruct transnormative narratives of linear transition. Trans scholarship has noted a cissexist and transnormative tendency to assume alignment with binary genders. That is, many people believe that TGNC individuals discover their "true" identity as either male or female, usually early in childhood, and that their goal is to align with the associated gender role as closely as possible (Ekins, 2005). However, only 23% of TGNC Ontarians's transition journeys correspond with this narrative (Scheim & Bauer, 2015). Levitt and Ippolito (2014) use a metaphor of painting to describe the struggle of nonbinary understandings of

gender: we are trying to "illustrate a vibrantly colored landscape when only black and white paints are available" (p. 1746). As we attempt to understand TGNC experiences, we must acknowledge how the dominant culture in Canada lacks concepts and ideas to encapsulate and communicate these variable experiences of gender. Many TGNC people do identify with a "binary" gender. For example, the term "trans woman" often describes someone who was assigned male at birth but identifies as a woman. However, TGNC people might also identify with a gender outside of the male-female binary. The umbrella term for these identities is "nonbinary," though people may choose one or more varied descriptors, including genderqueer, bi-gendered, genderfluid, agender, and more (Factor & Rothblum, 2008).

TGNC people may pursue social and/or medical transition. This could involve different clothing, different pronouns, voice training, hair removal, hormonal therapies, and/or surgeries. Surgeries - known as sex-reassignment surgery, gender-confirming surgery, or gender-affirming surgery - may include "top" or chest surgeries (such as mastectomy or breast augmentation), "bottom" or genital surgeries (including phalloplasty or vaginoplasty) or other affirming surgeries such as hysterectomy or facial surgeries (Centre for Addiction and Mental Health, n.d.; Deutsch, 2016). Not all TGNC people desire medical transition, and people who seek one treatment may not seek others. In fact, not all TGNC people desire transition of any kind, though many do. Either way, a TGNC person's transition goals cannot be assumed.

It is also important to discuss how gender affirming care can help support mental health for TGNC individuals. Many TGNC individuals do seek at least medical treatment (Deutsch, 2016). These services can be life-saving. Waiting for transition can cause increased social stigma, a sense of hopelessness, and worsened dysphoria (Pitts-Taylor, 2020). Indeed, among those who want medical transition, around 27% of TGNC Ontarians attempt suicide before they are able to

gain access (Bauer et al., 2013). However, suicide attempts drop as soon as soon as transition begins, and suicidality is close to 1% for TGNC Ontarians who have completed their desired transition (Bauer et al., 2013).

The "T" in LGBT

LGBT stands for "Lesbian, Gay, Bisexual, and Transgender," and often represents a catch-all term for all non-heterosexual and non-cisgender identities. Notably, there are many other terms that fall within this umbrella, and may be included in different iterations of the acronym. For example, queer, asexual, and intersex people are included in the acronym LGBTQAI. These identities are often studied under the LGBT 'umbrella,' with an assumption of homogeneity (Fassinger & Arseneau, 2007). However, individuals within this community face different sociocultural contexts. This is particularly true of TGNC people, as these identities involve gender rather than sexual orientation. Some people assume that gender nonconformity correlates directly with non-heterosexual relationships (Fassinger & Arseneau, 2007). Others assume that TGNC identity disqualifies same-sex attraction (Ekins, 2005). However, TGNC people can be heterosexual, homosexual, bisexual, asexual, or any other sexual orientation. It has also been noted that sexual orientation can change alongside gender exploration, but it may not (Ekins, 2005; G. E. Israel, 2005; Levitt & Ippolito, 2014).

The process of disclosing an LGBT identity is usually called "coming out of the closet" or simply "coming out." Coming out is different for TGNC people than LGB people. While declaring one's sexual orientation is usually seen as authentic or genuine, dominant cultures often distrust TGNC people because they reject the view that biological markers of sex are infallible (Zimman, 2009). That is, TGNC people are often seen as *inauthentic* because their gender presentation matches their gender identity rather than their assigned sex at birth. TGNC people may also use terms such as "stealth" to differentiate their experiences of non-disclosure (Zimman, 2009). This

term refers to a trans person's ability to 'pass' as their identified gender, and their decision not to reveal their transness to others.

Because TGNC people have been absorbed into the LGBT umbrella, many researchers suffer from the "silent T" phenomenon, a tendency to use the acronym "LGBT" while focusing on sexual orientation exclusively (Zimman, 2009). This is despite the significant differences in the ways that LGB and T identities are constructed and treated within society (Fassinger & Arseneau, 2007). Lived experiences often differ between TGNC people and cisgender LGB people, with trans individuals being more vulnerable to discrimination (Kcomt, 2019). Further, transphobic systems and attitudes may come from within LGBT institutions or groups (Fassinger & Arseneau, 2007; Klein et al., 2015). Therefore, TGNC concerns cannot be conflated with LGB concerns, nor absorbed completely under the LGBT umbrella.

Transphobia and Stigma

As a group, TGNC people are simultaneously disruptive to cultural norms and vulnerable to discrimination. Link and Phelan (2006) define stigma as a process by which people label and separate others from the dominant group, leading to discrimination and disenfranchisement based on unequal cultural, economic, and political power dynamics. The terms "transphobia" and "cissexism" both refer to a normative view of cisgender people as more socially acceptable than TGNC people (McGeorge et al., 2021). Because of these attitudes, TGNC people face systemic exclusion, harassment, discrimination, and abuse.

Systemic Barriers. Link and Phelan (2006) describe systemic stigma as a structural discrimination which favours those in one social group to the direct exclusion of another. Factor and Rothblum (2007) compared TGNC individuals to their cisgender siblings, and found discrepancies across several life domains. Trans people were more likely to have lower income, to experience workplace discrimination, and to live alone; they were less likely to be in relationships

or to have custody of their children. Other research shows that TGNC people lack equitable access to necessities like medical care (Kcomt, 2019) and housing (Casey et al., 2019) as compared to cisgender people. This is compounded by the 'horizontal' nature of TGNC children. That is, most transgender people are not born of transgender parents, which adds to their risk of social isolation and lack of support (Galman, 2020). Many encounter mistreatment, rejection, and violence from their cisgender family members (James et al., 2016).

In Ontario, the Trans PULSE survey was launched in 2004 to identify the impacts of both policy and social stigma on the health and wellbeing of TGNC Ontarians (Trans PULSE, 2012). According to the this survey, TGNC Ontarians report systemic barriers such as access to legal name changes (Bauer & Scheim, 2015) and underemployment despite higher overall education levels (Bauer et al., 2011). Transgender people in Canada are more likely to be living in poverty than others, including cisgender LGB people (Ross et al., 2016) and are more likely to require low-income subsidies than matched cisgender controls (Abramovich et al., 2020). TGNC youth face barriers to healthcare such as transphobic attitudes, concerns for their safety and acceptance, and a lack of clinician knowledge (Temple-Newhook, Benson et al., 2018).

Direct Stigma. Direct stigma refers to overt rejections based on social selection for similarity (Link & Phelan, 2006). California-based researchers Norton and Herek (2013) asked respondents to an online survey to rank their feelings for TGNC people on a 'temperature' scale from 0 to 101, with 50 being neutral. Respondents' attitudes towards trans people were generally unfavourable, with a mean score of 32.01, and no strata of participants reporting a mean score above 50 (Norton & Herek, 2013). This aligns with typical findings that, across the world, TGNC people face high risk of discrimination, violence, and victimization (Reisner, Poteat, et al., 2016).

These findings are true in Canada as well. TGNC Canadians are more likely to experience violence, sexual assault, and inappropriate behaviours than cisgender Canadians (Jaffray, 2020). At school, Canadian TGNC students across all grades regularly experience harassment, exclusion, and transphobic language (Peter et al., 2021). In Ontario, trans people face interpersonal discrimination, hate crimes, slurs, and more. For example, Bauer and Scheim (2015) determined that over 96% of respondents on the Trans PULSE survey had been told that they are abnormal. Over 20% had been physically or sexually assaulted for being transgender. An additional 34% had been verbally threatened or harassed (Bauer & Scheim, 2015).

Mental Health

Most studies about TGNC mental health focus on the high prevalence of mental disorders and traumatic experiences, or associations between risk factors and mental health outcomes (Reisner, Poteat, et al., 2016). For example, a recent meta-analysis demonstrated a strong link between TGNC identity and mental health problems, including depression, anxiety, substance use, and suicidality across the globe (Valentine & Shipherd, 2018). Depression, anxiety, stress disorders, and somatoform disorders are all higher in TGNC populations than in cisgender populations (Konrad & Kostev, 2020). TGNC people experience higher rates of PTSD than the general population, with higher symptomology being associated with more experiences of discrimination (Reisner, White-Hughto, et al., 2016). The Trans PULSE study found that more than 50% of TGNC Ontarians reported depressive symptoms (Bauer & Scheim, 2015). Further, 43% had a history of suicidal ideation, and 11.2% of surveyed TGNC participants in Ontario had attempted suicide in the past years (Bauer & Scheim, 2015). In Ontario, TGNC people report more mental-health-related healthcare needs, including visits to their physician and hospitalizations, than their matched cisgender peers (Abramovich et al., 2020). Canada-wide, TGNC people are more likely to self-report poor mental health than cisgender Canadians (Jaffray, 2020).

The high prevalence of mental health needs among TGNC people does not indicate an innate pathology or mental disorder. Research shows that social supports improve the mental health of TGNC youth to levels comparable to those of cisgender peers (Olson et al., 2016). Social support from friends and family may also decrease TGNC people's risk of suicidality (Moody & Smith, 2013). TGNC people do, of course, experience mental illness even when supported and accepted, just as cisgender people do. However, stigma and exclusion have led to higher rates of mental disorders for TGNC people as compared to cisgender peers.

Meyer's (2003) Minority Stress Model provides a framework for understanding how social stress, discrimination, and mental health interact among LGB individuals. This model has been adapted for use with TGNC populations by Hendricks and Testa (2012). The authors propose that a combination of external stressors (such as violence or discrimination), proximal stressors (vigilance to protect against violence), and internalized proximal stressors (learned negative attitudes toward the self) lead to negative mental health outcomes. These stressors are empirically linked to poor mental health and suicidality among LGBT populations (Sahin & Buyukgok, 2021; Saxena et al., 2014). In line with these findings, the Trans PULSE survey suggests that to decrease suicidality among TGNC people, Ontarians should seek ways to decrease transphobia and improve social supports, including medical supports such as transition services and psychotherapy.

It is worth noting – and celebrating – the numerous ways in which transgender people find resilience. These include community factors like participation in activism and community involvement, as well as individual factors such as self-worth, pride for identity, spirituality, and hope (Matsuno & Israel, 2018; Singh, 2013). Resiliency factors help mitigate the effects of minority stress and the impact to mental health (Grossman et al., 2011; Moody & Smith, 2013). Accessing community supports is particularly protective (Puckett et al., 2019). This indicates that

while transgender people often demonstrate immense individual strength and agency, it is still essential to fight minority stress through societal interventions.

TGNC Healthcare

TGNC people represent a unique population for medical care. First, TGNC people may seek medical transition services. Secondly, their greater risk of unemployment, histories of abuse and trauma, and limited social supports all affect TGNC people's physical and mental health (Davidson, 2015). Indeed, TGNC Ontarians are more likely to have chronic physical and mental health conditions than cisgender peers (Abramovich et al., 2020). Finally, as noted, TGNC populations report high incidence of mental illness. Many TGNC Ontarians seek mental healthcare alongside their medical needs (She et al., 2020). For TGNC people, medical support therefore involves interdisciplinary teams, which must work together to provide appropriate and supportive care.

Positive healthcare experiences include supportive language, safe-space designations, access to gender-neutral washrooms, well-trained staff, and clinician comfort with trans issues (Bell & Purkey, 2019). Such inclusive care is associated with a decrease in depression, anxiety, and suicidality (Valentine & Shipherd, 2018) and better health outcomes overall (Reisner, Poteat, et al., 2016). However, transgender people often face misunderstanding and rejection from institutions and social supports as they explore their identities (G. E. Israel, 2005). Healthcare providers often lack confidence in their ability to care for TGNC people appropriately. Poteat, German, and Kerrigan (2013) analysed interviews with medical professionals who provide care to TGNC people. They found that physicians who felt unfamiliar with TGNC issues managed their uncertainty by re-asserting their authority. This entailed blaming, shaming, othering, and discrimination (Poteat et al., 2013).

Most of the Canadian research on inclusive TGNC healthcare focuses on quantitative data from the Trans PULSE study. For example, 10% of TGNC Ontarians reported that they have been denied care or had care terminated prematurely because they were trans (Bauer & Scheim, 2015). Over one third of TGNC Ontarians reported unmet healthcare needs from the past year (Giblon & Bauer, 2017). Additionally, 21% of TGNC Ontarians have avoided emergency care when needed due to fear of discrimination (Bauer & Scheim, 2015). These fears of prejudice are not unfounded. Forty percent of TGNC Ontarians have experienced discrimination from a family doctor (Bauer & Scheim, 2015). TGNC people are also more likely to experience discrimination, verbal abuse, and physically rough handling from healthcare workers than their cisgender LBG contemporaries (Kcomt, 2019). TGNC people are uncomfortable with their doctors because they experience misunderstanding, barriers to autonomy, discrimination, and refusal of care (Bell & Purkey, 2019). These difficulties likely extend to mental healthcare and counselling, though research is sparse in this area. Williams and colleagues (2017) found that in Ontario, unmet mental healthcare needs are more likely among gender-non-conforming people, sexual minorities, and women with lower economic status. However, research around TGNC Ontarians' experiences with mental health services remains relatively unexplored.

Counsellor Competence with TGNC Clients

From the client perspective, a recent USA-based online survey suggests that a perceived lack of cultural competence with sexual minorities can hinder therapeutic alliances, leading to dissatisfaction with treatment and premature termination (K. N. Anderson et al., 2019). Specific competence is therefore necessary. It is also rare. Drake (2019) found that Canadian psychologists identified a dearth of mental health professionals competent in TGNC care. This poses a barrier to care for TGNC people, and an increased strain on those few professionals who work with the

population. Practitioners noted that their colleagues are often hesitant to work with TGNC individuals, possibly due to discomfort and unfamiliarity with this population (Drake, 2019).

To improve their competence, counsellors and therapists in Ontario may seek out resources, such as information about gender identity (i.e. Ontario Human Rights Commission, 2014) or about gender dysphoria (i.e. Brown, 2021). Additionally, Canadian researchers Weir and Piquette (2018) offer some insight into key issues when counselling TGNC people. These included information about gender, sex, and sexuality, acknowledgement of heteronormative and cisnormative biases, and discussion around how stigma can impact TGNC mental health. The authors recommend using affirmative language and continuing education about TGNC issues and healthcare.

Recently, Jordyn Banks (2021) conducted an investigation on how Canadian psychotherapists integrate knowledge of affirmative therapy and avoid microaggressions in their therapy with TGNC clients. Respondents suggested that therapists-in-training do not receive enough education about TGNC issues. However, as Banks points out, the methods and duration of training vary widely, with unpredictable results. Calls for "more training" may therefore represent an overly simplistic view of complex multicultural issues. Indeed, clinicians pursuing clinical competence with TGNC populations have identified that clinical knowledge was only a starting point from which to unlearn bias (Drake, 2019). Competence with TGNC people is not a matter of knowledge exclusively; it requires reflection, humility, and a willingness to learn about others' perspectives.

Additionally, some practitioners display misplaced confidence when reporting their ability to work with TGNC individuals. Whitman and Han (2017) found that mental health practitioners who reported beliefs that TGNC identities are immoral, unnatural, or unhealthy also rated

themselves as competent and skilled in their work with TGNC people. This finding also calls into question the ability of counselors to seek their own training, as those who lack competence with TGNC issues may also lack the ability to find adequate training resources (Hanssmann et al., 2008). Inaccurate or inappropriate trainings on culturally sensitive topics may lead to misunderstanding, tokenization, stereotyping, or further entrenched biases.

To address some of these issues, West (2019) developed a new measure to assess whether a clinical trainee is able to begin work with TGNC people. This tool provides a way for counselling supervisors to prevent their trainees from committing microaggressions against TGNC individuals, a first step towards affirmative care. It was developed in conjunction with subject matter experts to address the 'floor' (that is, incompetence) rather than 'ceilings' (a suitable level of competence) since aptitude with gender issues takes numerous forms and is difficult to measure concretely (West, 2019). The 'ceiling' is also difficult to define from the theoretical perspective of subject-matter experts. Therefore, TGNC client perspectives are crucial for a bottom-up approach on what is experienced as being harmful or helpful in therapy, and why.

Literature Review

The following chapter describes and investigates the existing qualitative research body on TGNC clients' experiences in psychotherapy. Additionally, we explore how the research aims and questions address gaps in the literature or areas where more investigation is warranted.

Research Findings

This section summarizes identified themes within the research, particularly those which investigated how clients labeled their experiences as positive or negative. These findings are organized according to the framework employed by the researchers: general qualitative inquiries, microaggressions research, and significant events research.

In addition, there has been one meta-analysis of the research body around TGNC clients' experiences of therapy. Compton and Morgan (2022) recently conducted a systematic review of the literature, and identified two analytic themes: (1) therapist identity and approach, which included themes around the therapist's technical approach, identity, and advocacy work, and (2) approaches to gender, which comprised themes around the salience of and bias within topics of gender diversity.

General qualitative inquiries. The majority of the literature does not specify a framework within which the researchers structured data collection or analysis. That is, researchers often asked TGNC clients to describe their experiences in therapy broadly or generally. These open-ended investigations provide an excellent foundation for understanding what topics are important to TGNC clients in therapy, but lack the structure to investigate specific moments, their outcomes, and their contexts. That is, while these inquiries explore a breadth of narratives, they do not describe the depth of lived experiences.

