An Exploration of the Experience of Irish Psychotherapists working with Transgender Clients. A phenomenological study

By

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# Table of Contents

List of Tables .................................................................................................................. iii

Abstract .............................................................................................................................. iv

Acknowledgements ........................................................................................................... v

Chapter One: Introduction ............................................................................................. 1

1.1 Background ............................................................................................................... 1

1.2 Context ...................................................................................................................... 2

1.3 Aims and Objectives ............................................................................................... 5

Chapter Two: Literature Review .................................................................................... 6

2.1 Gender Identity ....................................................................................................... 6

2.2 Issues and Challenges for Transgender People ....................................................... 7

2.3 Psychotherapy for Transgender Clients .................................................................. 9

2.4 The Psychotherapist’s Role ................................................................................... 11

2.5 Guidelines for Psychotherapists Working with Transgender Clients .................... 12

2.6 Issues and Challenges for the Psychotherapist ...................................................... 13

Chapter Three: Methodology ......................................................................................... 18

3.1 Research Aim ......................................................................................................... 18

3.2 Research Design .................................................................................................... 18

3.3 Rationale for a Qualitative Approach ................................................................... 18

3.4 Sample .................................................................................................................... 20

3.5 Recruitment .......................................................................................................... 21
3.6 Method of Data Collection ................................................................. 22
3.7 Method of Data Analysis ................................................................. 23

Chapter Four: Findings ........................................................................ 24
4.1 Introduction ..................................................................................... 24
4.2 Theme One: The Therapist’s Identification with Transgender Clients ........................................ 25
4.3 Theme Two: The Maternal / Paternal Countertransference ..................................................... 30
4.4 Theme Three: The Symptom of Confusion in the work with Transgender Clients ...... 36

Chapter Five: Discussion ..................................................................... 41
5.1 Introduction ..................................................................................... 41
5.2 Theme One: The Therapist’s Identification with Transgender Clients ........................................ 41
5.3 Theme Two: The Maternal / Paternal Countertransference ..................................................... 45
5.4 Theme Three: The Symptom of Confusion in the work with Transgender Clients ...... 49
5.5 Benefits experienced by Therapists ........................................................................... 52

Chapter Six: Conclusion ...................................................................... 54
6.1 Conclusion ...................................................................................... 54
6.2 Strengths and Limitations ................................................................. 55
6.3 Suggestions for Further Research ........................................................................... 55

References

Appendix
List of Tables

Table 1: Demographic of Sample .................................................................22
Abstract

Transgender and gender questioning people represent a unique group of clients who present specific challenges for psychotherapy. These clients experience a wide range of issues, some are gender specific while other issues are common among the wider population. This qualitative research paper explores the experiences of Irish psychotherapists working with transgender clients. It examines the subjective experience of three participant therapists and endeavours to make sense of the phenomenology that emerges from semi structured interviews. The phenomenological analysis of the data collected, results in three salient themes emerging. These themes are: (i) The therapist’s identification with transgender clients, (ii) The maternal/paternal countertransference and (iii) The symptom of confusion in the work with transgender clients. Strong identification with transgender people seems to act as a catalyst for psychotherapists to engage in this specific type of work. Their maternal/paternal countertransference effects the therapeutic approach and style of alliance they adopt. The symptom of confusion within the therapeutic space, reflects the client’s, the therapist’s and wider society’s confusion around transgenderism’s place within a binary culture.
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I wish to thank my family and friends who have supported me over the past four years. Particular mention must go to my husband, Stephen, who has been by my side every step of the way, encouraging me and reassuring me when I needed it the most. Finally, I wish to thanks our darling baby son, Luka, for allowing Daddy to spend so much time studying. I’m all yours now.
“Is IT a boy or a girl?” tends to be the first question asked when a baby is born. And a cursory look at the genitals usually provides the answer - quote from Vanessa Baird, *The No-nonsense guide to sexual diversity* (2007)

1.1 Background

In the last two decades, Ireland has slowly but steadily made significant advancement in the civil and legal rights of its Lesbian, Gay, Bi-sexual, Transgender and Intersex (LGBTI) citizens. As a direct consequence of these developments, Ireland has evolved from a society noted for being LGBTI oppressive to being considered internationally as a forerunner in ensuring the equal civil rights of LGBTI people (Higgins *et al*. 2016, p.21). “Indeed, there are few areas of the law that reflect so emphatically the transformation of Irish society in the course of the last three decades”, Fergus Ryan (2014, p.55).

Notwithstanding this, it must be acknowledged that these legislative developments may not equate to improved everyday experiences for all LGBTI people in all aspects of their lives. The available research both internationally and nationally has consistently demonstrated that LGBTI people remain a particularly ‘at risk’ cohort of the population who not only experience elevated rates of mental health difficulties, but do so in part as a result of minority stress (Higgins *et al*. 2016, p.29).

Higgins *et al*, suggest that a vast amount of prior research has collated lesbian, gay, bisexual, transgender, and intersex people into one seemingly homogenous group. This collation has, in
many instances, promoted the perception that the issues and the extent to which they experience them are the same for and across all LGBTI people (2016, p.30).

However, emerging evidence suggests that the experiences of LGBTI people are very different to one another, not least with respect to their mental health and to public attitudes towards them (Higgins et al, 2016, p.30).

1.2 Context

This research paper coincides with the relatively recent publication of two significant documents relating to aspects of mental health among the transgender community.

In December 2015, the American Psychological Association (APA) published its Guidelines for Psychological Practice with Transgender and Gender Nonconforming People. The purpose of that document was to assist psychologists in the provision of culturally competent, developmentally appropriate, and trans-affirmative psychological practice with Transgender and Gender Nonconforming (TGNC) people (APA, 2015). Whereby, trans-affirmative practice is the provision of care that is respectful, aware, and supportive of the identities and life experiences of TGNC people (Korell & Lorah, 2007).

The second paper, The LGBTIreland Report (Higgins et al, 2016), was officially launched in March 2016 by Dr. Mary McAleese. This report was carried out by Professor Agnes Higgins and her team from Trinity College Dublin and it provides detailed findings of a national study of the mental health and wellbeing of lesbian, gay, bisexual, transgender and intersex (LGBTI) people in
Ireland, with a special emphasis on young people. The report was commissioned by GLEN (Gay and Lesbian Equality Network) and BeLonG To, and funded by the HSE’s National Office for Suicide Prevention (NOSP).

These two publications highlight the vital role that psychotherapy can play in supporting positive mental health and wellbeing for the LBGTI community. They offer further insight into the specific mental health needs of the transgender community in particular. The LGBTIreland Report shows that within the wider LBGTI community the sub-groups of “transgender” and “intersex” people are the most vulnerable.

The LGBTIreland Report (2016) showed that over 48% of transgender participants had self-harmed (p.110) and over 75% had considered taking their own life (p.118). Transgender Equality Network Ireland’s (TENI) study in 2013, Speaking from the Margins: Trans Mental Health and Wellbeing in Ireland, found high levels of stress (83%), depression (82%), and anxiety (73%) among transgender participants. These figures are much higher than in people who are not transgender (p.29).