In these studies, participants often decided to disclose both positive and negative experience, which are pertinent to our investigation of helpful and hindering significant events. We identified five relevant areas of reported experiences in therapy: the therapeutic relationship, gender conversations in therapy, therapist knowledge of TGNC issues, practitioner attitudes to TGNC people, and therapists' gatekeeping medical transition.

***The therapeutic relationship*.** TGNC participants often noted the importance of a strong therapeutic relationship while undergoing psychotherapy (Applegarth & Nuttall, 2016). As with many therapeutic experiences, TGNC clients described different aspects of the therapeutic relationship as helpful or harmful. Several research teams have identified a client's trust in their practitioner as a helpful factor for TGNC participants (Bess & Stabb, 2009; J. Hunt, 2014; T. Israel

et al., 2008; McCullough et al., 2017). Others described helpful experiences such as feeling understood (J. Hunt, 2014; T. Israel et al., 2008), therapist empathy (Bess & Stabb, 2009), and professionalism (Elder, 2016). Clients appreciated respect from their therapists (Elder, 2016; T. Israel et al., 2008; McCullough et al., 2017). In addition, Joy (2008) describes a case study wherein a participant described a positive relationship with a therapist who mitigated their power imbalances through self-disclosure.

Conversely, the therapeutic relationship can be a source for unhelpful experiences as well. Researchers reported that participants suffered negative events with distant or uncaring practitioners (Elder, 2016; J. Hunt, 2014; T. Israel et al., 2008; Rachlin, 2002). Another researcher described some hesitation for clients to spend money on therapy when they didn't know what to expect (K. E. Benson, 2013). Clients described seeking therapists with recommendations from friends or community members, because it was difficult to trust a practitioner otherwise.

Gender conversations in therapy. The existing literature in this area deals heavily with the ways in which therapists approached the topic of gender (Compton & Morgan, 2022). Therapists helped clients through respect for gender identity (K. E. Benson, 2013; Bess & Stabb, 2009; Rachlin, 2002). Participants described positive experiences with therapists who considered the whole person rather than just gender issues, while still allowing space to explore gender (Bess & Stabb, 2009). Other studies reported that clients value therapist flexibility (Elder, 2016; Rachlin, 2002). Therapist adjustment to client needs, whether related to gender or not, is a factor in participants' perceptions of therapy. Respondents preferred when practitioners did not dictate when or how to discuss gender (K. E. Benson, 2013; T. Israel et al., 2008).

Clients responded negatively to therapist overemphasis on gender, but also to therapists who avoided gender discussions (J. Hunt, 2014; McCullough et al., 2017; Mizock & Lundquist,

2016). Compton and Morgan (2022) labelled this issue, "gender blind and gender blinded." For instance, Israel et al. (2008) reported that 23.8% of their LGBT respondents said that their therapists did not focus on what their clients wanted to discuss. In practice with TGNC people, practitioners might avoid discussing gender, regardless of its salience to the client, because they feel unprepared to discuss TGNC matters. On the other hand, clinicians may assume that TGNC identity causes all distress (Mizock & Lundquist, 2016). For example, one participant stated, "If I'm going to somebody for anxiety, all they want to talk about is how it must be because I'm trans, and how that must be the cause of all my problems" (Mizock & Lundquist, 2016, p. 151).

Some study participants across the literature also noted how the therapist's identity intersected with their competency treating TGNC clients. For example, some clients appreciated sharing an identity with their therapist while others found that trans therapists might have pre-existing assumptions that don't match the client experience (Elder, 2016). Additionally, TGNC people who also belong to other minority groups may face unique problems when discussing gender in therapy. McCullough et al. (2017) found that participants with intersectional identities sometimes had to find different therapists who specialized in their different issues. Exemplifying this, a Black TGNC respondent reported that he sought help from one therapist specializing in gender, and another who was Black, because neither understood the intersections of Blackness and transness together (McCullough et al., 2017). Lack of intersectional focus burdens clients unnecessarily.

Therapist knowledge of TGNC issues. Participants reported that many positive experiences were characterized by their therapists' demonstrated knowledge of gender and TGNC issues (Bess & Stabb, 2009; T. Israel et al., 2008; McCullough et al., 2017; Rachlin, 2002). Clients felt that therapists demonstrated this knowledge especially when they contributed to TGNC

advocacy (K. E. Benson, 2013; McCullough et al., 2017) and community organizing (Rachlin, 2002). McCullough et al. (2017) found that participants appreciated transparency about their therapist's knowledge of TGNC matters.

Researchers also observed that lack of provider knowledge around TGNC issues created negative experiences (Bess & Stabb, 2009; Elder, 2016; McCullough et al., 2017; Rachlin, 2002). Mizock & Lundquist (2016) identified the 'misstep' of educational burdening. Participants reported that because practitioners did not know correct gender terminology, clients had to take time and energy to correct them (Mizock & Lundquist, 2016). Similarly, Benson (2013) found that practitioners may rely on their clients for education on TGNC issues because available resources tend to be outdated or inaccurate. In other research, participants reported that their clinician held narrow or binary views of gender, and imposed their beliefs about gender roles onto TGNC individuals (T. Israel et al., 2008).

Practitioner attitudes to TGNC people. Participants appreciated therapists who respected and affirmed their clients' gender identities (K. E. Benson, 2013; Bess & Stabb, 2009; Rachlin, 2002). Others felt safe with practitioners who had a connection with the TGNC community (Rachlin, 2002). Anzani and colleagues (2019) identified several ways that therapists have affirmed transgender clients, such as acknowledging and disrupting cisnormativity, and seeing the client's authentic gender.

Conversely, participants reported negative experiences with gender pathologizing, which may stem from cis-normative psychological literature (Bess & Stabb, 2009; McCullough et al., 2017; Mizock & Lundquist, 2016). Some therapists stigmatized transgender identities as mental illnesses to be treated or eliminated (Mizock & Lundquist, 2016). Elder (2016) found that older TGNC individuals experienced harm when therapists referred to TGNC identities as disordered or

dysfunctional. Participants reported that therapists encouraged them not to "act on" their sexuality or feelings of gender dysphoria (Elder, 2016, p. 183). Similarly, a client in Mizock and Lundquist's (2016) study reported that a therapist suggested hypnosis to 'cure' their transgender ideation, and other clients felt that their therapist disapproved of their gender identity.

The literature also reflects that clients experience harm when therapists are biased against TGNC identities. For example, TGNC participants reported negative experiences where a therapist tried fit them within a traditional, normative gender role (Applegarth & Nuttall, 2016), or made assumptions about their sexual orientation (McCullough et al., 2017) or desired gender presentation (Bess & Stabb, 2009; Morris et al., 2020). Clients worried about stereotyping, especially if practitioners lack training outside of transnormative or medical-model approaches (K. E. Benson, 2013). In some cases, clients experienced overt hostility from practitioners who sought to eliminate the perceived problem of transness (Bess & Stabb, 2009; Morris et al., 2020). In general, LGBT clients might feel unsafe or uncomfortable with practitioners who hold hetero- and cis-normative views (T. Israel et al., 2008).

Finally, McCullough et al. (2017) reported client experiences with misgendering, meaning that therapists used incorrectly gendered pronouns, descriptors, or ideas. For example, one male participant reported that his therapist encouraged him to join women's groups (McCullough et al., 2017). Israel et al. (2008) also reported instances of misgendering, including therapists who used a non-preferred name for transgender clients.

Therapists' gatekeeping medical transition. Depending on their healthcare system and coverage, TGNC people may have to obtain at least one letter of approval from a clinician before accessing medical transition care. These letters exist to assess their dysphoria, mental state, and/or 'lived experience' as their identified gender (Coleman et al., 2012). TGNC people are often

expected to 'prove' their transness and ability to 'pass' as their identified gender before medical professionals – including providers of psychotherapy - will agree to write a letter. This positions mental health professionals as potential gatekeepers to medical care (Riggs et al., 2019; Stryker, 2008). It should be noted that according to the most recent edition of the international standards of care set out by the World Professional Association for Transgender Health (WPATH), psychotherapy is no longer a prerequisite for medical transition (Coleman et al., 2022; WPATH, 2022). However, while the standards of care continually progress, many institutions still rely on outdated precedents of rigidity and gatekeeping (Lev, 2016; W. Meyer et al., 2002).

A recent study by Brown and colleagues from the University of Kentucky (2020) explored transgender participants' perspectives on how letter requirements impacted their therapy and transition experiences. Of the 15 participants, 13 described negative impacts such as damage to the therapeutic alliance and reduced benefits from therapy. Conversely, 14 of the participants also described benefits, such as connecting with a new therapist and feeling tangible affirmation on receiving their letters (H. M. Brown et al., 2020). These findings echo previous research on therapy experiences for TGNC clients. One participant in Joy's (2008) case study described her therapist struggling with the gatekeeper role. The participant added that other therapists might be 'greedy' because TGNC people are forced to undergo therapy (Joy, 2008). Morris and colleagues (2020) reported on participants' experiences of coercion, wherein clinicians promised a letter in exchange for certain behaviours (such as quitting cannabis) or to continue the therapist's preferred method of treatment. Mizock and Lundquist (2016) linked unhelpful therapist aloofness to a perfunctory gatekeeping attitude. In another study, participants noted positive experiences around receiving a letter for treatment. These experiences included feeling affirmed in seeking treatment (K. E.

Benson, 2013) and feeling supported by a therapist while navigating bureaucracy and accessing treatment (Anzani et al., 2019; McCullough et al., 2017).

Clients and clinicians must navigate very specific standards set by healthcare systems, individual medical professionals such as surgeons, and insurance providers. These institutions change depending on location and personal factors (such as benefits provided by a client's workplace). So far, all of the research done around TGNC experiences of therapy have been conducted in the United States, aside from Hunt (2014) who recruited participants in the United Kingdom. It is worth noting that although one research team, Morris et al. (2020), conducted microaggressions research using online data from across the world, they reported that only 25.27% of their participants were from countries outside of the USA. While US and UK studies help to shed light on how TGNC people experience counselling generally, this topic has not been explored in a Canadian context.

Canadian healthcare is provincially regulated. In Ontario, most TGNC people seek care through primary care (Ziegler et al., 2019). TGNC Ontarians have access to some funding through the Ontario Health Insurance Plan (OHIP) for certain surgeries and hormone therapies. The Ontario Ministry of Health requires an assessment and accompanying letter for hormone therapies and top surgeries, and two letters for genital surgeries (Government of Ontario, 2023). Letters may be provided by doctors, nurses, psychologists, or social workers, many of whom may also provide therapy in Ontario. They must also confirm a diagnosis of persistent gender dysphoria. Additionally, gender-confirming surgeries may take place outside of Ontario, and individual surgeons may have different requirements for their particular patients (G. Hunt & Pelz, 2016; Woods, 2021). It is therefore essential to explore the lived experiences of TGNC Ontarians in therapy, including the intersections therapy has with gender affirming medical care.

Microaggressions research. Working within the minority stress model, microaggression research taxonomizes the commonplace words or actions which communicate hostility to marginalized groups (Sue et al., 2007). Common microaggressions against TGNC individuals involve incorrect terminology, transnormative and binary assumptions, harassment, ignorance, and expectations of education from marginalized sexualities (Johnson, 2014; Nadal et al., 2012).

Recently, two research teams used microaggression research to frame TGNC peoples' experiences with therapy. Morris et al. (2020) asked TGNC clients to describe their experiences with therapists' subtle gender-based hostilities. Participants disclosed several experiences with microaggressions, including disrespect, lack of therapist knowledge, awkwardness around the topic of gender, and a gatekeeping role within their therapeutic relationships. Clients also reported judgements, misunderstandings, and inappropriate remarks. Also using the minority stress model, Anzani and colleagues (2019) explored microaffirmations, which are subtly supportive statements or actions. The researchers then positioned therapist microaffirmations along a continuum, wherein each step necessitates the previous steps. To support micro-affirmative practice, therapists must first avoid microaggressions. Then, they must acknowledge cisnormativity, or ingrained social assumptions about gender norms and values. This allows practitioners to disrupt cisnormativity, and ultimately see authentic gender.

One major limitation of the microaggressions model involves the difficulty that participants face in differentiating micro-assaults from overt aggression (Donovan et al., 2013; Morris et al., 2020). Logically, participants would also have difficulty differentiating microaffirmations from less subtle supportive events. Both Anzani et al.'s (2019) and Morris et al.'s (2020) research is thus limited. Some participants in these studies may have ignored major events in their history because the researchers specifically asked them to describe subtleties. Other participants reported

major events regardless; for example, participants in Morris et al.'s (2020) investigation reported inappropriate jokes, sexual advances, and harsh criticism from therapists. Because TGNC people face overt stigma within healthcare settings (Donovan et al., 2013; Kcomt, 2019), it may be more appropriate to investigate TGNC clients' experiences of all significant events, not just those categorized as 'microaggressions' or 'microaffirmations.'

Significant Events. To date, there is only one investigation of TGNC peoples' experiences of therapy using a significant events framework. Israel and colleagues (2008) investigated the experiences of LGBT people in therapy from a significant events framework, coding contextual information alongside descriptions of helpful and harmful situations and their consequences. The researchers interviewed 42 participants, of whom six identified as transgender, and analyzed the data using ethnographic content analysis.

Israel et al. (2008) found that in the helpful situations, 33.3% of respondents had found their practitioner through a friend, compared to 9.5% in the unhelpful situations. Clients reported more helpful situations involving a private practice, with psychologists and social workers. Unhelpful situations involved more psychiatrists than did helpful situations. Participants were more likely to have a severe mental health issue or chronic health problem in unhelpful situations. Additionally, 'outness' characterized a large difference between helpful and unhelpful situations among TGNC participants. Over two thirds of the transgender clients reported that they were openly trans during their helpful experiences, while only 11.1% were completely 'out' during their unhelpful experiences (T. Israel et al., 2008). This differed from the LGB participants, who reported similar levels of 'outness' during both the helpful and unhelpful experiences. The researchers reported no notable differences in therapist age or ethnicity between the reported helpful and unhelpful situations.

The researchers found that helpful situations positively impacted the therapeutic relationship for 35.7% of participants, while unhelpful situations had a negative impact on the relationship for 64.3% of respondents (T. Israel et al., 2008). Unhelpful events led to clients hiding information from their counsellor or ending their treatment. Helpful situations improved clients' perceptions of therapy overall, while unhelpful situations negatively impacted these perceptions. Harmful and helpful situations impacted clients' self-perceptions regarding their gender identities and coming out. Finally, participants reported that helpful situations increased their self-awareness, insight, self-acceptance, and self esteem, leading to improved quality of life. Conversely, unhelpful situations negatively impacted clients' reported quality of life.

By using a significant events framework, this project allowed for deeper understanding of particular clients, which may support more effective therapy (Elliott & James, 1989). Ethnographic content analysis provided measures of frequency and correlation among themes. However, frequency counts do not allow for as much interpretation as other qualitative methods. That is, ethnographic content analysis does not allow for rich description of what the identified moments were like for clients. Identifying connections between process and outcomes is important, but does not capture the depth and nuance of participants' experiences.

Additionally, as previously stated, this research is limited by including TGNC individuals under the larger LGBT umbrella. Although transgender people do fall within a larger queer community, they represent a different facet of identity (i.e. gender, rather than orientation), and their experiences are therefore markedly different from their LGB peers. Familiarity with diverse sexual orientations does not translate to understanding TGNC concerns. While six of the participants were transgender, the researchers point out that the contexts of helpful and unhelpful events differed most between LGB and transgender participants. It is therefore important for

research to explore the richness of TGNC experiences on their own, not just in conjunction with LGB experiences.

Specific Aims and Research Questions

Using general qualitative inquiry, as well as specific frameworks such as microaggressions research and significant events frameworks, previous research has described how TGNC clients experience the therapeutic relationship, therapists' knowledge of, attitude towards, and ability to talk about gender, and encounters with gatekeeping from a therapist. As noted above, these studies provide important accounts of TGNC clients' experiences, but do not explore events deeply. The present study uses a significant events framework to deepen the inquiry, and expands on work which identified connections between events and outcomes, but did not explore what those experiences were like for the clients who lived them. To address these gaps, we have structured our analysis using discovery-oriented methodology that focuses on clients' lived experiences, their impacts, and their contexts.

Significant events research may focus on the client's perspective, the therapist's perspective, and/or observers' perspective (Elliott, 2010; Lilienfeld, 2007; Timulak, 2010). Client perspectives of therapy are better predictors of counselling outcomes than clinician ratings (Henkelman & Paulson, 2006). They are more salient to understanding the practical therapeutic applications, processes, and impacts (Castonguay et al., 2010) and can often reveal events which therapists deem unimportant (Timulak, 2010). This is especially relevant when an unequal power dynamic exists between therapist and client, such as TGNC clients with cisgender therapists (Levitt et al., 2016). Additionally, client perspectives can offer opportunities for therapists to move beyond a particular theory or set of rigid practices, instead offering a nuanced understanding of what a particular experience might be like for a client (Timulak & Keogh, 2017). We therefore chose to investigate significant events from the client's perspective.

Significant events may also involve inquiry into helpful events, hindering events, or both. Helpful events research can help identify interventions or techniques which lead to productive or positive outcomes (Timulak, 2010). Hindering events research, conversely, can construct understanding around client termination, poorer outcomes, and even iatrogenic harm (Henkelman & Paulson, 2006; Timulak, 2007). However, most research has focused on positive or helpful events only, and studies which explore hindering events often investigate therapists' perspectives rather than clients' (Burton, 2018). Therefore, it is important to explicitly consider both helpful and hindering events, as defined by clients.

The purpose of this study is to provide a deep and nuanced exploration of TGNC Ontarians' experiences in therapy, using rigorously structured methodology and analysis. This work presents the first study exploring TGNC people's experiences of therapy using a significant events framework. Furthermore, there has been no qualitative research examining TGNC experiences in therapy from a Canadian perspective; we therefore included a participant pool from Ontario exclusively, to explore how therapy unfolds within this specific healthcare context. The research question and sub-questions are as follows:

What events do TGNC Ontarians see as significant in their experiences in psychotherapy?

What is helpful or hindering about these events?

What are the specific contexts for these events?

How did these events influence the client and or therapeutic process?

Methodology

To examine therapy from TGNC clients' perspectives, we (the researchers) employed a significant events framework and reflexive thematic analysis to structure and interpret results. This

section describes the framework, ethics, and trustworthiness which informed this project's development, as well as the procedures for data collection and analysis.

Significant Events Framework

A significant events framework invites clients to evaluate whether a particular event is helpful or not, and why, and how the contexts of each event colour the experience itself (Elliott, 1983). This research represents a type of Change Process Research (CPR) which examines therapy events while also considering the contexts and outcomes of these moments (Levitt et al., 2006). It investigates what helpful or unhelpful events happen in therapy alongside the reasons, contexts, and impacts of each event (Elliott, 1983, 2010; Lilienfeld, 2007). This provides an essential look at critical moments within the therapeutic process, for deeper understanding around what makes therapy work (or not).

As noted in the literature review, we decided to seek client perspectives on therapy, and to focus on both helpful and hindering events. Client perspectives can provide a more nuanced view of therapeutic processes, and are more relevant to outcomes than therapist perspectives (Castonguay et al., 2010; Henkelman & Paulson, 2006; Timulak, 2010). A focus on both hindering and helpful events allows for better understanding around client outcomes and satisfaction with the therapy process (Henkelman & Paulson, 2006; Timulak, 2007, 2010).

Ethical Considerations

TGNC communities are presently and historically subject to unethical research practices, pathologizing attitudes, and voyeuristic boundary-crossing (Vincent, 2018). Therefore, in addition to adherence with the Tri-Council policy on ethics for research involving human participants from the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council (2018), we followed guidelines

set out by the Canadian Professional Association for Transgender Health (CPATH) for research involving transgender people and communities (Bauer et al., 2019).

For clarity and transparency, researcher positionality should also be considered. Social privilege can be experienced through social perceptions of race, gender, sexual orientation, socio-economic status, age, and (dis)ability (Black & Stone, 2005). I, the primary researcher, am a white nonbinary lesbian living in socioeconomic privilege. I am relatively young, though I do experience a chronic invisible disability. My privilege poses a potential for harm in research contexts. I mitigated these risks by disclosing positionality when relevant to participants and offering ways to maintain accountability (for example, emailing drafted manuscripts as requested). At the same time, my connection to the LGBTQ+ community, my explorations around my own gender, and my lived experience as a TGNC individual in therapy (as well as a TGNC therapist-in-training) all helped to inform the cultural relevance and collaborative standpoint of this qualitative investigation.

Trustworthiness

Trustworthiness indicates a precise, consistent, and exhaustive analysis which discloses enough detail about the process that readers might reasonably confirm the acceptability and usefulness of the research. The four criteria which comprise trustworthiness are credibility, dependability, transferability, and confirmability (Lincoln & Guba, 1985). Central to many of these procedures is reflexivity, which is a self-critical account of the research (Nowell et al., 2017).

First, credibility addresses the confidence with which we can represent our findings based on the collected data. Rather than attempting to find an objective 'truth' that is 'out there,' our research seeks to create verisimilitude through clear, systematic interpretive methods based on both theory and researcher-as-instrument (see below). Our research represents participant contributions as accurately as possible. We implemented investigator triangulation, with the

primary researcher coding and interpreting data, and the and co-author (and supervisor for this thesis project, Dr. Anne Thériault) auditing those codes. All parties brought subjectivity, knowledge, and positionality to critically engage with the data (Braun & Clarke, 2019).

Dependability refers to the stability or consistency of findings. Analysis always stems from conscious choices and does not 'emerge' unaided from the participants or the theory underpinning the research (Braun & Clarke, 2019). Therefore, we communicated decision processes, rationales, and assumptions throughout collection and encoding, creating a meticulous audit trail. Our written analysis includes verbatim quotes as exemplars, so that readers can follow theme construction. These factors support the reliability of any conclusions drawn and allow for structured comparisons to contiguous and future research.

In consideration of transferability, reported findings include thick descriptions of participant contexts and demographics. Readers who wish to generalize findings to other contexts have as much information as possible with which to do so (Nowell et al., 2017). Finally, confirmability refers to the neutrality and consistency of findings. Confirmability is established when credibility, transferability, and dependability are all achieved (Nowell et al., 2017).

Reflexivity and researcher-as-instrument. Braun and Clarke (2006) write that even inductive researchers "cannot free themselves of their theoretical and epistemological commitments" (p. 12). Our theoretical framework – significant events research – will therefore inform this project, from research design to analysis and writing, intersecting with researcher subjectivities (Braun & Clarke, 2019). Reflexive thematic analysis offers a way to contest assumptions of neutrality or objectivity, offering subjectivity as not just valid, but valuable. Cultural membership, social positioning, and ideology allow us to see participants as complex humans who may present accounts which do not fit neatly into theoretical frameworks. Gough and

Madill (2012) describe reflexivity as a "commitment to identifying and contextualizing the researcher's personal agenda" (p. 379). Rather than 'eliminating bias,' we endeavoured to acknowledge and remain aware of the theoretical and personal lenses through which we interpreted results.

Procedures

Instruments. Qualitative significant events research typically uses semi-structured interviews (Elliott, 2010). Several existing instruments informed the interview questions, including the Important Events Questionnaire (Cummings et al., 1992) and the Change Interview (Elliott, Slatick, & Urman, 2001, as cited in Elliott, 2010). Using these established protocols, we constructed an interview for this study which explored participant-reported experiences of therapy, including how they experienced and interpreted these events. The interview also invited participants to expand on the impacts that these events had, both personally and on the therapy, as well as the contexts in which they participated in therapy. Please see Appendix B for the full interview protocol.

Additionally, we asked participants to complete a demographic survey (Appendix C). The survey elicited information about participant age, gender identities, sexual orientation(s), racial and ethnic identities, socio-economic status, geographic locations, and mental health diagnoses.

Inclusion criteria. We included English-speaking, self-identified TGNC participants over the age of 18. Participants included only residents of Ontario who underwent individual psychotherapy with a practitioner who was (at the time of treatment) registered to practice in Ontario. In order to elicit a wide range of experiences, we asked that participants speak about at least one practitioner with whom they attended at least 10 sessions. This also ensured that if participants sought therapy to attain letters for medical transition, we were able to investigate other therapeutic events as well. We also asked that participants speak about therapy experiences wherein at least one session

occurred within the last 5 years, to minimize recall errors. Please see Appendix D for the screening questionnaire used to determine eligibility.

Participant Recruitment. After ethics approval was received from the Office of research Ethics and Integrity at the University of Ottawa, we recruited participants online, using transgender-affirming social media groups. These included Facebook, Reddit, and Twitter communities. We reached out to LGBTQ+ and trans-specific online groups for permission (see Appendix E for all email templates), then posted the recruitment flyer with information about the project, inclusion criteria, and contact information (see Appendix F for the poster text). We used a first-come first-served selection process to select participants. When potential participants reached out by email, they were provided with a screening questionnaire (Appendix D). Eligible individuals were officially invited to participate via email (see Appendix E) and provided with an informed consent document (Appendix G) and demographic survey (Appendix C).

Fifteen people emailed to express interest in participating. One participant was not eligible to participate. Two participants dropped out before completing the screening questionnaire. One participant filled out the questionnaire and consent form but dropped out before scheduling an interview. The final study comprises 11 participants. Each participant was assigned a pseudonym for analysis, which are also used to report results below.

Sample Characteristics. Participants were given a short demographic questionnaire wherein they identified their age, gender(s), sexual and/or romantic orientation(s), their racial and/or ethnic identities, socio-economic status, city of residence, and any diagnoses relevant to mental health treatment. Participant ages ranged from 22 to 44 (M=32.1). Six of the 11 participants identified as female or trans feminine, while three identified as male or trans masculine. Three participants were nonbinary, and one was bigender. Reported sexual and romantic orientations included those on the

asexual and aromantic spectrum, as well as participants identifying as pansexual, bisexual, gay, lesbian, queer, and polyamorous. Most participants were white (N=10) with only one participant identifying as racialized. Respondents listed socio-economic status from low to middle class. Many reported diagnoses of depression (N=7) or anxiety (N=8), with others reporting ADHD, borderline personality disorder, and gender dysphoria. See table 1 for a summary of reported demographic information. Please note that because participants sometimes offered more than one identifying word, total numbers for each demographic area may add up to more than the number of participants (N=11).

Table 1

Summary of participant demographics

	N	Percentage of the sample
Age		
20-24	1	9.1
25-29	2	18.2
30-34	5	45.5
35-39	1	9.2
40-44	2	18.2
Gender		
Nonbinary:	3	27.3
Bigender:	1	9.2
Woman/Trans Woman/Female	6	54.5
Transmasc:	1	9.2
Male:	2	18.2
Sexual/Romantic Orientation		
Aromantic/Asexual	1	9.2
Demi-romantic/Demi-sexual	2	18.2
Graysexual/Gray-Asexual	2	18.2
Bisexual	1	9.2
Gay	2	18.2
Lesbian	1	9.2
Pansexual	5	45.5
Polyamorous	2	18.2
Queer	2	18.2
Racial/Ethnic Identity		
Caucasian/White	10	90.9

Racialized	1	9.2
Socio-economic status		
Student	2	18.2
Lower class	3	27.3
Lower-Middle class	3	27.3
Middle class	3	27.3
Geographic area		
Northern Ontario	1	9.2
Eastern Ontario	4	36.4
Central Ontario	1	9.2
Greater Toronto Area	3	27.3
South-Western Ontario	2	18.2
Mental Health Diagnoses		
ADHD	3	27.3
Anxiety/Social Anxiety/GAD	8	72.7
Borderline Personality Disorder	2	18.2
Depression	7	63.6
Dysphoria	1	9.2
None	1	9.2

In total, the 11 participants spoke about 23 practitioners. Each participant discussed between 1 and 5 mental health workers (M=2.1). Reported treatment start dates ranged from 2018 to 2021, and end dates between 2018 and 2022. Seven participants spoke about at least one therapist with whom treatment was ongoing at the time of interview. Participants spoke about treatment in virtual settings (N=6), in-person settings (N=9), and courses of treatment which fluctuated between virtual and in-person (N=8).

Of the 23 therapists described, most were either psychotherapists (N=8) or social workers (N=8). Other practitioners included psychiatrists (N=3) and one family doctor. Three practitioners had unknown titles. Most were white (N=19), with only three practitioners of colour. Participants described work with male (N=8), female (N=10), and nonbinary (N=5) practitioners. Some therapists openly identified as trans and/or nonbinary (N=6) or otherwise within the LGBTQ+ community (N=9).

Interview procedure. Data collection was conducted through interviews via Microsoft Teams, following a semi-structured interview protocol (see Appendix B), and audio was recorded using the software, with participants' permission. Interview length ranged from 64 to 124 minutes long (M=84). It should be noted that the longest interview took place in two sessions due to technical difficulties; excluding this outlier, interview length ranged from 64 to 96 minutes (M=80). All interviews took place during the month of June 2022.

The interview explored participants' experiences with therapy, with the semi-structured protocol allowing for flexibility within the interview process. Participants described work with 1 to 5 therapists. They related contextual information about the course of therapy, specific events and processes, and outcomes and impacts from these events. The interviewing researcher prompted clients to deepen descriptions where possible.

Analysis

We employed structured thematic analysis (TA) to identify, analyze, and interpret collected qualitative data (Braun & Clarke, 2006, 2012). TA allows flexibility to not only describe collected data, but to *interpret* the experiences of a particular group, in a particular context, while also considering the influences, causes, or underpinnings of those experiences (Braun et al., 2019). This flexibility makes TA well suited for significant events research.

Reflexive TA, as proposed by Braun and Clarke (2006, 2012) involves a six-step process to systematically construct meanings from collected data. Recorded interviews were first transcribed by the principal researcher, to enable familiarization (step one). Preliminary ideas for codes were recorded alongside a field journal to maintain reflexivity and dependability.

Next, we generated initial codes (step two), to signify and interpret data that is meaningful to the research questions. The principal researcher formed the initial labels, which the secondary

researcher audited and expanded. We then organized codes into themes (step three) via *inductive* analysis. That is, we grouped codes based on shared meanings, organized around theoretical concepts and questions (Braun et al., 2019; Braun & Clarke, 2012). See Table 1 below for an example of this step in the coding process.

Table 2

Analysis Step 3: Organizing & mapping codes into themes

Major Theme	**Sub-Theme**	**Codes**	**Participant pseudonym (paragraph #) – Quote**
Establishing a therapeutic relationship	Professionalism	**Confidentiality** – expectation that therapist will maintain confidentiality	Valerie (134) – "she spoke about her practice and how she, you know, kept that confidentiality."
			Finn (426) – "they mentioned that like if we ever see each other in public, they won't acknowledge me unless I make the first kind of, you know, hello."
		Scheduling and communication – expectation that therapist will be organized and communicative	Valerie (348)– "she wasn't always the most organized in terms of meetings, and would sometimes forget"
			Cameron (126) – "it took me, I think it was a better part of a month to get a hold of her"
Working with TGNC clients	Attitudes towards transness	**Coming out to therapist** – how the therapist reacted & handled it	Darcy (80) - "first off and like just being, she just seems super comfortable asking for my pronouns, asking how I identify"
			Leslie (61) - "she was accepting. She wasn't… There was no negativity in her response "
			Melissa (246) - "He made sure that they changed my name in the system"
		Normative experiences – therapist endorses normative ideas around gender	Darcy (216) - "she'll, like reference, you know, some sort of like family relationship or like family role theory where I'm not in there, I feel like I'm not in that whole world "

		Finn (470) - "he hit the are you self harming question… He said, you know, more than you already have? And I was like, well, I think the boob removal was OK […] I think he was just trying to make a bad joke and it just came out wrong."
		Taylor (220) - "She didn't agree with what I was doing or why I wanted to do it. And I think I told her my pronouns, and like all that, and like how I felt about like being called a girl and stuff like that and she just kept referring to me that way"
Competency with trans clients	**Knowledge of TGNC topics** – how did the therapist's knowledge (or lack thereof) impact therapy?	Darcy (349) - "it doesn't feel like I've had to explain myself. Or yeah, like, teach her about what the heck I'm talking about."
		Finn (249) - "I don't know if he googled it or anything, but he got enough understanding to kind of at least roll with it when I explain something."
		Melissa (222) - "when it's less about me personally and more about trans experiences in general, I've, there's been, definitely been a part of my brain that flags that"
		Taylor (402) - "I had to explain everything to them. And like it took up so long and like was very irrelevant to what we were actually talking about."
	Matched identity – how did identity parallels and differences impact therapy?	Melissa (438) - "maybe I was lucky that I had a cis therapist in the sense of like, I was in that position of power, of being able to define myself. Because I knew more about trans stuff going in."
		Sam (505) - "they just understand on a different level, because they are a part of that community […] they've helped

	me a lot just by being themselves" Taylor (380) - "trans is a different thing, because they are very different. And talking to somebody who's gay is not going to be the same."

The fourth step of Braun and Clarke's method (2006, 2012) considers the coherence and fit of codes and themes, as we recursively reviewed the generated themes as they related to the dataset. This was achieved using the software QDA Miner Lite (Provalis Research, 2023). Using this interface, we organized (and reorganized) codes in a tree structure, then retrieved all coded text segments within a theme to check for fit and coherence. This allowed us to document patterns and relationships between themes, to determine which identified themes represented unique sets of codes. An example of this process, using retrieved segments from the QDA software, can be found in Appendix H. We then defined and named the final themes (step five) in a conceptual order (Appendix I) and constructed the report, presented in the Results section below.

Results

The following chapter summarizes the analysis results, alongside verbatim quotes from participants (using pseudonyms to identify them) which illustrate the themes and codes. The analysis yielded eight major themes, which were decided on by grouping and ordering the refined codes into a conceptual order (see Appendix I for the complete conceptual order in a table format). The eight themes included: *Helpful and Hindering Relational Gestures; Expectations about the Therapist's Role; Therapist's Perception of Transness; Topics in Therapy; Significant Relational-Emotional Experiences; Significant Event Impacts on the Client; Client Processes in Understanding Significant Therapy Events;* and *Contexts*.

Theme 1: Helpful and Hindering Relational Gestures

The first major theme comprised events relating to the therapist's relationship skills and ability to manage the therapy relationship. The *Helpful and Hindering Relational Gestures* theme was divided into three sub-themes: *Professionalism, Rapport*, and *Collaboration.*

Professionalism. The first sub-theme described how therapists' conduct aligned with or differed from what clients expected around a therapist's technical or ethical duties. Codes within this group include the following: confidentiality, scheduling and communication, and boundaries.

Confidentiality. Participants felt that therapists should explain and adhere to protocols which protect client privacy. For instance, Valerie remarked, "having that sense of confidentiality, having had built that rapport, it is really freeing" (paragraph 184). Similarly, Finn said that one of their therapists explained, "if we ever see each other in public, they won't acknowledge me unless I make the first kind of, you know, hello" (paragraph 426). They appreciated this clarification because a previous therapist had not explained how confidentiality might work in public. They described how they felt seeing their therapist at work: "he'd go through whatever, like, the self scan station I watched and I just felt weird" (paragraph 432).

Scheduling and communication. Participants reported that their therapists had varying levels of organization and information regarding how they managed appointments. Valerie stated, "she wasn't always the most organized in terms of meetings and would sometimes forget" (paragraph 348). Cameron described one therapist who completely stopped communicating for a time. He stated, "it took me, I think it was a better part of a month to get a hold of her" (paragraph 126).