Collins and Sheehan (2004), explored the health needs of trans people and health service responses to these needs in an Irish context. The findings suggested that trans people encounter significant difficulties in accessing appropriate health care. Findings from the report include, stigma, exclusion, and the underdevelopment of policy and practice to provide for transgender people (McNeil, Bailey, Ellis & Regan, 2013).
This report highlighted that working with the transgender sub-group of the LGBTI community presents unique challenges and opportunities for the mental health profession. Not least of these is the psychotherapist’s awareness around his or her own attitudes towards gender identity and gender expression. Cultural differences between psychotherapists (psychologists) and their clients, have a clinical impact (Isreal, Gorcheva, Burns, & Walther, 2008; Vasquez, 2007).

In addition, a lack of knowledge or training in providing affirmative care to transgender or gender nonconforming people (TGNC) can limit the psychotherapist’s (psychologist’s) effectiveness and perpetuate barriers to care (Bess & Stabb, 2009; Rachlin, 2002).

A nonbinary understanding of gender is fundamental to the provision of affirmative care for TGNC people (APA, 2015). Services that psychotherapists provide to TGNC clients require an understanding of this population and its needs, as well as the ability to respectfully interact in a trans-affirmative manner (Carroll, 2010).

In light of this information, the author believes that the psychotherapy profession and Irish society in general, must seek to educate themselves about the specific factors that impede the mental wellbeing of each sub-group within the LGBTI community, so that we can contribute to their positive affirmation and support them to live an authentic life. There are notable deficits in our knowledge surrounding the experience of transgender people attending psychotherapy in Ireland. This absence of comprehensive research is true from the perspectives of both the client and the therapist.
1.3 Aims and Objectives

In acknowledging this deficit of knowledge, the author has undertaken this present study entitled, “An exploration of the experience of Irish psychotherapists working with transgender clients. A phenomenological study” with the following aims:

- To gain a deeper insight into the subjective experience of Irish psychotherapists working with transgender clients
- To explore the challenges faced and benefits gained by psychotherapists working with this minority group.

It is a qualitative research paper, using Interpretational Phenomenological Analysis (IPA) to examine the subjective experiences of therapists working with transgender people. The research sets out to identify and make sense of the phenomenology that emerges from the experience of a sample group of three accredited psychotherapists working in the Dublin region.

The main objective of this research is to explore the therapists’ understanding of their work with transgender clients with reference to aspects such as transference, countertransference and the working alliance. It seeks to identify and make sense of the key themes that emerged from the phenomenology of the sample group, so that it may inform the field of psychotherapy in Ireland as to the specific implications of working with transgender clients.
CHAPTER TWO: LITERATURE REVIEW

2.1 Gender identity

In many cultures and religious traditions, gender has been perceived as a binary construct, with mutually exclusive categories of male or female, boy or girl, man or woman (Mollenkott, 2001). These mutually exclusive categories include an assumption that gender identity is always in alignment with sex assigned at birth (Bethea & McCollum, 2013).

“A much richer, more diverse reality exists. It includes female-to-male (FTMs) and male-to-female (MTFs) transsexuals; transvestites or cross dressers; intersexuals or hermaphrodites (born with ambiguous genitalia). It includes people who are transgendered in the sense that they live their lives as a gender different from their biological sex but have done nothing to alter their biology; people who had partial or total gender reassignment through surgery and hormone therapy; others who have elected for hormone therapy alone. And if that is not quite complex enough, some trans people describe themselves as ‘male-to-male’ or ‘female to female’ to reflect the feeling that they have always deep-down been the gender they feel themselves to be, regardless of social or biological assertions to the contrary” (Baird, 2007, p.125).

Gender identity is defined as a person’s deeply felt, inherent sense of being a girl, woman, or female; a boy, a man, or male; a blend of male or female; or an alternative gender (Bethea & McCollum, 2013).
Janet Mock is a transgender woman who has written extensively on the topic of gender. She explains that “Gender and gender identity, sex and sexuality, are spheres of self-discovery that overlap and relate but are not one and the same. Each and every one of us has a sexual orientation and a gender identity. Simply put, our sexual orientation has to do with whom we get into bed with, while our gender identity has to do with whom we get into bed as”. (Mock, 2014, p.50).

Therefore, for Transgender and Gender Nonconforming People (TGNC) people, gender identity differs from sex assigned at birth to varying degrees, and may be experienced and expressed outside of the gender binary (Harrison, Grant, & Herman, 2012). “The fact that many transgendered people, post-therapy or operation, are also gay or lesbian, is especially puzzling to the heterosexual mainstream”, (Baird, 2007, p.124).

Janet Mock (2014) expresses the view that “we must abolish the entitlement that deludes us into believing that we have the right to make assumptions about people’s identities and project those assumptions onto their gender and bodies” (p.254).

2.2 Issues and Challenges for Transgender People

In 2013, the Transgender Equality Network of Ireland (TENI) commissioned a report entitled, Speaking from the Margins: Trans Mental Health and Wellbeing in Ireland. This report showed that unemployment was high among the 164 trans participants, with only half employed part-time or full-time. Almost half had experienced some problems in work due to their trans status. More than 70% of participants considered media portrayals of trans people to be negative, and 40% stated that these representations negatively affected their emotional wellbeing or mental health (McNeil et al, 2013, p.8).
TENI’s report (2013, p.10) refers back to the Health Service Executive’s (HSE) 2009 report, which identified key health issues for trans people. These issues included, isolation, fear, stigma, physical violence and family rejection contributing to depression, anxiety, substance misuse, self-harm and suicide.

The 2009 report also states that trans people experience multiple discriminations – for example, where trans person also identifies as LGB, has a disability or is an ethnic minority. Furthermore, it identified an absence of designated gender specialists to coordinate delivery of national trans health services and a limited provision of psychological support services for the trans person’s family members and significant others. A limited availability of essential health services – surgeons, post-operative care, endocrinologists, psychiatrists and therapists, was also raised. On a more practical note, the prohibitive costs for gender reassignment treatment such as laser hair removal/electrolysis also created barriers for trans people’s wellbeing (HSE, 2009).

The LGBTIreland Report (2016) shows transgender people to be in the highest risk groups across many mental health issues. They are more likely to self-harm, to consider ending their life and to attempt suicide than other sub-groups of the LBGTI community. The report found that intersex people have the highest scores of depression, anxiety and stress followed closely by transgender people. The findings also show that transgender people face additional challenges in their day-to-day lives with approximately 60% having had someone use the wrong pronoun to refer to their gender and only 40% of transgender people feeling safe to express their gender identity in public, with 1 in 10 saying they would never do it.
Wider research echoes these findings, it documents the extensive experience of stigma and discrimination reported by transgender people and the mental health consequences of these experiences across their life span, including increased rates of depression and suicidality (Grant et al., 2011). Transgender people’s lack of access to trans-affirmative mental and physical health care is also noted as a common barrier. In worst case scenarios, transgender people are being denied care because of their gender identity (Xavier et al., 2012).

The LGBTIreland Report (2016) further shows that transgender people continue to experience victimisation and harassment in their day-to-day lives and that there had been no significant reduction in these experiences over the previous seven years since the Supporting LBGT Lives Study (Maycock et al, 2009). While a significant number of LGBTI people experienced some form of victimisation in public because of the LGBTI identity, there were different levels of harassment and violence experienced by LGBTI people. The findings showed that gay men, transgender people and intersex people experienced the highest levels of harassment and violence in public.

2.3 Psychotherapy for Transgender Clients

Despite high rates of stress, depression and anxiety, almost half of 164 respondents in TENI’s 2013 research, reported avoiding seeking urgent help or support when distressed. They reported often avoiding mental health services, due to prior negative experiences (McNeil et al., 2013).

This is of concern to our profession, as psychotherapy can support transgender clients in many ways. These supports include providing the client with a greater understanding of the meaning they afford to gender, as a construct in relation to themselves and society. Another valuable
element of support, is to enable the client to attain stability and acceptance of their gender role which may or may not, correlate with their biological sex and may or may not, fit within the binary framework of gender (Rachlin, 2002).

The provision of the therapeutic relationship allows for support, with the aim of exploring and sharing the meaning behind an individual’s experience. According to Fraser (2009), the issues that emerge in psychotherapy with transgender clients are about the true self and the self in relation to conveying one’s identity, with the outer reality as a transgender self, which is often unavailable to society and the outside world.

Transgender clients seek therapy for a variety of both general and gender specific reasons, including self-exploration, help with specific mental health symptoms, coping with life stressors, gender distress, and support in transitioning to one’s self-identified gender. Other experiences include, stress associated with the aggression and oppression encountered on a daily basis, for help in exploring their gender, or for personal growth and wellbeing and other concerns not necessarily related to their gender. Psychotherapy is a tool that can provide support. Its usual goal is to achieve a long-term stable lifestyle with realistic chance for success in relationships, education, employment and gender identity (Rachlin, 2002).

The LGBTIreland Report (2016) states that, knowing they would be supported and accepted by family, friends and others has helped LGBTI youth to come out. Furthermore, greater visibility of LGBTI people and more accepting attitudes are linked with an easier right-of-passage for young LGBTI people.
2.4 The Psychotherapist’s Role

Rachlin (2002) writes that, many transgender individuals experience a number of unique social stressors, which can be addressed in therapy. Psychotherapy therefore has a multifaceted role in gender transition. Only after a therapist has established a good working relationship with the client, should they begin to work on the initial goals. It is important to note at the outset that no educational, psychotherapeutic, medical or surgical therapy can permanently eradicate all vestiges of the person’s original sex assignment gendered experience.

A non-binary understanding of gender is fundamental to the provision of affirmative care for TGNC people. Psychotherapists are encouraged to adapt or modify their understanding of gender, broadening the range of variation viewed as healthy and normative. By understanding the spectrum of gender identities and gender expressions that exist, and that a person’s gender identity may not be in full alignment with sex assigned at birth, psychotherapists can increase their capacity to assist TGNC people, their families, and their communities (Lev, 2004). Respecting and supporting TGNC people in authentically articulating their gender identity and gender expression, as well as their lived experience, can improve TGNC people’s health, well-being, and quality of life (Witten, 2003).

Rachlin (2002) emphasises that, the role of the therapist, is that they should be supportive and actively explore with the client the multiple options that might be right for his/her unique needs. This will allow a collaborative therapeutic relationship and enable the clients to share their thoughts, feelings, events and relationships. The continuation of the psychotherapeutic relationship is often an important source of on-going empathic support for the individual as he/she settles into the transition to his/her aspired gender identity.
2.5 Guidelines for psychotherapists working with transgender clients.

The Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (APA, 2015) set out how psychologists and psychotherapists should approach the work with transgender clients. They state that psychotherapists should understand that gender is a non-binary construct that allows for a range of gender identities and that a person’s gender identity may not align with sex assigned at birth. They should also understand that gender identity and sexual orientation are distinct but interrelated constructs and be aware that gender identity intersects with the other cultural identities of TGNC people. The profession should seek to prepare trainees in Psychotherapy to work competently with TGNC people.

The guidelines go further in saying that psychotherapists should be aware of how their attitudes about and knowledge of gender identity and gender expression may affect the quality of care they provide to TGNC people and their families. The profession must recognise how stigma, prejudice, discrimination, and violence affect the health and wellbeing of TGNC people. They must strive to recognise the influence of institutional barriers on the lives of these clients and to assist in developing TGNC-affirmative environments. Psychotherapists should understand the need to promote social change that reduces the negative effects of stigma on the health and wellbeing of TGNC people.

Psychotherapists working with gender-questioning and TGNC youth should understand the different developmental needs of children and adolescents, and that not all youths will persist in a TGNC identity into adulthood. Furthermore, they should strive to understand both the particular challenges that TGNC elders experience and the resilience they can develop.
The guidelines outline how psychotherapists should strive to understand how mental health concerns may or may not be related to a TGNC person’s gender identity and the psychological effects of minority stress. Therapists recognise that TGNC people are more likely to experience positive life outcomes when they receive social support or trans-affirmative care.

In terms of their clients’ relationships, psychotherapists should strive to understand the effects that changes in gender identity and gender expression have on the romantic and sexual relationships of TGNC people. They should also seek to understand how parenting and family formation among TGNC people take a variety of forms.

Finally, therapists should be aware of the potential benefits of an interdisciplinary approach when providing care to TGNC people and strive to work collaboratively with other providers. They must respect the welfare and rights of TGNC participants in research and strive to represent results accurately and avoid misuse or misrepresentation of findings.

2.6 Issues and Challenges for the psychotherapist.

Henkin (2008), makes the point that the topic of transference is covered extensively in psychotherapy training and supervision. However, he claims that the same is not so regarding the therapist’s parallel experience, that is the countertransference. He believes countertransference is inevitable and if we have not worked through our own issues about gender or identity, it could impact our work with transgendered or gender questioning clients. He urges therapists to revisit their own transgender issues, to benefit themselves and ensure they remain honest in their work (Henkin, 2008).
In the conclusion to her 2014 paper, Winograd, talks about the “shifts in sociological climate toward more openness to sexual differences and gender fluidity” and how this will contribute to a reduction in discrimination and homophobia (Winograd, 2014, p.72). She also notes that more children and adolescents are openly questioning their sexual and gender identities. She highlights the need for “continued clinical research to further understanding of the biological and psychosocial, genetic and epigamic factors that predispose one to gender dysphoria” (Winograd, 2014, p.72).