Boundaries. Clients described how therapists communicated (explicitly or implicitly) the limits of a therapeutic relationship. Finn noted that their therapist self discloses only when asked, stating, "if I don't wanna know any personal things, they won't bring anything up" (paragraph 420).

Alexis took responsibility for some of the therapist's work-life balance, saying, "I've always felt a little off about like, if I ever had to call her outside of like a session or anything, which I don't think I ever have" (paragraph 229).

Rapport. The second sub-theme described how participants experienced their therapist's ability to connect relationally. Codes within this sub-theme included: kindness, listening skills, safety and trust, nonjudgement, and openness.

Kindness. Participants described feeling a sense of benevolence from a therapist, or a lack thereof. Finn stated simply that they "just didn't vibe" (paragraph 96). In contrast, Valerie found that her therapist was "very friendly and open as a person, accepting and welcoming" (paragraph 58). Similarly, Sam described thinking, "yeah, this person's cool. We can talk" (paragraph 355).

Listening skills. Clients described their therapists' ability to attend and convey interest. Cameron felt that one of his therapists "wasn't listening" (paragraph 504). Taylor similarly noted, "it felt like she wasn't really listening because she would just like do nothing" (paragraph 78). In contrast, Valerie described: ""she would actively listen. She would repeat back in her own words to make sure" (paragraph 246).

Safety and trust. Clients felt varying levels of emotional security with their therapists. Taylor stated that given his therapist's actions, "it made me not want to trust her" (paragraph 90). However, Sydney said, "I kind of felt at home, being able to talk to him" (paragraph 166), indicating a level of comfort.

Nonjudgement. Participants expressed the importance of a therapeutic space free from criticism and bias. Hunter said she felt she "was being judged for like the pace of [her] transition" (paragraph 92). Taylor said of one therapist, "she was acting as if I insulted her by saying that"

(paragraph 194), which conveyed a sense of judgement. Some therapists, however, did provide "neutral or non-judgmental space" (Alexis, paragraph 433).

Openness. Clients described feeling both hesitant and free to discuss certain topics, depending on the therapist's attitude. Taylor stated, about his surgery, "I felt like I couldn't talk about anymore without, like, insulting her" (paragraph 234). Other clients felt that their therapists welcomed all topics. Sydney noted a freedom to discuss anything: "being able to talk about like anything I could, even like this stuff that like, I felt very weird and awkward talking about" (paragraph 130).

Collaboration. The third sub-theme related to the ways in which practitioners navigated give-and-take within the therapy relationship. Codes included: client agency, consistency, and feedback.

Client agency. Clients described moments wherein therapists either explicitly or implicitly tried to influence client values or choices. For instance, Hunter stated, "it definitely felt like she had some sort of agenda or idea that she would like me to do, that she was trying to push on to me, but never like outright said that" (paragraph 110). Sam, similarly, described how their therapist berated them: "being told that I had like made the wrong choice, in a situation where I felt very strongly that I had made the right choice […] was really unhelpful" (paragraph 198). Sydney's therapist repeatedly questioned her gender, and she said she felt pressure to not be trans: "like he was trying to get me to like, I don't know, almost. like repress it almost" (paragraph 36). Conversely, other participants described their therapists encouraging them to follow their own path. A different practitioner helped Sydney regain agency: "he's all like, this is your journey […] don't let me or anyone else tell you how to do this" (paragraph 326).

Consistency. Two participants noted inconsistencies in their therapists' opinions or stance, indicating a lack of transparency or honesty. Taylor described a shift depending on whether the sessions were individual or not: "as soon as my mom came into the room […] she'd just completely change what she said and like sided with my mom" (paragraph 82). Hunter also noted inconsistencies. When she asked her therapist for a letter of reference for surgery, she described, "his tone changed and he suddenly became concerned about things" (paragraph 154).

Feedback. Some clients noted that their therapists adapted based on client input. For instance, Leslie stated: "I just gave feedback that it wasn't working, or that wasn't working for me in that session" (paragraph 201).

Theme 2: Expectations about the Therapist's Role

The second major theme was constructed from accounts of what therapists did in sessions, compared to the client's expectations of what therapists ought to do. The *Expectations about the Therapist's Role* theme was divided into two sub-themes: *Session Structure*, and *Therapeutic Procedures.*

Session Structure. This sub-theme related the different ways that participants described the therapist's ability to organize and guide sessions, including the following codes: directiveness, links between sessions, questions, and pace.

Directiveness. Clients expected therapists to provide guidance in sessions, without controlling conversations completely. Hunter felt that her therapist lacked directiveness, and said that instead of "meeting somebody to just listen, […] I actually wanted like an active participant" (paragraph 58). Leslie appreciated the direction her therapist provided: "having somebody who can kind of just guide me in the right direction is helpful" (paragraph 509). Valerie, in comparison, preferred a less directive approach: "she really let me drive the discussions" (paragraph 58).

Links between sessions. Participants noted how therapists can help track progress, previous topics, and conversational threads across the course of treatment. Darcy stated of her therapist: “she takes a lot of effort […] to remind me of the progress that she's seen" (paragraph 64). On termination, Leslie’s therapist provided “bullet points” (paragraph 401) to summarize their work together.

Questions. Therapists were expected to ask questions to facilitate client sharing. Taylor missed this aspect in some of her therapy, stating, “nobody asked me questions about the things I was talking about" (paragraph 282). Hunter would have preferred more questions from one practitioner as well: "if she'd asked the right questions, it probably would have led into more, like trauma wounds" (paragraph 50). Melissa described how “being asked a question gives [her] permission to talk about things” (paragraph 294), and Valerie stated that her therapist’s questions seemed “very open-ended and designed to get [her] to talk” (paragraph 112).

Pace. Clients recognized the need to manage the intensity of sessions and regulate conversations appropriately. Leslie felt a momentary misalignment in pacing, and described “having the therapist, you know, push and continue to try and prompt me doesn't help because I'm overwhelmed" (paragraph 189). Alexis noted how therapy “could actually stir stuff up that you weren't prepared for” (paragraph 405).

Therapeutic Procedures. This sub-theme comprised participants’ accounts on what was done in therapy, sometimes in comparison with their views on what should be done in therapy. Codes included unpacking, gentle confrontation, psychoeducation, problem-solving, and relationship skills.

Unpacking. Clients described spending time on narrative accounts and describing their life events. Hunter stated, “80% of like what I do in therapy now is kind of like unpacking trauma" (paragraph 304).

Gentle confrontation. Participants expected their therapists to gently challenge their problematic patterns. Sam stated that therapists are “supposed to challenge you a little bit, and they're supposed to, like, push you outside of your comfort zone" (paragraph 106). Hunter described how one therapist would push back when she judged herself: “he's like, you know, what you're saying sounds kind of transphobic” (paragraph 196).

Psychoeducation. Clients noted that therapists sometimes provide information. Alexis was given “a book on borderline personality disorder” (paragraph 305) and Finn’s therapist suggested they “read a like, children of narcissistic parents book” (paragraph 325). Sam believed that they might have more easily recognized abuse had their therapist given more information around relationships. Sam recalled learning on their own, thinking, “I don't understand why, like my therapist never told me any of this stuff” (paragraph 264).

Problem-solving. Clients described how therapists supported decision making and solution-focused processes. Valerie stated: "that's probably the biggest thing is being able to break it down piece by piece, but also to kind of help me stop catastrophizing and looking for those solutions" (paragraph 288).

Relationship skills. Clients described working with therapists to learn communication and advocacy skills. For example, Darcy said, “I've been trying to set like better boundaries with like work-life balance" (paragraph 312) and Melissa stated a goal around “communicating clearly to [her] dad” (paragraph 63).

Theme 3: Therapist's Perception of Transness

The third major theme described how therapists demonstrated variable mindsets around TGNC-related issues. These mindsets ranged from ease and celebration to discomfort and rejection. Two sub-themes were constructed within this theme: *Attitudes Towards Transness* and *Competency with Trans Clients.*

Attitudes Towards Transness. This sub-theme described client encounters with therapists' preconceived notions around transness, whether positive or negative. Codes include: reactions to coming out, cisnormative assumptions, transphobic views, and support and celebration.

Reactions to coming out. Clients perceived therapist opinions on transness beginning with the moment of coming out. For instance, when Leslie came out to her therapist, she noted that "there was no negativity in her response" (paragraph 61). Melissa's therapist began advocating with her immediately; she stated, "he made sure that they changed my name in the system" (paragraph 246).

Cisnormative assumptions. Participants described moments that seemed to reflect assumptions which excluded trans experiences. For instance, Darcy said that though her therapist understands nonbinary ways of being, she sometimes references "family relationship or like family role theory," leaving Darcy to realize, "I'm not in there, I feel like I'm not in that whole world" (paragraph 216). Taylor found that even their gender counsellors espoused normativity: "It's just kind of assumed after I get top surgery that I'm gonna get hormones" (paragraph 432). Finn reflected on a moment wherein their therapist jokingly compared surgery to self-harm, tacitly endorsing the normative view that gender affirming care is inherently harmful. Finn stated, "he hit the 'are you self harming' question. He said, you know, more than you already have?" (paragraph 470).

Transphobic views. Some clients realized that their practitioners were actively transphobic. When Sydney's counsellor repeatedly asked her to defend her gender identity, she thought, "he's trying to go in the direction of like, being trans is wrong" (paragraph 36). Similarly, Taylor described their therapist's attitude:

> She didn't agree with what I was doing or why I wanted to do it. And I think I told her my pronouns, and like all that, and like how I felt about like being called a girl and stuff like that and she just kept referring to me that way. (Paragraph 220)

Support and celebration. Participants noted that support is not the same as embracing trans ways of being. Sam noticed that their therapist did not seem to celebrate their gender-related goals with them: "after I had top surgery, she was actually, like, surprised at how happy I was" (paragraph 114). They differentiated between allyship, or support, and being an accomplice: "an ally is like, rah rah. You can do it. An accomplice will like break the door down if you need it broken" (paragraph 485). In a similar way, Melissa noted, "people who want to call themselves allies to trans people, most do the bare minimum right? Accepting me. Listening to me" (paragraph 470). She explained that professionals need to be more vocal in their celebration of transness: "I need you to have pride colors everywhere, 365 days a year" (paragraph 474).

Competency with Trans Clients. This sub-theme examined the ways that clients determine therapists' ability to help transgender clients. Codes include: educational burdening, identity matching, and competency with nonbinary clients.

Educational burdening. Participants described how therapists may, to varying degrees, expect a client to inform the therapist regarding TGNC topics. Clients reported varying levels of educational burdening. Some participants felt that their therapists were very informed. Darcy stated, "it doesn't feel like I've had to explain myself. Or yeah, like, teach her about what the heck

I'm talking about" (paragraph 349). Similarly, Sydney felt supported by her therapist's knowledge: "he had all these resources that I didn't have access to before" (paragraph 250). Other therapists seemed not to know much at first, but were still able to help their trans clients. Finn said of their psychiatrist, "I don't know if he googled it or anything, but he got enough understanding to kind of at least roll with it" (paragraph 249). Leslie noted her therapist's transparency about her lack of knowledge: "It was just like, I'll admit, I don't know a lot, but I'd like to help" (paragraph 81).

Other participants noted the burden of having to educate a therapist on trans topics. Taylor expressed frustration at taking up session time to explain, but noted, "if I don't explain it, I mean, I'm gonna get misgendered the whole time" (paragraph 412). Melissa expressed the difference between sharing and educating: "when it's less about me personally and more about trans experiences in general, I've, there's been, definitely been a part of my brain that flags that" (paragraph 222).

Identity matching. Participants described different experiences around having shared, parallel, and different identities with their therapists. Some expressed feelings of solidarity with trans and queer therapists. For example, Sam stated of their nonbinary counsellor, "they just understand on a different level, because they are a part of that community […] they've helped me a lot just by being themselves" (paragraph 505). Cameron said that with a gay therapist, "there's a level of empathy there that is helpful" (paragraph 100).

Conversely, some participants noted that queer identity was not always enough to indicate support of transness. Taylor noted, "trans is a different thing […] and talking to somebody who's gay is not going to be the same" (paragraph 380), Sydney experienced transphobia from a self-identified gay therapist, and noted, "he was like, more LGB. And then like, yeah, just drop the T" (paragraph 78).

Participants also discussed how therapists can be supportive without necessarily sharing queer or trans identity. Melissa appreciated having a cisgender therapist, saying, “I was in that position of power, of being able to define myself. Because I knew more about trans stuff” (paragraph 438). Valerie was not concerned with her therapist’s identity at all, saying that once rapport was established, “it really didn't matter if she identified as a member of the community or not” (paragraph 82). Sam also noted, "the intention has to be there and I find a lot of straight people don't necessarily have that intentionality because they don't need to” (paragraph 481).

Competency with nonbinary clients. Nonbinary participants noted that competency with binary transness does not always equate to competency with nonbinary identity. Taylor noted:

> There's a huge difference being somebody who's researched, like, binary transitions to somebody who's researched nonbinary transitions […] Because I face completely different aspects of feeling invalid in my gender than somebody who's in binary transition would (paragraph 382).

Darcy acknowledged their therapist’s ability to work with their changing gender identity, saying, “she understands how fluid identity is. It doesn't feel like it's something that it's like a one and done conversation" (paragraph 355).

Theme 4: Topics in Therapy

This fourth theme identified subjects that clients deemed important to discuss in therapy. Participants also discussed how these topics were handled in session. The *Topics in Therapy* theme includes four sub-themes: *Gender, Transition Support, Intersectionality*, and *Suicide*.

Gender. The Gender sub-theme reflected topics around identity, presentation, and the effects of transitioning. Codes included: dysphoria, sense of self, and impact of transition on significant relationships.

Dysphoria. Participants described how gender dysphoria impacted them. Alexis provided a simile for living with dysphoria, saying, “It's like putting the wrong shoe on the wrong foot. Can you do it? Yes. Could you live life like it? Sure. Are you in constant discomfort and pain? Yeah, for sure” (paragraph 157). Valerie described her struggles during puberty, stating, “I used to be like an honor roll student, and that fell apart. I leaned on drugs and alcohol and I wasn't really sure why. I was feeling so horrible about myself” (paragraph 46). It took time and effort to discover that dysphoria was the cause of her distress: “I still didn't know why I felt the way I felt. And again, I didn't have that language” (paragraph 50).

Sense of self. Transition and self-discovery were described as ongoing processes, which clients discussed in therapy as needed. Darcy described ongoing conversations with their therapist: "I've just kind of been like questioning, like, pronouns that I don't wanna use, like labels that I want to identify with” (paragraph 86). Valerie noted that self-discovery was major theme in therapy: “those were the biggest things that were discussed. So coming out, essentially coming out to myself and finding myself" (paragraph 366).

Impact of transition on significant relationships. Clients discussed how their relationships might change as they came out and transitioned. Melissa stated, “we talked a little bit in that first session about my plans for coming out to people how I was planning to do that" (paragraph 166). Similarly, Finn sought support coming out at work: “I decided I wanted to be more like up front about it” (paragraph 257). Alexis discussed the coming-out process to her family, and her eventual separation from them: "I don't speak to my family at all now. They don't accept me as being a transgender person” (paragraph 137). Additionally, Hunter noted that her marriage was an important topic in therapy: “trying to navigate my relationship with my wife and like how it's going

to affect her" (paragraph 30). Cameron noted that he discussed his marriage as well, as his ex-wife "said some really hurtful things" (paragraph 240) when he came out as gay.

Transition support. This sub-theme identified discussions in therapy about how to identify and attain transition goals. Codes included the topics of transition anxiety, medical decisions, surgery preparations, and active support for transition.

Transition anxiety. Participants identified internalized transphobia which caused anxiety around presentation and/or 'passing.' Hunter described working through these fears: "the transphobia that I was holding within, a lot of like misogyny and stuff, was what I really worked through with him, like a lot of fears around socially transitioning" (paragraph 130). Melissa noted that she had to cope with the lack of representation for people who transition in later adulthood:

> The representation that we have is largely biased in favor of people who transitioned younger and as a result, even if they don't pass – which is a concept I kind of reject in general – even if they don't pass, they have a very different experience from people who come out in their 30s or 40s or beyond (paragraph 436).

Similarly, Cameron expressed worries about seeing the effects of treatments: "And when is that gonna cause enough change to make me feel different?" (paragraph 396).

Medical decisions. Clients discussed potential gender-affirming treatments with therapists. Hunter said that therapy involved, "trying to figure out like what transition even meant for me, whether or not it was gonna involve hormones or surgeries" (paragraph 30). Darcy noted that they haven't made up their mind about some treatments, and that they wouldn't want to undergo surgery "until that feeling becomes like maybe a little bit more regular or consistent or solid" (paragraph 399).

Surgery preparations. Participants described how therapists helped inform and support clients' plans for gender affirming procedures, so they were ready to undergo their chosen procedure(s). Finn said that their therapist used personal experiences to help them prepare, "explaining their experiences they knew about and what to expect. And felt like that and just what kind of info I might need to get" (paragraph 233). Sydney said that her therapist was excited for her, but also balanced that with practical considerations: "He was like […] it's exciting, but there's also a ton of stuff that is involved from my end that needs to go into it, like especially for like the aftercare" (paragraph 306). Hunter noted that her therapist's inconsistent messaging about surgery was unhelpful, noting that while "there's a long recovery to [surgery]" (paragraph 220), her therapist "was waving this stuff off earlier in our in [their] conversations" (paragraph 222).