King (2012), writes about her countertransference experiences during the therapeutic journey of her 53-year old Male to Female (MTF) transsexual client, Dawn. This paper gives the reader an insight to the countertransference experience of a female therapists working with a MTF trans client. Despite King’s genuine fondness for this client and her empathic feelings towards Dawn, she describes her struggle in the countertransference which represents the complex parallel processes going on for both therapist and client.

King (2012) cites Lothstein’s (1977) article, Countertransference Reactions to Gender Dysphoric Patients, when she says that to establish a therapeutic alliance with a transgender client the therapist needs to keep an open mind about the possibility of surgery, a willingness to partially gratify some of the client’s narcissistic needs, and an awareness of the countertransference or the therapist’s emotional reactions to the client.

King (2012, p.38) was aware that her verbal and non-verbal reactions to Dawn’s outward appearance could reveal or conceal her feelings towards her, which in turn could impede or
facilitate the therapeutic work. She writes, “Dawn really tested my ability to be fully present. From our very first meeting I struggled to feel fully comfortable. I was aware of a little niggly feeling deep in the pit of my stomach. I initially put this discomfort down to anxiety about my limited experience of working with a transsexual client”.

King describes feeling breathless and having a lump in her throat as her client spoke. She recalls wondering if she would become, in the transference, the client’s mother who wished to feminise her son? Would she become the role model of the ideal woman of whom her client is envious and jealous? She surmised that her feelings of discomfort emanated from her client’s projections onto her as well as her unconscious impulses. She associates her sense of something unpalatable in the relationship with her client’s pending castration under gender reassignment surgery. King also experienced pain in her genitals when her client spoke graphically about the reassignment surgery. She later recognised this pain was akin to what she had experienced some years earlier, post minor surgery on her genitals.

King recalls how aware she was of Dawn’s need for King to admire her carefully presented appearance. Yet she acknowledges she struggled with feelings of revulsion and questioning where these feelings were coming from. Were they all her own? Or was she picking up her client’s disowned or disassociated feelings? Dawn had shared her feelings of revulsion with her ‘male’ parts which she claimed did not belong to her (King, 2012).

King describes their therapeutic journey together as “continuing to sit with uncomfortable ‘objects’ in the room”. As “a period of work that was filled with confusion, conflict, guilt, panic and a sense
of Dawn purging herself from David” (King, 2012, p. 43). King admits that her own feelings of
revulsion where never far below the surface. She describes an awareness of her client’s envious
glances at her breasts and how she felt repelled and angry by this. Only later to recall, how she as
a flat chested teenager, envied her more full-breasted peers.

Withers (2015), gives an insight into the countertransference experience of a male therapist
working with a pre-surgery Male to Female (MTF) trans client. He writes, “In my wish to warn
John of the possible dangers of surgery, I temporarily undermined his faith in its ability to solve
his problems”, (Withers, 2015, p.402). Withers later realised that in saying this to his client, he
undermined the client’s psychotic system that was holding him together, tipping him into psychotic
anxiety. Withers reflected that it may have been his attachment to his own penis (castration
anxiety) that prevented him from consciously identifying sufficiently with his client to appreciate
the effect his remark would have (Withers, 2015).

Winograd (2014), writes about her countertransference experience as a female therapist with breast
cancer and facing a mastectomy, while working with a Female to Male (FTM) trans client. She
was “stricken and saddened by the prospect of losing her breasts”, while her client “B” was binding
hers, eager for the same surgery that her therapist was dreading. Winograd queries how much
were her “queasy feelings” about B moving forward with hormone treatment and sexual
reassignment surgery influenced by her own experience of being “mutilated by the very same
Winogard admits to struggling with her wish to slow down B’s push toward sexual reassignment surgery. At times, wondering if this delay was prolonging B’s suffering. Winograd also highlights one of the difficulties for her when working with transgender adolescents, that sense of being rushed. She writes that “despite the fact that they have their whole lives ahead of them and usually feel immortal, there is often a sense of urgency in solving a problem or deciding something. It must be done now” (Winograd, 2014, p.73)

She was aware that the urgency, at least in part, stemmed from her client’s intense, almost intolerable ambivalence, yet Winograd longed for a sense of leisure and time to work through all the potential conflicts with B. She felt that once the hormones began, they would only be able to do that type work as B’s physical changes pushed forward, with no regard for the slow and patient process of psychoanalysis (Winograd, 2014, p73).
CHAPTER THREE: METHODOLOGY

3.1 Research Aims

The specific aims of this research are:

- To gain a deeper insight into the subjective experience of Irish psychotherapists working with transgender clients
- To explore the challenges faced and benefits gained by psychotherapists working with this minority group.

3.2 Research Design

This research paper takes a qualitative approach to investigate the subjective experience of Irish psychotherapists working with transgender clients. As the literature indicates, there is a lack of research into Irish psychotherapists’ experience of working with this minority group and it is the researcher’s goal to gain greater insight into the phenomenological experiences of such therapists.

3.3 Rationale for a Qualitative Approach

Qualitative research is particularly well suited to studying clinical practice. First, it uses words rather than numbers to describe psychological phenomena. Typical data gathering methods include focus groups, open-ended interviews, and field observations. This focus on language and behaviour is similar to a clinical interview or psychotherapy session and provides a rich description of subjective experience, a goal shared by clinical practice. The qualitative paradigm requires that the researcher be self-reflective – that is, examine bias and monitor the dynamic interaction between researcher and participants, much as the therapist in clinical practice attends to transference and counter-transference (Silverstein et al. 2006).
The aim of this research was best met within a qualitative paradigm as the study sought to understand a phenomenon from within an individual’s own framework. Qualitative research aims to build theory by engaging with those individuals, who have personal experience within the chosen area of study and in doing so gives them an opportunity to express their own values and views of their experiences and the meaning that they give to them (McLeod, 2009).

Interpretative Phenomenological Analysis (IPA) was chosen as the methodological approach for this research as it is concerned with the individual subjective narratives of the participants. The goal of phenomenological research is to arrive at the essence of the lived experience of a phenomenon (Moustakas, 1994).

The theoretical and philosophical underpinnings of IPA include phenomenology, hermeneutics and symbolic interactionism. IPA places particular emphasis on capturing and exploring the meaning that participants assign to experience, in order to gain an insider’s perspective on the area of research interest. The approach also recognises the central, interpretative role of the researcher in analysing and making sense of these experiences (Smith et al. 2009).

In IPA research, our attempts to understand other people’s relationship to the world are necessarily interpretative, and will focus upon their attempts to make meaning out of their activities and to the things happening to them (Smith et al. 2009, p.21). The interpretations must always be grounded in the meeting of researcher and text.
IPA is a twofold approach to the interpretation process or double-hermeneutic interpretation analysis: in which the researcher tries to interpret the participant’s sense-making practice. “The participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world” (Smith & Osborn, 2003, p.53).