Active support for transition. Clients experienced varying levels of logistical support from therapists as they navigated transition. Sydney's therapist took on many of the logistics himself: "I don't have as much pressure to do things like trying to find a doctor or like, I didn't have to deal with the headaches of, like, trying to contact Montreal" (paragraph 264). Other clients said their therapists made good referrals. Leslie said of her therapist, "She made the referral to my endo, and then my endo has been able to help with a lot of the other healthcare aspects" (paragraph 55). Some client needed letters from their therapists. Valerie stated of this process, "the fact that I had to get the letters is a bit infantilizing. But the process that I dealt with to get it was amazing" (paragraph 400). In contrast, Taylor described having an unhelpful experience with one therapist: "the person didn't really know what they were talking about […] it took me a long time to go and get a new therapist that I had kind of worked it out on my own" (paragraph 358). That is, Taylor's therapist was unhelpful in providing a support letter, such that they sought their letter elsewhere.

Intersectionality. The *Intersectionality* sub-theme was constructed from accounts of how different aspects of identity and life situations affected clients' existence as trans people. Codes included language, race, orientation, family planning, and body image and fatphobia.

Language. Participants noted how different languages, particularly French, affected their ability to navigate gender and pronouns. Darcy described unpacking this: "talking about like my experience with the French language and feeling like I couldn't be nonbinary all throughout school because there's just no language to support it" (paragraph 158). Sam experienced this phenomenon when their own therapist struggled with their pronouns: "she's also like French Canadian and like, they're like, I'm sure you know their language is very, very, very gendered" (paragraph 152).

Race. Sam mentioned that their race was a topic of conversation, though not necessarily in relation to their trans identity: "ethnically, I identify as a racialized worker […] and that impacted a lot of my upbringing" (paragraph 32). Melissa described some of her thoughts on the relative privilege of coming out as a white trans woman: "trans women of color have it so much harder and even just people of color often experience a lot of things I'm never gonna experience" (paragraph 352).

Orientation. Clients discussed their sexual and/or romantic orientations with therapists. For example, Valerie's transition prompted some questions around her orientation: ""It kind of got me questioning, again, bits of my identity. Well, I don't really feel like that, you know, that level of attraction that people feel" (paragraph 338). Similarly, when Cameron came out as gay, it opened up different gender expressions: "I just came out as a gay man last year and to be able to embrace even more what would be perceived as more feminine mannerisms and that sort of thing" (paragraph 62). However, Melissa stated that her orientation is unchanged by transition: "my

transition has clarified aspects of my asexuality […] but it's not changing whom I'm attracted to" (paragraph 184).

Family planning. Participants described how planning for children or for contraception intersected with their transitions. For example, Taylor said, "I was considering whether or not I wanted top surgery and I was struggling with the idea of not being able to breastfeed my children in the future" (paragraph 192). Hunter similarly considered her wife and family: "I want to [start] estrogen, which is going to affect fertility. So then like, we have to talk about fertility planning" (paragraph 128).

Body image and fatphobia. Participants discussed the overlap and the differences between self-esteem, societal bias against fatness, and gender dysphoria. Sam noted, "as trans people we put so much pressure on ourselves to have like this body that matches our brain," (paragraph 559), but also that "body acceptance for trans people can be really harmful too" (paragraph 565). Indeed, when discussing their therapist's push for 'self love instead of gender affirming treatments, Taylor clarified, "the fact that I have a stomach is something that does bother me, but that has nothing to do with my gender. That has to do with my body" (paragraph 318). They explained further:

> But it kind of gets cloudy because when you think of your idealized version of yourself, you kind of picture both like your body and your gender dysphoria going away. But you kind of have to be like, OK, well, what if I was a fat version of what I want to be? And then you can kind of figure out what's body dysphoria and what's gender dysphoria (paragraph 320).

Body size also came up in relation to seeking treatment. Alexis was told that she could not access other treatments for her mental health until she tried to lose weight: "that was always his big thing. Oh, you just need to lose weight. Just need to lose weight" (paragraph 465). Taylor also had to pay

more for surgery due to their size: "I paid an extra $6000 out of pocket just because I was fat and there was only one surgeon that would cover it" (paragraph 326).

Suicide. This sub-theme represented how therapists and clients navigated discussions of self-harm and/or suicide. Codes included approach to suicide, treatment, and safety plans.

Approach to suicide. Participants described how they felt broaching the topic of suicide, depending on their therapist's attitude towards the subject. For example, Cameron said, "it took me a long time to tell if therapist that I felt suicidal because I thought they'd put me in a mental institution immediately" (paragraph 134). Sydney's therapist noticed her self-harm marks, and asked about them; she stated, "I felt better, being able to, like, talk about it with him" (paragraph 446). In contrast, Sam realized in retrospect: "I was always kind of surprised that [Therapist One] didn't show more concern because I probably was like in danger" (paragraph 409).

Treatment. Clients described how they and their therapists discussed suicide and self harm treatments. Sydney described an approach to harm reduction while self-harming, as her therapist told her, "if you are going to do it, here's how you do your best to reduce the amount of harm" (paragraph 416). Leslie pointed to the relationship as the main healing factor: "the biggest thing that can help when I feel bad, and things kind of get to that point of, you know, thinking about taking my life, it's feeling seen, and feeling heard" (paragraph 477).

Safety plans. Participants discussed how therapists presented ways to prepare for suicidality and prevent harm. For example, Sydney said, "we talked about, like any sort of like safety plans and stuff like that for myself, and then like he gave me different suicide hotlines" (paragraph 500). Clients also noted the limitations of the available crisis support. Sam stated, "the police and like those systems aren't really gonna help you" (paragraph 413).

Theme 5: Significant Relational-Emotional Experiences

The fifth theme represented the different client-identified emotions towards the therapist that arose during or following significant therapy events within the relationship. This theme was divided into two sub-themes: *Helpful Relational Experiences* and *Hindering Relational Experiences*.

Helpful relational experiences. This sub-theme comprises the emotional reactions which contributed positively to the therapeutic relationship following a significant event. Codes included understanding, emotional relief, and validation.

Affinity. Clients described feeling understood and seen by their therapists. For example, Darcy said of their therapist, “it feels like she understands me on a deeper level" (paragraph 371). Similarly, Cameron stated, "I know on some level he understands it on more than just a clinical level" (paragraph 100).

Emotional relief. Participants expressed feeling relieved or unburdened after therapy sessions. Alexis said, for example, "I've always left feeling much, much better” (paragraph 77). Hunter also described, “every session, just I just feel like weights are being lifted off, and like I'm digging into stuff that I never thought of before" (paragraph 294).

Validation. Clients experienced affirmation and support from their therapist. Darcy how external support can be important: "hearing it out loud from somebody who, like, who knows me and who's worked with me for a while, it's just so affirming” (paragraph 11).

Hindering relational experiences. This sub-theme comprises the emotional reactions which detracted from the therapeutic relationship following a significant event. Codes included anxiety, awkwardness, frustration, and hurt.

Anxiety. Participants expressed feeling fearful due to an event. Taylor stated, "I was also terrified because she was like, yelling" (paragraph 226). After receiving an email from her

therapist, Hunter said, “I fell apart. I spiraled into like an anxiety attack or something. I completely lost control of my emotions” (paragraph 212). Similarly, Cameron described having to be in his previous therapist’s office building: "It took me a while, but yeah, it took me a while to get over that feeling, just feeling tense. Definitely a fight-or-flight response that just kicked in" (paragraph 110).

Awkwardness. Clients described feeling ‘off’ or uncomfortable around their therapist. For example, Finn described their therapist’s bad joke as “a little off-putting” (paragraph 486). Sam reacted to one of their therapist’s questions: "It was kind of weird in the moment to be asked that" (paragraph 200).

Frustration. Participants expressed feeling angry or annoyed. For example, Hunter stated of one experience, "towards the end I was getting a little, like, I was getting frustrated” (paragraph 64).

Hurt. Clients felt harmed or betrayed by their therapists. For example, Taylor described, "I was painfully angry and just upset and emotional the entire time and it ended up being a super negative relationship" (paragraph 100). Describing their therapist berating them, Sam said, "It was really hard. I kind of had a meltdown afterward” (paragraph 180). Hunter explained how their therapist’s inconsistency affected her: “I was just really hurt and for like several days afterwards” (paragraph 214). Cameron also felt hurt by his therapist’s sudden lack of communication: "It was really hurtful and really kind of scary, you know, like I didn't have that support” (paragraph 130).

Theme 6: Impact of Helpful Events on the Client

The sixth major theme described how helpful significant events affected the client’s way of being, internally and externally. That is, this theme encompassed how significant events changed the client’s mindset and/or lifestyle. Sub-themes within this major theme included: *Integrated Therapy Skills*, *Relationship with Self*, and *Long-Term Changes*.

Integrated Therapy Skills. This sub-theme was constructed to demonstrate how clients applied helpful therapy experiences to their lives and ways of being. Codes included introspection and insight, individuation, mindfulness, and emotional regulation.

Introspection and insight. Participants indicated that therapy provided new ways of understanding the self. For example, Hunter described, "learning the behaviors that I have, and why I have them" (paragraph 304). Alexis noted, "sometimes you don't realize what you've gone through until you're out of that situation" (paragraph 147). Valerie described a lasting impact on her self-reflection: "I wouldn't say it was like one 'aha' moment. I think it was more I understood how to be truly introspective" (paragraph 98).

Individuation. Clients described how, through therapy, they were able to take responsibility for their own actions within relationships, while also recognizing their limits. Cameron described a shift in perspective with his past relationships: "what I'm working on now is trying to understand that I'm not responsible for her happiness" (paragraph 252). Alexis spoke of softening codependent and people-pleasing tendencies, saying, "It took a little while to be able to work up the gumption to be able to recognize that I had value outside of that" (paragraph 201). Hunter described conversations around transition in a transphobic world: "learning that I can't control other people's emotions and that I can choose who I associate with and like, I don't owe people anything regarding my transition" (paragraph 198).

Mindfulness. Participants noted how they have integrated techniques to improve present-moment awareness or grounding. For example, Cameron said, "my therapist […] gave me a really good meditation to use" (paragraph 360). Similarly, Leslie explained of her therapy work, "this was a different way of looking at mindfulness that helped me approach it, and I've been able to use that for everything" (paragraph 113).

Emotional regulation. Clients used skills that they learned in therapy to understand and process their feelings. Valerie explained, “this gave me a way, the tools and the language to be able to figure out, OK, well, this is this is how I'm feeling” (paragraph 124). Hunter also expressed, “I'm getting better at like naming emotions. You know, I'm not shutting down during conversations or conflict. And I'm better able to regulate myself" (paragraph 308).

Relationship with Self. This sub-theme was constructed to capture how participants linked significant events to their ways of relating to themselves. Codes included empowerment and self-talk.

Empowerment. Helpful events, in comparison, were often related to a sense of self-reliance or confidence. Valerie explained one lesson she took from therapy: “to look to yourself to make the changes, to get you to a safe place, to get you into a better mind state” (paragraph 208). Alexis said of her therapy work, “it helped me find the strength in myself, to advocate for myself” (paragraph 539).

Self-talk. Clients expressed shifts in their inner voices. Darcy described helpful affirmations: “reminding myself that it's OK to be who I am and it's OK to like to be nonbinary in my own way” (paragraph 316). Cameron also integrated new ways to speak to himself: "I remember she gave me a phrase, to trust in my own resiliency"(paragraph 94).

Long-Term Changes. Participants indicated lasting differences in their ways of being, relating, and existing after significant therapy events. Codes included authenticity, improved relational capacity, and survival.

Authenticity. Clients explained how they discovered and became more comfortable with their genuine selves. Leslie said of therapy: "I feel like it has allowed me to see myself” (paragraph 505). Valerie used therapy as a space to explore her gender:

> to be able to put words to my feelings in terms of my identity. So not just like who I am, but that it's OK to be who I am, and it's OK to be a woman, and it's OK to be feel happy about that (paragraph 418).

Hunter explained how she used therapy to explore her new identity as a transgender woman: "I describe it as like I lost touch with myself […] I'm rediscovering who I am as like an individual" (paragraph 314).

Improved relational capacity. Participants expressed feeling more open and available in their relationships following helpful therapy experiences. Hunter stated, "as a parent, like I feel more confident. I feel like I'm doing a better job. I feel like I'm more available" (paragraph 272). Similarly, Valerie said of her friendships, "I'm willing to share more of myself and discuss my feelings more openly" (paragraph 128). Leslie explained how she feels that self-understanding has improved her relationships: "If I can understand what's going on in my own head, I can communicate it to other people and we can work on it together" (paragraph 325).

Survival. Participants explained that one significant long-term effect of helpful therapy was simply staying alive long enough to see positive change. Cameron explained how therapy has provided the hope he needed: "knowing I have a therapy appointment coming, even, can be a thing that keeps me going" (paragraph 218). Sydney also stated, "I still get suicidal ideations, stuff like that, but it's, I feel like I have the support that I need" (paragraph 544). Leslie stated simply, "I don't know who I would be if I didn't have therapy. I probably wouldn't be alive right now" (paragraph 319).

Theme 7: Client Processes in Understanding Significant Therapy Events

The seventh theme was constructed to explore how clients processed and understood the significant events, both immediately and in retrospect. Sub-themes included *Reactions to Therapist Ineptitude*, *Evaluations*, and *Retrospective Appraisal of Therapy*

Reactions to Therapist Ineptitude. This sub-theme comprised they ways that clients managed hindering events. Three codes were constructed within this theme: self-doubt, self-defence and termination.

Self-doubt. Following hindering events, participants expressed a lack of trust in themselves. For example, Sydney said, "he kind of made me like, question things a little bit. Like kind of, like, am I the one that's wrong?" (paragraph 60). She went on to explain, “in my mind, it's like, he's the expert. So it's like, I don't know, did he see something that I'm not?" (paragraph 64). Similarly, Sam said of one hindering event, “it just made me feel like I was bad. Like I had done something bad” (paragraph 186).

Self-defence. Participants indicated the ways that they protected or explained themselves following a hindering event. For example, Hunter stood up for herself after receiving a hurtful email: “I sent him a very stern email basically saying like. What you're doing is not what we discussed” (paragraph 168). Sam noted that while they felt their gender was being questioned by a therapist, they were able to stay confident: "I was thoroughly convinced of who I was and what I needed to do and going for surgery and stuff. So […] that strengthened my conviction a lot more” (paragraph 210).

Termination. Participants explained how hindering events led to the end of their therapy relationships. Cameron simply stated, "it didn't feel good. So I didn't continue” (paragraph 156). Sam told their therapist why they wouldn’t be returning: “I wrote her a very long email just being like, this isn't working" (paragraph 162). Taylor explained that their therapist suggested ending treatment: "they just gave up and were like, there's no point of you coming anymore” (paragraph 90).

Evaluations. This sub-theme described how clients made sense of their therapist's role and responsibility in both hindering and helpful events. Codes included: critiques, excusing the therapist, and appreciation.

Critiques. Clients expressed varying levels of disapproval of their therapist's actions. Sydney spoke with a friend about her experience and realized, "any good therapist wouldn't be like saying things like that" (paragraph 94). Taylor reported their therapist: "So she ended up being really awful and I reported her" (paragraph 206). Cameron also reported his therapist: "I emailed the director of care not because I wanted her to be in trouble, just because I wanted to drive home the gravity" (paragraph 170).

Excusing the therapist. Participants also noted the complexity of their situations and events, and sometimes minimized the therapist's responsibility for hindering events. For example, when Hunter explained how her therapist didn't connect the way she needed, she speculated on her own role, saying, "maybe I wasn't clear enough in that expectation" (paragraph 60). Even though their therapist didn't understand nonbinary identities, Sam stated, "I think she tried. I think, like in her heart, like she's a nice person" (paragraph 152). Similarly, while Finn said that their psychiatrist's joke was poorly done, they also noted, "I don't think it was supposed to be negative […] I think it was just a really bad joke" (paragraph 488).

Appreciation. Clients expressed appreciation of their therapists, for the helpful events that occurred. Alexis stated, "I very much count myself as having been fortunate and lucky in finding such a great therapist" (paragraph 541). Similarly, Melissa said, "I appreciate that because I know that many people don't have that experience in therapy" (paragraph 404).

Retrospective Appraisal of Therapy. This sub-theme identified moments when participants indicated looking back on their therapy experiences and how they have contributed to their worldviews now. Codes included: learning experiences and faith in therapy.

Learning experiences. Participants explained what they gleaned from both hindering and helpful events in therapy. For example, Sam explained how hindering events taught them what they needed from therapy: “that really only came because I had negative experiences and it gave me a chance to see, like, what I wanted from future therapy experiences.” Additionally, Cameron learned what he is capable of. He said of one hurtful experience, "I learned from that that I can't, like, I'm able to stand up for myself” (paragraph 529).

Faith in therapy. Some participants expressed feeling that therapy was more difficult following hindering events; however, most described the overall general benefits of therapy as well. For example, Sydney stated, "I was like, if all of them were gonna be like this, like, what's the point of trying to talk to any therapist?" (paragraph 90). Hunter expressed a similar sentiment: "I started to get a little bit like resentful and like kind of turned off of doing therapy” (paragraph 66). Sam explored the tension between hindering experiences and the hope for positive experiences in the future: "It's been hard for me too when I've had bad experiences, but like, I would always encourage people to like take the time you need to heal from those bad experiences, to keep putting yourself out there” (paragraph 531). Leslie expressed the importance of therapy for her, saying, “I think most people could probably benefit from some therapy” (paragraph 297), and adding that “trans people especially" (paragraph 299) could use some counselling support.

Theme 8: Contexts

The final theme described contextual events which intersected with the described significant events. Three sub-themes were constructed within this theme: *Healing Beyond Therapy, COVID-19,* and *Access and Privilege*.

Healing beyond therapy. This theme described the factors which participants found healing, but which were not directly related to therapy events or processes. Codes included: transition, life changes, and medication.

Transition. Participants expressed how living and expressing themselves in alliance with their genders was healing and even life-saving. For example, Finn stated, "coming out did make a huge difference" (paragraph 560) and Sam similarly said, "transitioning socially and physically has had such a positive impact on my mental health" (paragraph 214). Alexis explained further how coming out affected her mental health: "I think it's hard to do anything when you're not actually connected with yourself internally. And even before I started hormones, just being able to acknowledge the things that I had felt, like I said, my entire life" (301).