Interpretation in IPA is a form of amplification or illumination of meaning, which is cued or sparked by a close engagement with the data, and which requires creativity, reflection and critical awareness for its full development (Smith et al. 2009, p.205)

3.4 Sample

Sampling must be theoretically consistent with qualitative paradigm in general and with IPA’s orientation in particular. This means that they are selected purposively because of what they can offer to the research project in terms of insight into a particular experience (Smith et al, 2009). It is suggested that n=3 is the default size for an undergraduate or Masters level IPA study (Smith et al, 2009)

In keeping with the aim of this study, three participants were recruited on the following criteria:

1. They were an Irish based psychotherapist who is accredited by an Irish professional body. (Preferably of a Humanistic and Integrative orientation).
2. They have a minimum of three years post accredited clinical experience.
3. They have limited experience of working with transgender clients in private practice. (Note: The criterion for “limited experience” as opposed to a psychotherapist who works
exclusively or predominately with transgender clients was to avoid any distortion in the data resulting from a therapist’s over familiarity with this minority group of clients).

Psychotherapists who were working towards accreditation and student therapists were excluded from this project.

3.5 Recruitment

The following documentation were prepared for presentation to suitable candidates in order to recruit their participation in this research.

An information sheet outlining this research project, a consent form for the candidate to sign agreeing to their participation and guidelines on confidentiality and the process available to them should they chose to withdraw from the research. See Appendix 1.

Originally, it is proposed to recruit one psychotherapist who matches the criteria through e-mail or telephone contact. This therapist would be selected based on their professional profile having “gender issues” included in the field of practice. However, the first candidate was contacted on recommendation of a fellow therapist who had professional connections to both candidate and the researcher.

It was then proposed to follow a “snowball” strategy of recruiting the second and third participants, whereby, the first participant recommends the second participant as a suitable candidate and the second recommends the third. This approach proved successful in recruiting three suitable interview candidates.
The following table illustrates the demographic of the sample.

<table>
<thead>
<tr>
<th>Accrediting Body:</th>
<th>Candidate #1</th>
<th>Candidate #2</th>
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Table 1: Demographic of Sample

3.6 Method of Data Collection

The method of data collection was semi-structured interviews, lasting approximately one hour. The preference for semi-structured interviews was based on the desire to provide participants the opportunity to express their views in an environment that allows for unanticipated issues to emerge and be accommodated. Individual interviews were preferable to group interviews as the individual interview, affords greater control over the data collection process, more latitude to probe deeper into participants’ responses and the potential to be more responsive to non-verbal information (Creswell, 2007).

The questions were designed to be open ended and to reflect some of the themes that are set out in The Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (APA, 2015). In doing so, it was proposed that the design of the interview questions would have a correlation with the most recent guidelines for best practice with transgender clients.
Furthermore, the questions were designed with reference to the findings of The LGBTIreland Report (2016), as it represents that most recent body of research pertaining to transgender people living in Ireland. A schedule of the interview questions is provided in Appendix 2.

3.7 Method of Data Analysis

The transcript of each interview was analysed on a number of occasions. Read and reread to ensure that the researcher became familiar with each account. Each reading threw up new insights. The initial analysis noted any interesting or significant comments by the participants, noting use of language, general content and broad themes.

Further analysis narrowed down these general themes to key themes. The structure of the analysis table comprised the Original Transcript, Close Line by Line Analysis, Researcher’s Thoughts and Themes. See Appendix 3.

Each transcript was analysed independently of the others before moving to discover commonly held themes connecting across the three transcripts. Any connected themes were clustered into superordinate themes based on the richness of their supporting evidence from the transcripts and researcher’s notes. Then these superordinate themes were written up into a narrative account by the researcher with verbatim extracts from the transcripts to support the research findings.
CHAPTER FOUR: FINDINGS

4.1 Introduction

The goal of this research is to gain insight into the phenomenological experience of Irish psychotherapists working with transgender clients. It set out to gain an understanding of their subjective experience in the work and to highlight the unique challenges they experience in the therapeutic relationship with their transgender clients. It also seeks to identify the benefits they have experienced through their work with trans clients.

The three interviews provided valuable insight for the researcher. The conversation from each interview was transcribed and these transcripts were then analysed, in accordance with Interpretative Phenomenological Analysis (IPA) guidelines. This process delivered a number of common experiences or themes among the therapists.

For the purpose of this research paper, the three most salient themes will be discussed. These are as follows:

1. The Therapist’s Identification with Transgender Clients

2. The Maternal / Paternal Countertransference

3. The Symptom of Confusion in the work with Transgender Clients
4.2 Theme One: The Therapist’s Identification with Transgender Clients

During the interview process, and later while reflecting on and analysing the transcripts, the author became aware of the common belief among the interviewees that working with transgender clients is not for every therapist. It would appear that the therapists who participated in this research had a strong identification with transgender people and as such, were motivated to work with transgender clients. They spoke of a certain profile of therapist who is better suited or more drawn towards working with this minority group.

While reflecting on her work with trans clients over the years, Participant One, shared her view on how she imagines, “that there are many people who would not be able to sit with trans people”, but she believes “that is up to them (the therapists) to find out”. In expressing this view, the author interpreted that Participant One was referring to the identification with transgender people that a therapist would need in order to “sit” comfortably with them in the therapeutic space.

Similarly, as Participant Two, spoke about the nature of this type of work and about what characteristics a suitable therapist might have, she explained, “I think you need a specific personality. I don’t know whether a specific skill set is the right way of putting it?” She then acknowledges that “I think you need to be that little bit different” which the author interpreted as a reference to her own difference, being a lesbian woman who has done extensive personal process on sexuality and gender. “You need a little bit more and I think certain people have it and others don’t”.
In trying to illustrate the difference she perceived between those therapists who works with trans clients and the wider profession, Participant Two, explained her point as follows, “You are going to have therapists who go, how do you feel about that? And they give a good therapeutic nod and all the rest of it. For me, that’s not enough when working within the trans community”.

When expressing her view on the nature of this work and what it requires from the therapist, Participant Three, also refers to the in-depth personal process the therapist needs to have done, “You have to be very sure on where you are. It’s not an area that you just go into”. She equated working with transgender clients with another very specific type of work she does around crisis pregnancy, “It’s a bit like abortion work, it’s not an area that you just go into. You have to be sure that this is something that fits with me”.

As the theme emerged, that certain types of therapists are drawn towards working with the trans community, the author sought to gain an understanding of what identification process might be at play and what are the motivating factors for those therapists who take on this work.

During the interviews, it was disclosed that each of the three therapists had a personal connection or specific interest in the areas of sexuality or gender identity. The topics of sexuality or gender identity had presented in either, the therapist’s personal process or that of a close friend or family member. The author interpreted this to be the catalyst which brought the therapist into the realm of working with transgender clients. These disclosures also provided the author with a clearer understanding of the counter transference experiences that each therapist alluded to during their interviews.
The therapists’ personal association with sexuality and gender identity issues appears to have strengthened their identification with trans people. It seems to have increased their empathic capacity for their trans clients. Participant One, demonstrates this point when she shared her personal involvement in supporting a close friend transition from male to female, long before she became a psychotherapist.