Life changes. Participants explained how their situations changed, which aided their mental health. For example, Taylor was able to heal when they moved away from their mom: "once I was able to kind of create my own life and create my own routine, things got better" (paragraph 310). Sydney expressed how ending a personal relationship was helpful, saying, "It's been a lot better since he's been out" (paragraph 402).

Medication. Participants pointed to proper medication as a support for mental health. For example, Finn said, "the big turning point was getting the medication that actually worked" (paragraph 566).

COVID-19. This theme was constructed to explore the ways in which the COVID-19 pandemic impacted clients' mental health and therapy experiences. Two codes were identified: pandemic impacts and virtual therapy.

Pandemic impacts. Clients described how the pandemic affected their lives and mental health. For example, Melissa stated, “the pandemic has certainly hindered my social development in many ways” (paragraph 446).

Virtual therapy. Participants expressed opinions on the switch to online therapy, and how that compared to in-person sessions. Some noted the difficulty of being physically distant from a practitioner. For example, Alexis explained, "if I'm not physically in the room with the person, it's way more difficult for me to pick up on those feelings of emotional support” (paragraph 363). Finn struggled with a specific modality in a virtual space: "I was in the process of doing EMDR with them, which requires more in person than online” (paragraph 127). In contrast, other clients noted the relative benefit of not having to leave their house to attend therapy. Darcy described feeling more comfortable with their gender presentation: "not being in person and not having to like, make those decisions about like my expression allows me to just kind of be completely comfortable at home” (paragraph 268).

Access and privilege. This theme represented participants’ statements around the ability to undergo therapy in Ontario. Two codes were constructed within this theme: availability and financial access.

Availability. Participants noted a lack of available practitioners with enough competency to treat TGNC individuals. Valerie said, for example, “there is not enough folks that that have the language to be able to speak with trans folks in a compassionate way. A lot of lot of medical practitioners just have no idea how to treat trans people" (paragraph 470). Taylor expressed frustration about a lack of available long-term therapy: "I had to completely restart and continue to repeat everything and all my trauma over and over again. Every single time I got a new one. So it just made me dread therapy” (paragraph 52). Darcy tried to access services through their school,

but said, “I just found it like to be really inconsistent. And just like, kind of surface level” (paragraph 48). Leslie expressed concern about finding competent care once her therapist leaves her practice: "I don't wanna make a compromise on, you know, my own health […] but in order to receive services, I might need to make compromises like that" (paragraph 383).

Financial access. Participants noted the financial barriers to accessing adequate mental healthcare. Alexis explained, "I haven't been able to see her lately. Just financially" (paragraph 107), indicating that she would like to see her therapist again, but can’t afford to. Melissa noted the impacts of social and financial disparities:

> the trans people who can afford to go to therapy and access those services are the ones who have a stable enough job and income or insurance to pay for therapy, and therefore we may be a little bit more well adjusted. And trans people who maybe would benefit even more from these services often can't access them (paragraph 240).

Sam expressed how financial burdens impact TGNC people more often: "I believe in paying people what they're worth, but […] if you're trans person, you don't have much money, and you're trying to save like whatever money you have for surgery" (paragraph 549).

Discussion

The results presented above provide an overview of how participants recount the experience of therapy. From these findings, we constructed an account of what TGNC individuals find both helpful and hindering in therapy, alongside the contexts of and impacts from identified events. The following section will summarize the study’s findings, compare the results to the previous literature on this topic, and explore implications for practice and for further study.

Summary of Findings

Through structured thematic analysis, we created eight major themes: (1) *Helpful and Hindering Relational Gestures;* (2) *Expectations about the Therapist's Role;* (3) *Therapist's Perception of Transness*; (4) *Topics in Therapy;* (5) *Significant Relational-Emotional Experiences;* (6) *Significant Event Impacts on the Client;* (7) *Client Processes in Understanding Significant Therapy Events;* and (8) *Contexts*.

Participants described significant events relating to the therapist's relational skills in *Helpful and Hindering Relational Gestures,* including evaluations of professionalism, rapport, and collaboration from the therapist. The second sub-theme, *Expectations about the Therapist's Role,* related less to the relationship itself, and more to the ways that therapists structured and guided procedures within therapy.

The interviewed individuals also noted relevant topics around their TGNC identities. In the third theme, *Therapist's Perception of Transness*, we organized client accounts of how therapists demonstrated their attitudes towards and competency with TGNC topics. Relatedly, the fourth theme (*Topics in Therapy*) outlined some subjects relating to gender that were critical to participants, such as dysphoria and transition treatments. Further analysis indicates that a therapist's approach to medical transition might also intersect with client agency, cisnormativity, and transphobic views. Participants also described the valence of therapeutic conversations around other topics such as family planning and body image. Many participants mentioned treating suicidality and self harm as important factors in treatment.

The fifth theme, *Significant Relational-Emotional Experiences*, described participants' emotional reactions to therapeutic events, particularly in the therapeutic relationship. For example, clients described feelings of affinity and validation from positive experiences, and anxiety, frustration, and hurt when there was a rupture to the alliance. The sixth theme, *Significant Event*

Impacts on the Client, refers to lasting effects on clients following significant events. These impacts include learned skills and shifts in mindset.

A seventh theme was constructed to capture the ways participants made sense of the events they described: *Client Processes in Understanding Significant Therapy Events*. This theme organized participant reactions to and evaluations of therapists, and of therapy itself. For example, some participants criticized their therapists. However, some of these criticisms were offered alongside excuses for the therapist's behaviour or with sympathetic language, perhaps to minimize the sense of blame or censure.

Finally, the eighth theme, *Contexts*, captures the factors that participants brought forth that did not relate directly to therapy events. Participants mentioned non-therapy treatment for mental health, such as medication. They also discussed the impacts of the COVID-19 pandemic, especially as it related to mental health and therapy modalities. Most participants mentioned issues of availability and affordability, noting that Ontario's healthcare system does not adequately provide mental healthcare for those who need it most.

Comparisons with the Literature

The following section compares the results from the present study to the existing literature on TGNC experiences in therapy.

Helpful and Hindering Relational Gestures. The current study supports the importance of relationship factors, such as professionalism and rapport, in therapy. Additionally, some of the existing literature indicated the importance of a therapist's collaborative skills. For example, participants in Elder's (2016) study recommended to practitioners that they attempt to mitigate their assumptions and biases in therapy. This notion was deepened and identified as theme in our analysis. Participants indicated that their therapists' biases came through, leaving them feeling

pressured or shamed for their actions or desires. Others noted the importance of consistent messaging from their therapists, as well as two-way feedback to mitigate power differences.

Expectations about the Therapist's Role. Most existing explorations of TGNC clients' experiences in therapy understandably focus on topics relevant to gender. However, participants provided descriptions of what their therapists did in sessions, not just in relation to the client's gender journey, but in terms of supporting their mental health overall. Participants also compared this to their expectations of the therapist's techniques. Other researchers have also mentioned certain therapeutic interventions as being helpful or hindering. Elder (2016) identified that one participant appreciated a 'reframing' of her mindset, similar to the identified code of 'gentle confrontation.' T. Israel and colleagues (2008) also indicated the unhelpfulness of "interventions that clients found ineffective (e.g., meditation, ''why'' questions, excessive self-disclosure, excessive use of silence, withholding feedback from clients) or harmful (e.g., involuntary hospitalization)" (p. 300). These identified processes reflect some of the codes identified in our results. For example, clients identified 'questions' as something therapists ought to employ effectively to facilitate conversations. Additionally, we analysed client-identified expectations of their therapists around session structure (e.g., directiveness and pace) and procedures (e.g., psychoeducation and problem-solving).

Therapist's Perception of Transness. Accounts of TGNC clients in therapy invariably include discussion of the therapist's attitude towards transgender people. Our findings support and expand on existing literature in this area. Research has shown how TGNC clients can feel rejected, misunderstood, discouraged, and invalidated in therapy (see literature review section). These experiences range from a vague sense that the therapist doesn't approve (Morris et al., 2020) to reflections of biased psychological literature (Elder, 2016) to outright attempts at conversion

therapy (Mizock & Lundquist, 2016). Similarly, the codes 'cisnormative assumptions' and 'transphobic views' capture how participants felt the anti-transgender biases within the therapy field in general and outright rejection from their therapists specifically. Additionally, participants described the process of coming out to a therapist, which may be an important factor for clients in determining their therapist's level of support.

Anzani and colleagues (2019) constructed a model of microaffirmation for transgender people in therapy. The describe how therapists can move from an absence of microaggressions, into acknowledging and disrupting cisnormativity and finally seeing authentic gender. This model reflects other findings in the literature, which indicate that affirmative care is defined by clients as involving a lack of discrimination, presence of affirmation, and whole-hearted support for trans ways of being (i.e. Benson, 2019; McCullough et al., 2017). Our participants enriched this description by sharing their opinions of what constitutes support for transness. These accounts indicate that acceptance is simply a first step into learning and unlearning normative views.

Knowledge and Competency. Related to support and affirmation, a therapist's level of knowledge also contributes to their perceived competence with TGNC clients. Clients in the literature and in our results emphasized the importance of understanding TGNC issues. Participants noted how therapists provided resources and information, citing these events as helpful. Others reported on the hindering nature of educational burdening; that is, clients reported feeling frustrated when therapists relied on them to explain the basics of transgender topics.

Additionally, nonbinary participants in this study and the literature body note that competence with some forms of transness does not always translate to understanding existence outside of binary norms. These findings reflect some of the previous literature. Participants have noted the importance of therapist flexibility around gender (Bess & Stabb, 2009; Mizock &

Lundquist, 2016) and that nonbinary identities can differ from other trans identities (Morris et al., 2020).

Identity Matching. Cultural competency and identity matching are important topics in the psychotherapeutic literature. Some argue that cultural competency is itself problematic, as it may reinforce difference among groups and prevent relatively privileged therapists from confronting socially constructed power imbalances (Pon, 2009). From the client perspective, research has found, for example, that clients of colour may feel misunderstood and unsupported in some areas by White therapists (Chang & Yoon, 2011). Several participants in the current study explored how their therapist's identity and experiences might influence knowledge and acceptance of TGNC clients.

Existing literature also touched on this topic at times. For example, McCullough and colleagues (2017) identified that some participants appreciated having transgender therapists, and others had mixed experiences with LGB counsellors. However, client opinion on identity matching is still relatively unexplored among LGBTQ+ populations, and especially among TGNC populations specifically. There is evidence that some LGBTQ+ clients prefer therapists within the queer community, though this is not a consistent finding by far (King et al., 2007). Jumarali (2022) recently conducted interviews with LGBTQ people of colour, describing their experiences seeking and undergoing therapy with practitioners whose identities matched their own. Results indicated that clients hoped for, and often experienced, safety, increased trust, and understanding from identity-matched therapists.

The identity matching code presents participants' complex views on this topic, especially since TGNC identities are parallel to, but not always overlapping, LGB communities. Some LGB therapists are able to offer a sense of shared community to their TGNC clients, while others

perpetuate transphobia and cissexism despite their marginalized orientation. Additionally, some clients experienced positive and healing relationships with therapists whose identities were either unknown or did not match. Participants noted that straight, cisgender therapists are capable of the same level of support and affirmation, but may simply be less inclined to research, understand, and integrate a trans-affirmative worldview.

Gender Affirming Medical Care. Transition decisions and medical care are essential topics of discussion in therapy for TGNC people. The present work supports previous findings, that clients appreciate both support and information when transitioning. Participant discussions around their transition choices echoed a sentiment from Joy's (2008) pilot study, wherein the participant indicated a sense of responsibility for their own medical decisions. This sense of personal responsibility intersects with the general sense that gatekeeping roles are problematic in therapy (see literature review). That is, clients report being perfectly able to make informed choices about their transitions, without needing approval from a mental healthcare practitioner.

Our participants also appreciated when therapists prepared them adequately for procedures such as surgery. This preparation came in the form of education and discussion. This echoes other findings that therapists can help clients adequately prepare for transition (Bess & Stabb, 2009; Elder, 2016). In contrast, other codes indicated that while one client received both information and support from a therapist, others experienced subtle indications that the therapist disapproved of gender affirming procedures.

Additionally, while some of the therapists described in this study were active advocates for their clients, writing letters and making appointments for them, other clients were able to obtain their letters elsewhere if necessary. This contrasts the experiences of participants in the United States, who often felt coerced into therapy with a particular provider in exchange for affirming

medical care. Ontarian therapists can provide beneficial logistical and administrative support for transitioning clients, but clients in this study did not appear to find their therapists' power to be as absolute as the reported experiences of TGNC Americans in therapy.

Emphasis on Gender. Participants discussed important topics, both related to gender and unrelated, that were covered in their therapeutic work. Accounts of gender-related topics, such as dysphoria, sense of self, and the impact of transition on relationships reflected some aspects of the existing literature. However, previous studies reflect more emphasis on how gender can be both over- and under-emphasized in therapy (see literature review). In discussions of medical care, this is colloquially known as 'Trans Broken Arm Syndrome,' wherein all medical issues – even unrelated ones, like a broken arm – are assumed to be due to the patient's transness (Payton, 2015). This issue was not particularly noted by participants of the current study. Some noted that it was helpful when their therapists adopted a whole-person view, which also reflects the existing literature body. Clients acknowledge that gender is an important aspect of identity, while also holding that it is only one facet of the whole self. We also explored client accounts of working through dysphoria and rejection from others to engage with self-discovery and a deeper understanding of the self.

Intersectionality. Originally coined to capture the unique experiences of Black women, intersectionality refers to the lenses of personal identity (such as race, gender, and class) overlap to influence lived experience and marginalization (Crenshaw, 1989). McCullough and colleagues (2017) explored intersectional concerns as they related to Black TGNC male participants. These individuals noted how some therapists understand transness, while others can discuss the racism experienced by Black men in America. However, it is difficult to find a therapist who can manage

both identities simultaneously. Jumarali (2022) points to the dearth of research on multiply marginalized communities in therapy as well.

Our study included only one participant of colour. However, one white participant also reflected on her relative racial privilege. Additionally, we investigated intersections of language, sexual orientation, family planning, and fatphobia. Several participants discussed the overlap of body image and gender dysphoria, as this intersection is difficult to navigate for TGNC individuals. Others noted how language, and particularly the French language, can make it difficult for people to understand non-gendered pronouns. This issue is of particular concern for Canadian TGNC people, as French is one of the two national languages in this country.

Suicide. One important topic of discussion, which is influenced by but not related to gender, was the topic of suicide. It is well documented that TGNC people are at higher risk of suicidality, due to dysphoria and minority stress. T. Israel and colleagues (2008) noted that LGBT participants found involuntary hospitalizations to be unhelpful. Similarly, Elder (2016) noted that restraints and over-medication were experienced negatively. Our work expands on these indications. Participants offered descriptions of what it was like to broach suicidality, discuss it, and make safety plans with their therapists.

Reactions and Impacts. As this work presents the only research on TGNC clients' experiences in therapy from a significant events framework, much of the extant literature does not explore the client's phenomenological experience of significant therapy moments. Furthermore, while T. Israel and colleagues (2008) explored the impacts of significant events for LGBT participants, their analysis did not explore subjective accounts of what the events were like. The researchers did indicate that helpful events sometimes positively impacted the therapy relationship, and unhelpful events often negatively impacted the relationship (T. Israel et al., 2008). We offer a

richer description of what their subjective experiences were, according to clients. For example, participants expressed feeling understood, relieved, and validated after helpful events, while hindering events were linked with anxiety, awkwardness, frustration, and hurt.

Similarly, T. Israel and colleagues (2008) explored how significant events impacted clients' relationships with themselves, skills such as insight, and quality of life. Additionally, Applegarth and Nuttall (2016) noted how participants valued a move from treatment to self-reliance through increased capacity to make their own decisions. These findings are reflected in our analysis of how clients integrated therapeutic skills, improved their relationships with the self, and changed their ways of being to support quality of life.

Processing and Understanding Events. The significant events framework may also investigate how clients made sense of the identified significant events. T. Israel and colleagues (2008) described how clients evaluated therapy overall, with helpful events improving perceptions and unhelpful events negatively impacting their opinions in general. Our results also explore how clients view therapy now, given the events they described, as well as what they learned from their experiences. Analysis also identified in-the-moment reactions to hindering events, such as self-doubt, self-defence, and retroactive evaluations of the therapist's skill and/or ownership of the problem. These findings reflect other work in the significant events research body. For example, clients report questioning their therapist's skills and feeling dissatisfied with the therapeutic process (Burton, 2018).

Contexts. Analyses of significant events also include contextual information. T. Israel and colleagues (2008) analysed how the therapist's title, the presenting problems, and participant 'outness,' among other factors, overlapped with positive and negative identified events. Other qualitative research described some contextual information as well, often around presenting

problems and where clients find their therapists. Some participants note how financial barriers and a lack of trans-affirming practitioners can impact one's ability to receive mental healthcare (F. Benson, 2019; Elder, 2016; J. Hunt, 2014). This finding is reflected in our results, wherein many participants discussed similar issues accessing care. Additionally, we explored contextual influences on healing (i.e. transitioning, life changes, and medication). COVID-19 emerged as a significant theme among participants. Participants described how the pandemic influenced their mental health and discussed implications for virtual therapy in comparison with in-person care.

Implications for Practice

The following section summarizes how the results of this research, along with the literature body, can inform therapeutic practice for TGNC clients in Ontario.

Alliance, identity, and understanding. Participants in this study and in the research body generally identified significant experiences relating to their therapist's attitude and personality. Clients expressed a need to feel safety, trust, nonjudgement, and kindness. Thus, the therapeutic alliance was once again identified as an important element of therapeutic work. Interestingly, participants offered varying opinions on whether identity-matched therapists provide a better counselling alliance. Many expressed feelings of solidarity among TGNC practitioners, while experiences with others in the queer community were variable. It should not be concluded, though, that straight and/or cisgender therapists cannot comprehend transgender people well enough to provide adequate therapy. Instead, therapists' attitudes towards transness emerged as a significant factor, as well as the client's subjective experience of feeling seen and understood.

Collaboration with clients. As with many other works about significant therapy events, our results demonstrate that clients have variable opinions on and expectations about how therapy should be conducted. However, as noted in research on hindering events, therapist feedback and transparency may help clients and therapists find agreement in these areas (Burton, 2018).

Feedback-informed practitioners posit that professional development occurs not from formal trainings, but from direct conversations on what works and doesn't, according to each individual client (Miller et al., 2015). Next steps then include reflecting on performance and deliberately trying to improve, based on what clients say they need. While feedback-informed practice most often employs 'routine outcome monitoring' in the form of post-session surveys, other methods for soliciting feedback are also possible. For example, a collaborative approach might include conversations where both therapist and client transparently discuss positionality and dialogically co-create change (H. Anderson, 2001).

Whether through structured surveys or ongoing conversation, a collaborative element is foundational to therapeutic success. Our analysis identified hidden judgements and inconsistent statements as hindrances to collaboration. That is, clients perceived that their therapists held certain biases which they tried to keep hidden. It is possible that these therapists were aware of and attempting to unlearn cultural biases, to privilege client viewpoints in the therapy room. Another potential explanation is that therapists were not aware of how their biases and assumptions were seen and felt by clients. This lack of transparency was noted by some, who found it hindering. Other participants appreciated that their therapists acknowledged the limits of their competencies. However, this was usually in conjunction with the therapist's willingness to research TGNC topics outside of the session. Educational burdening is a significant theme throughout the literature. It is not a client's job to explain the basics of transgender ways of being. Therefore, therapists might consider how best to evaluate and communicate their own levels of competency, while also seeking feedback to improve that competency through their own efforts. Clinicians in Ontario may start with foundational courses on LGBT2SQ healthcare such as those offered by Rainbow Health Ontario (n.d.).

Access to and preparation for transition. TGNC individuals seek therapy for many reasons. Participants in this study identified that one such reason is to explore gender identity, including how one's presentation and identity can affect relationships. Therapists can support TGNC individuals as they decide how to express themselves, how to come out to others, and how to stay safe, yet authentic, in different social circles. Other clients wished to weigh the choices involved with gender affirming medical care, such as hormones and surgery. Competent practitioners were able to provide information on the risks and benefits of various procedures, such that clients could make an informed decision. Other therapists made referrals to those who could provide more information, like endocrinologists or gender specialty clinics. These helpful actions require some level of knowledge on the clinician's part about how such care is managed.

In Ontario, an assessment and one or two letters, written by a clinician who can diagnose gender dysphoria, are required to receive OHIP funding for gender affirming medical care (Government of Ontario, 2023). The Centre for Addiction and Mental Health, or CAMH, in Toronto offers a clinic which provides the necessary assessments, letters, and referrals for surgery, but this clinic requires a referral from a physician (CAMH, 2023). Practitioners who are qualified (i.e. physicians, nurse practitioners) can take courses on how to write letters or make referrals through the Rainbow Health Ontario learning portal (Rainbow Health Ontario, n.d.). Other practitioners could research and understand some of the bureaucratic processes and medical procedures, including the potential risks and necessary recovery considerations, to better support clients who are making transition decisions. Additionally, understanding how different procedures affect fertility may be useful, as some participants noted in this work.

Finally, participants expressed the helpfulness of a therapist believing in and celebrating their clients' choices. That is, clients want not only to have control over their bodies, but also to

have their self-expression celebrated. A competent therapist may therefore seek understanding of both the difficulties and the joys of transition.

Handling body image. Trans bodies have historically and continually been sites for debate and outrage. This contentiousness overlaps significantly with societal anti-fat bias, and clients in this study explored the complex narratives of body image, dysphoria, diet culture, and fatphobia. Many recognized the importance of acknowledging fatphobia and fighting against disordered eating and body shaming. However, lines of variable solidity were drawn around the separate, but overlapping, issue of gender-related body dysphoria.

Additionally, participants discussed how fatphobia can present another barrier to accessing affordable medical care, such as surgery. Anti-fat bias shows up in many kinds of medical care, and ranges from physicians' lectures to overweight patients to misdiagnosis of severe, life-threatening conditions due to an assumption that a patient's weight is always the cause of poor health (Gordon, 2020). Matacin and Simone (2019) describe how fat activism might help to empower clients. It is worth exploring how social pressures of thinness and gender expression overlap, while also acknowledging that some individuals suffer dysphoria which could be treated with gender affirming care.

This topic was acknowledged by participants as difficult and contentious. As Asay (2020) writes, "There is an inherent friction and tension between the idea of a body that should not change and a body that needs to" (p. 6). Clients expressed how their therapists struggled to differentiate dysphoria and dysmorphia, trying to support body positivity. At the same time, many acknowledged that this was a personal struggle, to learn to love and accept their bodies while also seeking to change them medically. However, all participants who discussed this issue indicated that body acceptance doesn't necessarily change one's desire for gender affirming care. They

emphasized the personal nature of this internal conflict and felt hindered by therapists' attempts to push them towards one option or another. Therapists can use this information to reflect on how dysphoria and dysmorphia intersect, as well as how their own biases might colour perceptions of body size, gender affirmation, or both.

Accomplices in the fight against conversion therapy. Conversion therapy refers to the too-common attempt at 'treating' non-normative genders or sexual orientations to reduce or eliminate them. Green and colleagues (2020) compared suicidality in young LGBTQ+ people who had undergone conversion therapy and found that those who had experienced conversion efforts were twice as likely to report having attempted suicide. Indeed, activists have spoken out against conversion efforts for decades. Conversion therapy also reflects a narrow range of modern, Western mores, as evidence of sacred and celebrated gender diversity appears in every society for which we have historical record (Armstrong, 2021; Haldeman, 2022).

TGNC clients throughout the literature have expressed that their genders are not problems to be solved. In the present study, participants spoke of the subtle ways their therapists signalled disapproval and called their identity into question. Clients felt that their therapists' biases were clear, even as they noted the practitioner's attempts to appear neutral. Furthermore, even when therapists stated support, clients were surprised and disappointed by therapists' missed opportunities to validate authentic gendered expressions. These experiences indicate that for some, it is not enough for therapists to be 'open to' trans ways of being. These clients wish for active and explicit trans celebration.

Recently, Spiliadis (2019) posited a model of therapy that he supposed could provide a kind of middle ground between overly permissive affirmative practices and unethical conversion therapies. He called this method the Gender Exploration Model, or GEM. Ashley (2022) provides

an interrogation of this model, pointing to the problematic assertion that GEM is somehow neutral or unbiased, as well as the lack of clarity on its actual interventions, the underlying implications that TGNC identities are pathological, and the conceptual similarities of GEM to conversion therapy. This academic debate reflects a broader cultural problem wherein transphobic views are shielded by their proponents' assertion that they are 'just asking questions' (O'Neil, 2023).

Questions are not bias-free. Indeed, several participants in this study expressed exactly that sentiment. A therapist's questions can be experienced as an imbalance of power and left clients feeling hurt, confused, and doubting themselves. It is not possible for a therapist to be truly neutral, which reflects in the questions we choose to ask. Therapists who work with TGNC clients could reflect instead on their acquired assumptions around gender, biases they might need to unlearn, what they need to learn about transgender healthcare, and importantly, how they might know and understand transgender joy. For example, gender affirming surgeries are often seen as inherently harmful due to their permanent nature (see Spiliadis, 2019), but such moral panics tend to ignore the extensive benefits to individuals who choose to have them (e.g. Almazan & Keuroghlian, 2021; Owen-Smith et al., 2018; Wiepjes et al., 2018). Therapists may be interested to know that among the rare cases of de-transitioning (wherein someone undergoes gender affirming procedures and later reverses some of those changes), very few regret their initial decision to undergo surgery or hormones (MacKinnon et al., 2022; Urquhart, 2023). As we listen more to TGNC people's perspectives, therapists may be better suited to counteract the cultural biases that are trying to eradicate transness.

Suicide and survival. Therapists often feel the weight of keeping people alive long enough for them to heal psychologically. Participants in this study at times pointed to therapy as one of many factors which kept them from dying. They also noted that adequate medication, supportive

life circumstances, and access to transition care were also contributors. While some objected to aspects of safety planning, such as wellness calls or hospitalizations, most also acknowledged that these are necessary aspects of a therapist's responsibility to prevent harm to their clients. Objections were also raised around the relative lack of alternative crisis services, and around the lack of competent and affordable mental healthcare generally. As clients noted that therapy is, at times, essential to combatting suicidal ideation, the call for accessible care becomes even more pressing. Practitioners might explore advocacy at the provincial level, to inform policymakers of the intense need and dire lack of care. Meanwhile, it is important to assess and treat suicidality in all clients. TGNC individuals may be at higher risk, especially if they experience rejection or are waiting for affirmative care.

Limitations and Delimitations

This study provides an account of the significant therapy experiences of 11 individuals from Ontario, Canada, recruited through online posters on social media. Ten of these identified themselves as White, while one said they were racialized. Additionally, the age range comprised mostly young adults, from 22 to 44 years old (M=32.1). These results may not be representative of demographics outside the sample, especially transgender people of colour and adults older than middle-age. Additionally, for practical and safety-related reasons during the COVID-19 pandemic, recruitment and participation all took place online (i.e. participants were recruited from social media and interviewed over MS Teams). This decision to conduct research online undoubtedly excludes many potential participants who do not have access to or ability to use the required technology.

It is worth noting that participant inclusion required that the individual speak about at least one recent therapy experience (i.e., within the past five years) with whom they had undergone at least 10 sessions. The purpose of this criterion was to ensure a depth of experience,

and to investigate long-term therapy rather than assessments. However, it is unlikely that an individual who experiences serious harm in therapy will continue with that same therapist, or indeed, continue with any therapy. Additionally, it can be difficult for a client to criticize a therapist, especially after a long course of treatment (Paulson et al., 2001). The exclusion of participants with shorter-term therapy experiences may have limited the number or severity of the hindering events that participants reported.

Finally, we should acknowledge that Significant Events research usually focusses on a specific kind of process, with analysis around sequencing events and relating them to outcomes. We designed the research questions to elicit client accounts of what therapy processes they found to be significant, why they were important, and in what ways and contexts. However, we also chose an inductive design. That is, we invited participants to interpret what *significance* meant to them, without working from or towards a defined taxonomy of events. The results therefore reflect not only the identified helpful and hindering events, but also contextual information which enriches understanding of those events, centering client accounts of their own lived experiences, Future Directions

Future research might expand on the above findings in several ways. Firstly, a recreation of this work with purposeful sampling could include participants from more variable demographics, particularly transgender people of colour in Ontario. Additionally, an older or younger demographic might enrich our understandings of how mental health treatment can support those groups better. Finally, nonbinary participants in this study noted the significant differences that mark competency with binary TGNC people and those who do not fit within a male/female dichotomy. It would therefore be worthwhile to explore the experiences of nonbinary individuals in therapy.

The present work also describes several issues which warrant further, deeper investigation. For example, given that participants disclosed how difficult it can be to disentangle body image issues and gender-related dysphoria, more investigation is surely needed. Future work could explore how TGNC individuals navigate fatphobia, body image, dysphoria, gender affirming care, and mental health. Transgender studies may exclude fat bodies due to this complexity, while fat activism does not always embrace TGNC ways of being (Asay, 2020). How do fat transgender people experience this intersection?

Other intersections also provide a foundation for further work. In Canada especially, the overlap of gender and language is of particular interest. French-speaking individuals construct and use language differently, which might impact therapeutic co-construction around gender. Researchers could investigate how language affects the experiences of TGNC individuals in therapy with francophone practitioners.

Conclusion

Transgender and gender non-conforming individuals face unique challenges and bring unique resilience to the therapy room. Therapists have an essential role to play; this is both an honour and an immense responsibility. We are called to be supporters, to be in relationship with clients, and to advocate for their diverse ways of being. The transgender body is not a site of otherness and fear, but of freedom and expression. Similarly, TGNC people are unique, whole, and inherently worth knowing in all aspects of their identities. As a queer, nonbinary practitioner, I stand between and within my community and my practice. I call on my transgender siblings to know that I am listening. I call on my colleagues to hear us.

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Appendix A: Glossary of Terms

Cisgender: someone whose gender identity aligns with their assigned sex at birth

Cissexism: automatic and unconscious bias against transgender people, based in an assumption that cisgender identities are more acceptable, normal, or healthy than transgender identities – AKA transphobia or cisnormativity

Gender Dysphoria: designated in the DSM-5, dysphoria relates to the strong distress experienced by those whose primary and/or secondary sex characteristics do not align with their desired gender presentation. Not all transgender or gender diverse people experience dysphoria.

Gender (or Gender Identity): a personal or internal sense of gender as it relates to social categories, such as ”man” or ”woman” which comprises identity, presentation, and cultural interpretations.

Gender Presentation: the ways in which people socially express their gender identity through clothes, style, and behaviours.

Intersex: people whose sex characteristics do not fit typical definitions of male or female; they may be of any gender identity.

Nonbinary: an umbrella term referring to people whose gender identity lies outside the boundaries of a strict male-female dichotomy regardless of assigned sex at birth. Approximately 20% of TGNC Ontarians are nonbinary (Bauer & Scheim, 2015).

Passing: this refers to a transgender person’s ability to be perceived as the gender with which they identify, as well as their ability to be perceived as cisgender. TGNC people may seek to ‘pass’ to alleviate their own dysphoria, but many wish to ‘pass’ for their safety in public; that is, by appearing cisgender, a trans person can escape transphobic violence.

Sex (also known as assigned sex at birth): the reproductive phenotype which is determined (or assigned) based on genitalia, chromosomes, hormones, and/or secondary sex characteristics. Most people are either assigned male at birth (AMAB) or assigned female at birth (AFAB).

Sexual Orientation: indicates whether one is attracted to their same gender, other genders, both, or neither.

Stealth: while many LGBT people refer to being"in the closet," TGNC people may additionally refer to themselves as 'stealth,' indicating that they 'pass' as cisgender and have chosen not to disclose their transness.

Transgender and Gender-Nonconforming (TGNC): those whose gender identity does not align with their assigned sex at birth.

Transition: the process of socially and/or physically matching gender identity to gender expression and cultural perceptions – this can, but does not always, involve clothing, style, voice training, hormone therapy, surgery, etc.

Transnormative: the pervasive idea that TGNC experiences and expressions are homogenous, conforming as closely as possible to cisgender experiences and expressions.

Trans man: also known as"female-to-male" (or FTM) trans people, these are individuals assigned female at birth, but who have a male gender identity

Trans woman: also known as"male-to-female" (or MTF) trans people, these are individuals assigned male at birth, but who have a female gender identity

Appendix B: Semi-Structured Interview Protocol

Introduction: This interview is going to explore specific events in therapy. An 'event' in therapy is something that happened, such as an action or conversation, something you said or did, or something your therapist said or did. They can be from one course of therapy, or multiple, but they should all be from therapy which took place recently (within the last year).

Clinician Contexts

1 – Will you be talking about therapy with one clinician, or multiple?

For each clinician ask:

2 – Can you describe the context of the therapy with this clinician?

- What were your reasons for seeking therapy?

3 – Can you describe what the therapy was like overall?

- Location and modality (in-person or online)
- What your life was like then
- Your reasons for seeking therapy
- The goals you were working on
- The therapist's approach
- Your relationship with the therapist generally
- The outcomes of therapy (so far, if ongoing)

Significant Events: Now, I'd like to explore some of the important moments in your therapy process(es), and we'll discuss each one in detail. These events may have to do with gender identity, but they may not. An event can be anything that happened in session, including words and actions.

4 – First, what kinds of events in therapy have been important or helpful for you personally? Can you describe one (or more) of them in detail?

5 – Second, what kinds of events in therapy have been unhelpful or negative for you? Can you describe one (or more) of them in detail?

For each event, ask:

6 – Do you remember the session in which the event took place? What else was happening in the session?

7 – Do you have any sense of what preceded or caused this event? Can you describe that?

8 – How did you react to this event in the moment? What about later?

9 – In your view, what was the impact of this event on you personally?

10 – How did this event impact your view of the therapy?

11 – How do you feel talking about this event with me right now?

Appendix C: Demographic Survey

Thank you for agreeing to participate in this study! Please answer the following questions to the best of your ability. Use as many term(s) or descriptions that you'd like for each question. You may also choose not to answer any or all questions; this does not prevent you from participating in the rest of the project.

Please note – your answers to these questions will remain confidential regardless of your final level of participation in this study. Contact Rebecca McIntyre [contact information redacted] with any questions or concerns. Thank you again for your participation.

(1) What is your gender?

(2) What is your date of birth?

(3) What is your racial and/or ethnic identity?

(4) What is your sexual and/or romantic orientation?

(5) How would you describe your current socio-economic status?

(6) In what city or township do you reside?

(7) Have you ever been diagnosed with any illness, mental disorder, personality disorder, etc.? Please specify.

(8) What was your employment status and economic status at the time of the treatment in question?