*In my beauty therapy role, I would have really helped somebody transition through the use of electrolysis and make-up. So, I walked with somebody as they learned to be in role.*

Participant Three, also provides us with an insight into her motivation for working with transgender clients when she shares her niece’s experience of transitioning from female to male.

*I also have personal experience, I have a niece who is going through transition, transitioning to male. I often wondered what was this about, so when it was presented to me to work with trans clients, I took it up.*

Each interviewee reports that they have engaged in deep personal process around their own sexuality and have participated in advanced training at post graduate higher diploma and master’s level in the areas of sexuality or psychosexual psychotherapy. Not to mention CPD training that covered topics relevant to transgender issues.

In discussing the specific training, she undertook, Participant One, demonstrates the personal investment required by the therapist, as much of the specialist psychosexual training takes place in the UK.

*I would have attended the world sexual health conferences...I would have attended workshops and gone over to attend Christina Richards in London...I have trained with her a couple of times to broaden it for me...In those trainings, there were always trans people who were working as therapists. So, you get the opportunity to hear their stories.*
Participant Two, took a different training route, she completed a MA in Sexuality Studies in Dublin. Here she describes how her area of interest being, Intersex, led her into researching the realm of transgender.

Where my research brought me was to the differences in sex development and intersex conditions. But because there is so little known about it (intersex), most of the research around is about transgender issues and there is a very big difference between intersex and transgender. So, my interest just kept growing and growing

While sitting with these therapists the author experienced them to be caring professionals with a desire to connect with their clients at an authentic level. Their insight and compassion for their transgender clients, is underpinned by the therapists’ personal experience with issues that are relevant to the transgender community.

The author experienced these therapists as being well informed in relation to topic of gender identity. This allows them to be with their trans clients at an authentic level in the therapeutic space. The therapists’ extensive personal process around their own sexuality, equips them to explore the realm of sexuality with their trans clients. It further equips them to identify and meet the needs of these clients.

The data compiled from these interviews would suggest that deep personal process around sexuality and/or gender identity, may not be experienced by the wider psychotherapy profession. This key component in the personal process of each participant appears to differentiate them from many psychotherapists in the wider field.
Participant Two, illustrates this point when she compares her experience of personal therapy with how she imagines the wider profession might have experienced their personal therapy.

*My sense is that you really have got to have done the work on yourself and gone there yourself around sexuality, gender, levels of comfort around the whole thing? I don’t know whether is it because of the process that I went through and me coming to terms with my own sexuality that it has led me to being much more open and comfortable. Whereas I think a lot of heterosexual people have never had to do that work. Now that’s not so say that heterosexual people don’t do very good work with trans clients.*

This differentiation in personal process and their identification with trans people, appears to have ignited the motivation of these Participants to educate themselves on transgender matters. Each having engaged in specialist training and self-directed research to better equip themselves for this work.

The following quotes serve to illustrate this point. Each therapist speaks about the specific research and training they perused to ensure that they felt equipped to sit across from their trans clients. Again, the author was struck by the motivation required by these therapists to expand their knowledge on such a specific section of the field of psychotherapeutic work.

Participant One says,

*Yes, I would have read a lot about it at one stage...I would have tried to understand, where has this thing come from?... I would have read about brain sex and things like that.*

When discussing how she has become comfortable in this work, a comfort embedded in familiarity with the subject matter, Participant Two, again refers to the extensive research she has engaged in.

*Probably because of the reading that I have done around it and the information that I have, I understand what the surgery entails. I understand the process as much as I can understand. So, for somebody to get into the nitty gritty, I’m comfortable with that.*
In reflecting on her journey into this area of psychotherapy work, Participant Three, refers to her post graduate in psychosexual studies which took place in London. While this higher diploma covers the full spectrum of psychosexual material, it appears to have provided valuable exposé to trans issues and other marginalised groups.

*I went to London two years ago and did a post graduate diploma psychosexual psychotherapy over two years. We worked on the trans piece and marginalised groups in the psychosexual training.*

4.3 Theme Two: The Maternal / Paternal Countertransference

The second theme that emerged related to the therapists’ experience of their clients’ maternal or paternal transference towards them. This transference seems to activate the therapists to manage their maternal countertransference towards their clients.

The author believes that despite the therapists’ efforts to manage their countertransference, their maternal concerns for these clients shapes their therapeutic approach. The author likens their approach to that of a concerned parent, watching out for their child’s welfare and safety, ensuring their child is well informed in order to make the right choices for themselves.

The following quotations serve to illustrate the author’s interpretation of the maternal / paternal countertransference in the work. Participant One, seemed most aware of her maternal countertransference and the author relates this to the fact that she is the only mother among the three Participants. Participant Two and Participant Three, have no children.
Participant One:

*My concerns are that they would be taken advantage of...that they would be safe...that they would be accepted...that they would pass...that they would be sure their decision was the right decision...that they are happier now they have done it. I would also have concerns that they would have a community who would accept them.*

Later in her interview, Participant One, spoke about taking her concerns about her maternal countertransference to, Christina Richards, who is a well-known psychotherapist and trainer, specialising in transgender issues. Christina eased Participant One’s concerns.

*But I remember doing a training with Christina Richards in London about trans and I spoke about how sometimes I had fears that they (trans clients) would have difficulty fitting in and she told me that was not my business.*

Participant Two, also spoke about her experience of the maternal transference and countertransference in the work,

*They want you to be the missing mother/father or a mix of both, or older sibling. You are the person that they can go to and they can give you all of this stuff. It’s sometimes mother and sometimes father or a mix of both.*

She then spoke about her conscious effort not to play into this countertransference and of her focus to stay in role as therapist. Participant Two, admits her temptation to act from her maternal countertransference position,

*I am very conscious of not being mother... I focus on just being as real as I can in the process for them ... it’s a natural instinct to jump in ... especially when a client is telling you something and you are thinking, ah that’s terrible ... want to jump in and fix it ... come to me and I’ll sort that out ... I am aware of making sure that I am not doing that.*

When asked about their therapeutic approach to this work, each therapist spoke about similar essential elements in the process. These elements involve the therapist’s complete acceptance of their client’s authentic gender, regardless of their sex assigned at birth. There is a need for the
therapist to fully believe their client’s story. It could be said, that this requirement for acceptance reflects the humanistic principles for any therapeutic alliance and as such, is not specific to working with transgender clients.