(9) For each therapy experience that you wish to speak about in this study, please indicate the following:
   a. The practitioner's title (i.e., social worker, psychiatrist, etc.):
   b. The practitioner's work setting (i.e., private practice, group practice, agency, hospital, etc.):
   c. Other demographic information about the practitioner (approximate age, race, gender, etc.):
   d. Your main reason for seeking therapy with this practitioner:
   e. The number of sessions you underwent with them:
   f. The date range of treatment with them:
   g. The modality of treatment (online or in-person; individual, family, group):

(10) Have you had other therapy experiences that you don't wish to speak about, or which do not fit the criteria for this study (i.e., not recent enough, not enough sessions completed)? Please state the following for each of these experiences:

a. The practitioner's title (i.e., social worker, psychiatrist, etc.):
b. The practitioner's work setting (i.e., private practice, group practice, agency, hospital, etc.):
c. Your main reason for seeking therapy with this practitioner:
d. The number of sessions you underwent with them:
e. The date range of treatment with them:
f. The modality of treatment (online or in-person; individual, family, group):

Appendix D: Screening Questionnaire

Thank you for your interest in participation! Please answer the following questions to determine your eligibility for this study.

(1) Are you over the age of 18? Yes ☐ No ☐

(2) Do you speak English fluently? Yes ☐ No ☐

(3) Are you transgender and/or nonbinary and/or gender non-conforming? Yes ☐ No ☐

(4) Have you undergone individual psychotherapy with a practitioner who was (at the time of your treatment) registered to practice psychotherapy in Ontario? *This may include psychotherapists, social workers, psychologists, and psychiatrists.* Yes ☐ No ☐

(5) Did you attend at least 10 sessions with this practitioner? Yes ☐ No ☐

(6) Did at least one session take place within the last 5 years? Yes ☐ No ☐

(7) Were you a resident of Ontario during this experience with therapy? Yes ☐ No ☐

Please note – your answers to these questions will remain confidential regardless of your final level of participation in this study. Contact Rebecca McIntyre [contact information redacted] with any questions or concerns. Thank you again for your interest in this project.

Appendix E: Recruitment Email Templates

Permission to post recruitment poster

To whom it may concern,

I'm a Master's candidate at the University of Ottawa, studying to become a psychotherapist. I'm conducting a small qualitative research project about trans people's experiences of therapy in Ontario, including the harmful and helpful events that they encounter. I'd like to ask your permission to post a flyer inviting people to participate. I'll attach the flyer here; please let me know if it would be okay for me to post it. Thanks very much!

Rebecca McIntyre (she/they)
M.A. Candidate in Counselling Psychology at the University of Ottawa

<Attachments: Recruitment Poster>

Respond to interest

Hello, and thank you for your interest in this research project!

First things first: I'm attaching a consent form for you to fill in. It explains the purpose of this study, how participation works, potential risks and benefits, confidentiality procedures, and other important information. Please read it in full before continuing with this project. If you'd like to participate, you can sign the form and return it to me at this email address.

To determine your eligibility for this study, I am also attaching a brief screening questionnaire. Please fill it out (it should take less than 5 minutes) and return it to me alongside your consent form. If you fit the participation criteria, I'll get back to you with an offer of participation, and we can set up a time to complete the next step. If you don't fit the criteria, I'll let you know that too. In any case, your answers to this questionnaire will remain completely confidential.

Thanks again, and I look forward to hearing from you soon.

Rebecca McIntyre (she/they)
M.A. Candidate in Counselling Psychology at the University of Ottawa

<Attachments: Consent Form & Screening Tool>

Respond to interest: no more participants needed

Hello, and thank you for your interest in this research project! We have reached capacity for participation, and no longer require volunteers. Please let me know if you have any questions or concerns.

Thank you,
Rebecca McIntyre (she/they)
M.A. Candidate in Counselling Psychology at the University of Ottawa

Respond to screening tool: non-eligible

Thank you for returning the screening questionnaire. Unfortunately, one or more of your responses to the screening questionnaire make you ineligible to participate. Your information will remain confidential. I will delete your responses from my research records, as well as any correspondence. Please let me know if you have any questions or concerns.

Thank you,
Rebecca McIntyre (she/they)
M.A. Candidate in Counselling Psychology at the University of Ottawa

Respond to screening tool: eligible/invitation to participate

Hello,

Thank you for returning the screening questionnaire and consent form! You are eligible to participate in this project. If you decide to continue your participation, we can now set up a time to meet (online, via MS Teams) to conduct an interview about your experiences in therapy.

The interview should take between 60 and 90 minutes. I will record the audio of our meeting, which I will use to transcribe the information. After transcription, the audio will be deleted and all identifying information will be removed from the transcript. The transcriptions will then be analyzed by the researchers for themes and meaning.

Generally, I am free any weekday between 9 AM and 4 PM. I'm also free most Monday and Tuesday evenings between 4 PM and 7 PM. I have limited availability on Saturdays, from 11 AM until 6 PM. Please let me know two or three times that work best for you to meet with me online, preferably in the next week or two.

Additionally, I am attaching a short demographic questionnaire. This questionnaire will help us provide transparency about the applicability of our research to various intersections of the trans

community. You can complete this and return it to me here. Your answers will be stored using your ID number only, not your name, for confidentiality purposes.

Finally, as a token of appreciation, I would like to offer you a gift card (of $25 value) to a store of your choice, as long as gift cards are available for online purchase. Please let me know where you'd like to spend your gift and I will send it to your email.

Please return your demographic questionnaire at your convenience, and do let me know your availability for an interview as soon as you can.

Thank you,
Rebecca McIntyre (she/they)
M.A. Candidate in Counselling Psychology at the University of Ottawa

<Attachments: Demographic Survey>

Appendix F: Recruitment Poster Text

Transgender Clients of Therapy…We want to hear from you! Our study seeks to understand how trans people in Ontario experience psychotherapy, including both positive and negative experiences. Reach out to participate* if:

- You are transgender, nonbinary, or otherwise gender non-conforming
- You've been engaged in long-term individual psychotherapy (i.e. more than 10 sessions) within the past 5 years
- You live in Ontario, Canada
- You're over 18 years old
- You feel comfortable sharing the helpful and harmful aspects of your therapy experience

About the project: participants will complete a short demographic survey, followed by an online interview (approximately 60-90 minutes) with the researcher, to explore significant events in psychotherapy

Contact: Rebecca McIntyre, Master of Arts candidate in counselling psychology, University of Ottawa [contact information redacted]

*Up to 12 participants who fit the criteria will be retained on a 1st come, 1st served basis. Volunteers who are selected for participation will receive a $25 gift card as thanks!

This project is supervised by Dr. Anne Thériault, Ph.D. [contact information redacted]

This project has received approbation by the University of Ottawa's Social Sciences and Humanities Research Ethics Board

Appendix G: Informed Consent Form

Significant Events in Psychotherapy from the Viewpoint of Transgender Clients

Researchers:
Rebecca McIntyre, M.A. Candidate in Counselling Psychology, Faculty of Education, University of Ottawa [contact information redacted]
Supervised by Anne Thériault, Associate Professor, Educational Counselling, Faculty of Education. [contact information redacted]

Invitation to Participate: I am invited to participate in the abovementioned research study conducted by Rebecca McIntyre and supervised by Anne Thériault.

Purpose of the Study: The purpose of the study is to explore how transgender and gender nonconforming (TGNC) Ontarians experience therapy, including the harmful and helpful events that they encounter.

Participation: My participation will consist of one interview session that will last approximately 60-90 minutes and that will be conducted on MS Teams. The interviewer will ask me about significant moments, both helpful and harmful, that took place in therapy. I will also be asked to complete a demographic questionnaire prior to the interview.

Risks: The risks involved in participating in this study are minimal. My participation in this study will entail that I volunteer personal information. I might feel some discomfort (anxiety or sadness) when recalling harmful moments of therapy or when thinking of the stigma against transgender people. If this is the case, the following crisis intervention services are available to me:

- **Wellness Together Canada** provides free, phone-based counselling. This non-emergency service is available 24/7. Call 1-866-585-0445 or text"wellness" to 741741
- **Distress and Crisis Ontario** provides chat- and text-based support from 2PM to 2AM daily. Chat online at DCOntario.org, or text"support" to 258258
- **Trans Lifeline** provides peer support to trans people. The helpline is open 24/7, but operators are only guaranteed from 5 PM to 1 AM. Call 1-877-330-6366 to speak with a peer support volunteer. For more information and resources, visit TransLifeline.org

Benefits: My participation in this study will allow me to reflect upon the experience of therapy as a TGNC person. Other benefits will be mostly indirect; my responses will contribute to the accumulation of knowledge related to unhelpful and hindering moments in psychotherapy. This knowledge will be used for the betterment of therapy services generally for other TGNC individuals. This research may inform practitioners in Ontario to better serve TGNC clients and to navigate potential harms

Confidentiality: I have received assurance from the researcher that the information I will share will remain strictly confidential. My responses to all questionnaires and interview questions will be kept private. Wherever possible, my name will be replaced by an ID number (for data collection) or a pseudonym (in the analysis and written reports).

Consent to record: I understand that the interview will be audio-taped and transcribed for the purpose of data analysis. The interview will also be videotaped but the images will not be used for research purposes. The video will be used to clarify any unclear verbal exchanges.

Conservation of data: The data collected via the interview and questionnaires will be kept in a secure manner. The questionnaires, transcripts, and demographic data will be stored in password-protected files on a USB drive, stored under lock and key in the researcher's office (Rebecca McIntyre). Only the two researchers involved in the study will have access to these materials. In five years, the electronic files will be erased using secure means.

Compensation: This study is not financially compensated, however, eligible participants will receive a $25 gift card to a store of their choice, so long as there is an option for online purchase of a gift card. I will receive this token of appreciation when and if I am chosen for participation. Participants are chosen based on eligibility criteria set out in the screening questionnaire, and based on a first-come first-served basis. If I choose to withdraw from the study after being chosen for participation, I will still receive this gift.

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 withdraw participation or refuse to answer questions, I will still receive the financial token of appreciation as outlined above. If I choose to withdraw, all data gathered prior to the withdrawal will be destroyed.

Acceptance: I, _____, agree to participate in the above research study conducted by Rebecca McIntyre, which research is under the supervision of Anne Thériault from the Faculty of Education.

If I have any questions about the study, I may contact the researchers.

If I have any questions regarding the ethical conduct of this study, I may contact the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 154, Ottawa, ON, K1N 6N5
Tel.: (613) 562-5387
Email: ethics@uottawa.ca

I may keep a copy of this consent form for my records.

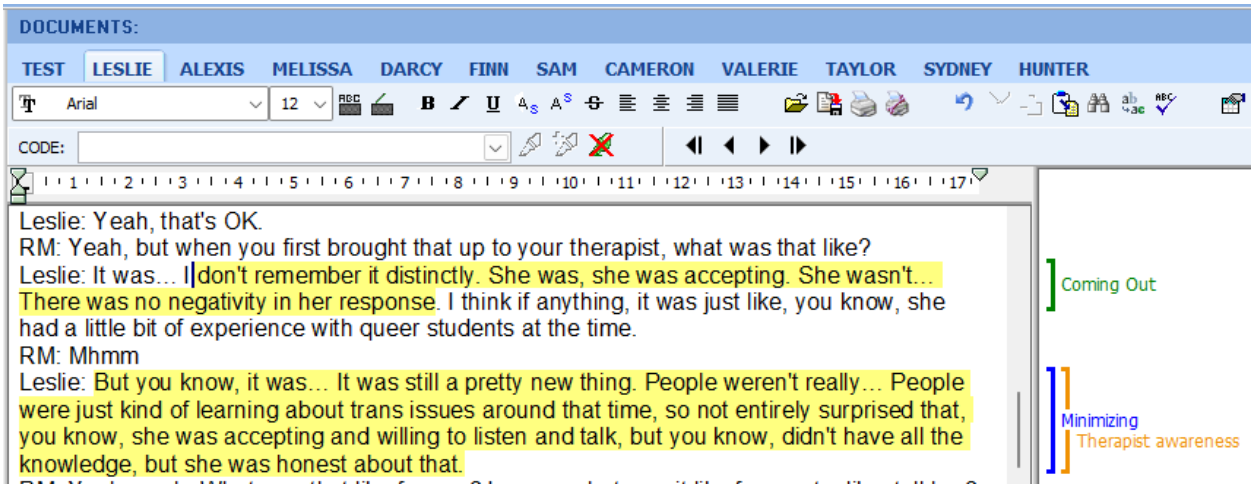
Participant's signature: _____ Date: _____

Researcher's signature: _____ Date: _____

Appendix H: Demonstrating the Coding and Refinement Process

The following is an example of the text coding, retrieval and comparison, and refining process, aided by the QDA Miner software (Provalis Research, 2023). To illustrate the process, I will outline how I identified and organized text segments relating to *coming out.*

At first, I analysed the transcripts in Microsoft Word, highlighting and commenting on important text segments. Then I uploaded the transcripts to QDA and used the software to tag these identified segments with codes and/or themes, as shown in this screenshot:



Using the QDA software, I was able to retrieve all segments, across all 11 transcripts, which were tagged with 'coming out.' This yielded 271 unique text segments. I then read through these segments and began sorting them into separate codes. In the first attempt, I identified nine separate codes related to coming out, which I organized into two themes:

Preliminary Theme	**Preliminary Codes**
Coming out to Self	Dysphoria
	Exploring gender
Coming out to Others	Coming out to the therapist
	Coming out to family
	Coming out to friends
	Coming out to coworkers
	Reaction to coming out: rejection

	Reaction to coming out: acceptance
	Coping with rejection

This process was then repeated: I tagged the text segments with their relevant code(s) and then retrieved all segments tagged with that code. I repeated this process of tagging, retrieval, and refinement four times using the QDA software. The first refinement largely involved creating new codes to better identify the different aspects of coming out; later refinements collapsed some similar codes together using QDA's built-in tree structure to organize levels of coding and themeing. For example, in the second refinement, I collapsed the codes of 'coming out to family,' 'coming out to friends,' and 'coming out to coworkers' into one code, 'coming out to others.' This was later combined with another code, becoming the final identified code, 'impact of transition on significant relationships,' under Theme 3, Processing Specific Issues in Therapy.

Finally, this table highlights how I coded and organized the various ideas under the umbrella idea of 'coming out' (relevant sections taken from the conceptual order in Appendix I):

Theme	**Sub-Theme**	**Code**
Client Perceptions of Therapists' Gender Beliefs	Perceived Attitudes Towards Transness	Reactions to coming out
Processing Specific Issues in Therapy	Gender	Dysphoria
		Sense of self
		Impact of transition on significant relationships
	Transition support	Transition anxiety
Long-Term Helpful Impacts on Clients	Integrated therapy skills	Building healthier boundaries
	Relationship with self	Self-empowerment
	Changed Ways of Being	Living authentically

Over time, I identified that the concept of coming out to one's therapist - a code which remained throughout each refinement - was an important factor in a client's assessment of the therapist's

attitude towards and perception of transness. The idea of 'coming out to self' was integrated under the theme Processing Specific Issues in Therapy, and the sub-theme of Gender. Two codes – 'dysphoria' and 'sense of self' – represent how clients and therapists unpacked the process of recognizing understanding one's own gender. As previously stated, the code 'impact of transition on significant relationships' corresponds to how clients and therapists discussed coming out to others, as well as other impacts that their transitions may have had on relationships. Similarly, the code 'transition anxiety,' under the sub-theme Transition Support, captures how clients and therapists discussed a client's concerns about their transition, such as coming out to others. Other preliminary codes – participant descriptions of acceptance or rejection on coming out – were included in discussions under theme 7, Long-Term Helpful Impacts on Clients. Participants discussed how unpacking others' reactions to their gender led, at times, to a better sense of individuation, more self-empowerment, and the courage to live authentically. Thus these ideas were included within the codes 'building healthier boundaries,' 'self-empowerment,' and 'living authentically.'

In sum, the QDA software simplified the construction and revision of codes and themes by easily retrieving the text segments relevant to each tagged idea. I used these composite documents to analyse the coherence, uniqueness, and overall fit of each code and theme within the analysis (Braun et al., 2019).

Appendix I: Conceptual Ordering

Theme	Sub-Theme	Code
Helpful and Hindering Relational Gestures	Professionalism	Confidentiality
		Scheduling and communication
		Boundaries
	Rapport	Kindness
		Listening skills
		Safety and trust
		Nonjudgement
		Openness
	Collaboration	Client agency
		Consistency
		Feedback
Expectations about the Therapist's Role	Session Structure	Directiveness
		Links between sessions
		Questions
		Pace
	Therapeutic Procedures	Unpacking
		Gentle confrontation
		Psychoeducation
		Problem-solving
		Relationship skills
Therapist's Perception of Transness	Attitudes towards transness	Reactions to coming out
		Cisnormative assumptions
		Transphobic views
		Support and celebration
	Competency with trans clients	Educational burdening
		Identity matching
		Competency with nonbinary clients
Topics in Therapy	Gender	Dysphoria
		Sense of self
		Impact of transition on significant relationships
	Transition support	Transition anxiety
		Medical decisions
		Surgery preparations
		Active support for transition
	Intersectionality	Language
		Race

		Orientation
		Family planning
		Body image & fatphobia
	Suicide	Approach to suicide
		Treatment
		Safety plans
Significant Relational-Emotional Experiences	Helpful relational experiences	Affinity
		Emotional relief
		Validation
	Hindering relational experiences	Anxiety
		Awkwardness
		Frustration
		Hurt
Significant Event Impacts on the Client	Integrated therapy skills	Introspection and insight
		Individuation
		Mindfulness
		Emotional regulation
	Relationship with self	Empowerment
		Self-talk
	Long-term changes	Authenticity
		Improved relational capacity
		Survival
Client Processes in Understanding Significant Therapy Events	Reactions to therapist ineptitude	Self-doubt
		Self-defense
		Termination
	Evaluations	Critiques
		Excusing the therapist
		Appreciation
	Retrospective appraisal of therapy	Learning experiences
		Faith in Therapy
Contexts	Healing beyond therapy	Transition
		Life changes
		Medication
	COVID-19	Pandemic impacts
		Virtual therapy
	Access and privilege	Availability
		Financial access