In expressing her view of the importance of acceptance in the work with trans clients, Participant One, emphasised the client’s need to be believed,

*I think to be believed ... to be accepted ... to bear witness to their story.*

She also mentions the fact that these clients have held a secret or a sense of being different from a very young age. The author had experienced Participant Two’s maternal empathy for these trans children who may feel difference but cannot express or understand it,

*there is always the story for all of our clients and with transgender, it very often goes back to where they recall being 3 or 4 years old and wanting to wear dresses or play with dolls. Or, not being interested in the boys’ game*

Participant Two, also spoke about the secret that her trans clients have carried throughout their lives and the importance of her reaction to them sharing this secret. Her maternal countertransference was evident as she spoke about her reaction, wanting to portray acceptance and support, just as a mother would for her child,

*I think that a lot of the time when trans people come in, I may be the first person they have said this to. So, my reactions and how I react matters hugely in that space because I may be the representative of what they are looking for and how they are going to proceed. I think they want somebody who sees beyond the external image. Sees them for who they believe themselves to be*

Participant Three, emphasised the importance of acceptance when she put it simply as,

*We need to say, Ok, this is a person, regardless of how they present*
Where the work with transgender clients differs from the wider humanistic approach is with regard to the other elements of the therapeutic alliance that were identified by the three interviewees. These require the therapist to be knowledgeable with regard to the specific transgender issues and language.

For example, knowledge of the different stages of transition from one gender to another and having knowledge of the correct pronouns to use at each stage of the client’s transitional journey. The author experienced this as the therapist meeting their clients’ demand for a knowledgeable and supportive parent.

In relation to the differences in the therapeutic approach when working with trans clients, Participant One, seems to be speaking from a caring maternal viewpoint when she says,

\[
To resource them ... to let them know what the next stage is ... there is a clinic in Belfast ... there is Christina Richards in London ... there’s York and different places ... that they would actually find their way to a centre of excellence, particularly around the surgery
\]

Participant One, later spoke about the additional burden she experienced in the work while trying not to cause hurt or offense to her trans clients. The author perceived the Participant’s sense of being burdened, as the weight of her maternal countertransference applying pressure on her to be the good enough mother. Maybe the mother that her client had never experienced in relation to their gender identity,

\[
I would have had to careful of my pronouns and my language ... simply not to offend ... I go in a little bit wary that I don’t want to hurt or cause any further difficulty for them if I made a mistake ... I think this is probably a little bit of an extra burden
\]
In her explanation of the difference in the therapeutic approach to working with trans clients, as opposed to cis gender clients, Participant Two, refers to the in-depth knowledge of trans issues that is required by the therapist,

*What matters to them is that they don’t have to explain it. That they have somebody who has an understanding of it and who isn’t judging them*

Participant Two, expressed her concern around the potential risks associated with an inexperienced therapist taking on a transgender client. Her protective countertransference was evident to the author as she shared her belief that,

*You can work with anxiety and other issues. But if you don’t have any experience, knowledge or awareness of what’s going on for transgender clients, the damage you could cause would be untold*

Echoing this theme, that specialist knowledge is necessary in order for a therapist the ensure the well-being of their trans clients, Participant Three, demonstrates the educational aspect to this work,

*They also need to know that I have the information that they want ... that I can point them in the right direction ... it’s usually questions about transitioning ... usually questions about where they can go ... if the therapist does not know this information, they won’t be able to contain the person ... the client will feel that off you anyway*

Participant Three, concurred with her fellow Participants, in relation to the need for the therapist to have an in-depth knowledge of the appropriate language, pronouns and vocabulary associated with transgender issues.

*That you would know the difference when they start to talk about cis gender etc. They have a whole language now themselves and that you have some knowledge of that language*

Another common view that emerged when considering their specific approach to working with trans clients relates to the client’s safety. The therapists seem concerned that the clients remain in
touch with the reality of their situation. It appears to the author, that at key moments in the client’s process, the therapists feel the need to conduct a reality check with them.

In this regard, a more directive and practical approach seems to run parallel with the humanistic approach, creating what the author experienced as a dual approach. It was as if the therapist was in a parental or protective role, ensuring the welfare and safety of their client both inside and outside of the therapeutic space. Participant One, illustrates her concern for her clients’ safety when she said,

*As you know, the transition is done in stages ... it begins with the hormones ... I would have always made sure that the clients knew what they were embarking on before they start the hormone treatment ... I would ask, Are you sure? ... To ensure that they know the enormity of the journey they had begun*

Participant Two, demonstrates the internal conflict going on for her at times. She wants her clients to be happy in their chosen identity but she is concerned about the potential risks along the transitional journey. She wants to alert her clients of the risks without undermining their psychic structure by introducing additional anxiety.

*Don’t get me wrong, it is not that I don’t challenge or ask questions about it and why somebody is doing it ... if that is what they need to do for the internal to become more external ... then, I’m okay with that*

In relation to the author’s sense of a parallel or dual process taking place in the therapeutic relationship, Participant Three’s, comments echo this sense of a practical or directive approach co-existing with a more humanistic approach. The practical piece reflecting the maternal countertransference that is at play,

*A lot of the time it’s not about waiting to see what evolves. It’s about, this is what you can be doing while we are doing this other therapeutic process ...the practical piece ... there is quite a direct approach but that’s okay ... What do you need?... What do you want?...*
4.4 Theme Three: The Symptom of Confusion in the work with Transgender Clients

The final theme to be considered in this paper relates to the symptom of confusion being present in the therapeutic relationship with transgender clients. Each of the participants made the point that Irish society, as is the case with most societies, works on a binary model. The general population are conditioned to view people as male or female, masculine or feminine and heterosexual or homosexual.

But each participant also suggested that when it comes to the realm of transgender, the therapist needs to set aside this cultural conditioning as it can cause both conscious and unconscious feelings of confusion. They noted that a further contributor to the symptom of confusion in the therapeutic space, is society’s misconception that gender and sexuality are one and the same thing. They each acknowledged that these two aspects of a person may be related but suggested that the therapist must consider each of them as separate issues.

Participant Two, illustrates this point and refers to the symptom of confusion when she says,

realising that sexual orientation is a completely different issue to being trans and it’s not about confusion around their sexual orientation, it’s something else

In this statement, Participant Two, acknowledges society’s limited understanding around trans issues. This lack of knowledge causes confusion which leaks into the therapy space. She continues on this point by saying,

I think that quite a lot of people, when it comes to sex and gender identity, have little understanding. People in Ireland, as in lots of places around the world, don’t understand
the difference between sex and gender. I didn’t understand it either until I started doing this work and my research into it

While, Participant Two, spoke about society’s confusion, Participant Three, referred to the client’s confusion and how they struggle at a very deep level to gain clarity around their lived experiences as a transgender person,

It’s different work but it is hard to say why it’s different because you are working with somebody who has this innate difference that they are trying to put into words, what is going on for them and how do they feel

Participant Three, then offers an explanation that links society’s confusion with the client’s personal confusion and how that impacts the therapist,

They have been socialised into being one person and yet they feel different. So, in the room, in between you, there is a whole question around a sense of self. Whether that’s all their’s or if some of it is mine?

As these quotations help to illustrate, society’s opinion of what it is to be male or female, has a strong influence on the transgender client’s sense of self. Each of the therapists spoke of their clients’ idealised view of their preferred gender identity and of how their views on gender roles have been influenced by our modern culture. The clients’ fantasies and aspirations seem to focus on idealised versions of the sexes.

In reality, the woman or man, that these clients eventually become can be very different to their fantasy. The process of transitioning can create confusion for these clients as they learn to be in their new role. Participant One, make this point when she says, “You would be surprised about what people don’t know about how to be in their new role until they experience it”.
Reflecting Participant One’s point, about the client’s lack of knowledge on how to be in their chosen gender role, Participant Two, offers an explanation as to why the client may be confused about how to be a man or how to be a woman,

\[\text{The cultural perception ... we tend to put people in boxes ... So, men think that women are going to act and walk a particular way and women think that men are going to do it in a certain way ... The trans person will often have an image of the woman they want to be ... it’s very different to who they end up being ... they start to realise that they have this idealised version of womanhood ... It’s culturally gendered ... We live in a binary world, you’re homosexual or heterosexual, you’re male or female, you’re masculine or feminine. So, if you are a trans woman, a man who believes you are a woman, and you start to transition ... you start to transition in the way you assume society sees a woman, rather than how a woman actually is}\]

Similarly, Participant Three, spoke about the client’s idealised view of womanhood and how this impacted upon her own sense of being a woman.

\[\text{They can have a vision in their head of what a female is or how a female presents or how a female behaves. Depending on where we are in the therapy, I would say “I’m wondering what it is like for you to be sitting in front of a female therapist?” ... Does it meet their fantasy? ... So, you have that transference in the fantasy, that they have an ideal view of a female and how they should behave and act}\]

Each of the therapists spoke of the symptom of confusion being present in the therapeutic space on occasions when their clients presented in their preferred gender identity. The author interpreted this sense of confusion as the therapists’ struggle to see beyond the client’s presentation and to focus on the person inside. It demonstrated to the author the therapists’ desire to gain an understanding of the client’s process.

Participant One, spoke of an occasion when her MTF client first presented in her preferred gender identity. The reception staff in the counselling agency where not aware that this client would
present as female on the day and the therapist had to manage the staff’s confusion while respecting her client’s confidentiality,

_But the interesting thing is that it caused a bit of difficulty for that agency because they didn’t quite know the client (when she arrived dressed in role). Then they were waiting for me and I had to get over that. I said to myself, this is my client and this is what my client needs_

Participant Three, shares how at times she struggles to manage her own feelings of confusion in the therapeutic space.

_It’s a bit like that brain disconnect that’s going on ... visually you are seeing something that is different to what is underneath ... you have to be very present, very careful around the language that you use ... you can get caught up in ... is it a man? ... is it a woman? ... what is it? ... I use “It” with the greatest respect ... your brain is trying to catch up_

She continues by sharing how her “brain disconnect” results in her turning her questions onto herself and her own sense of being a woman.

_when I am sitting there ... I’m questioning, where am I with what they are telling me? ... I’m female, I know I’m female ... I don’t have any question about it ... It fits ... It’s right ... I’m trying to work out what it must be like to be in something that they feel they don’t belong in ... but that society is telling them something very different_

It would appear that transgender people are dealing with confusion in their day to day lives. This confusion may be their own innate sense of being different or society’s confusion around them not fitting into a binary model.

Participant Two, speaks of the importance of reducing this sense of confusion in the therapeutic space. She explains that the more informed the therapist is regarding trans issues, the greater their capacity to manage the symptom of confusion in the therapeutic space which in turn provides the client with a rest-bite from having to explain.
I think to be able to sit with someone who will use the right pronouns, who will see them as the woman they are, matters hugely. That they (the client) don’t say something and have somebody say, ok, could you just explain that to me because I don’t really get that

This chapter has presented the compiled data that relates to the three main themes. These themes are the therapists’ identification with transgender people, The maternal / paternal countertransference and the symptom of confusion within the work. The following chapter will examine these themes with reference to the literature compiled in Chapter Two: Literature Review.
CHAPTER FIVE: DISCUSSION

5.1 Introduction

The qualitative methodological approach undertaken in this research paper involved semi-structured interviews with three accredited psychotherapists, who work with transgender clients. The data collected from these interviews was then analysed using Interpretative Phenomenological Analysis (IPA) which resulted in three main themes emerging. In this chapter, each of these themes will be considered and discussed, with reference to the corresponding psychotherapeutic literature as presented in Chapter Two of this document.

5.2 Theme One: The Therapist’s Identification with Transgender Clients

The therapists’ strong identification with transsexual people was apparent. It appears that this strong identification is directly linked to the therapists’ personal experiences and their own therapeutic process, resulting from those experiences. The therapists appear to have worked through similar issues relating to their own sexuality, as their trans clients have had to do.

Henkin (2008) says, if the therapist has not worked through their own issues around gender or identity, it can impact their work with transgender or gender questioning clients. He also urges therapists to revisit their own transgender issues, to benefit themselves and to ensure they remain honest in their work.

The data emerging from this current research paper concurs with Henkin’s point but would also suggest that it was the therapists’ own process around their sexuality and gender identity, that drew them towards working with trans clients.
While transgender clients may have complex issues, the participant therapists identified with their clients’ issues relating to their sexuality in particular. As previously outlined in the paper, the areas of sexuality and gender are separate aspects of the person but are very closely linked. The data from this research would suggest that the participants have a sense of walking a similar path to their trans clients. This situation could be compared to a therapist with personal experience of addiction, who is then drawn to working in addiction counselling.

During her interview, Participant Two, spoke about accepting her own sexuality and coming out as lesbian. She was married to a man when she fell in love with her current female partner. She spoke of not being able to come to terms with people knowing about her and she described feeling absolutely terrified of how others would react.

The author compared Participant Two’s fear of stigma and her sense of shame, with those feelings associated with transgender people. The HSE’s report (2009) outlined such feelings. It identified the key mental health issues for trans people to include isolation, fear, stigma and family rejection. All of which contributes to the trans community’s high levels of depression, anxiety, substance misuse, self-harm and suicide.

Henkin (2008), makes the point that the topic of transference is covered extensively in psychotherapy training and supervision. However, he claims that the same is not so regarding the therapist’s parallel experience, that is the countertransference. He believes countertransference is inevitable in this work.
The author experienced the therapists’ countertransference as them identifying part of themselves in their clients. As Participant Two suggested gay therapists will have done different types of work on themselves. They will have come to terms with being part of a minority group. She believes that gay therapists who work with trans clients, represents one minority group supporting another minority group.

She continued by saying that while heterosexual therapists will have engaged in deep personal work on many aspects of themselves, because they are considered the norm in terms of sexuality and gender identity, they would typically have done little deep work of these aspects of themselves. She stressed that point, that trans clients should not seek out gay therapists specifically but she acknowledged the level of comfort present in this type of therapeutic relationship.

The APA (2015) guidelines suggest that psychotherapists should be aware of how their attitudes about and knowledge of gender identity and gender expression may affect the quality of care they provide to TGNC people and their families. This suggestion was echoed by each of the therapists involved in this current research.

When asked what advice they would offer a fellow therapist who is embarking of a therapeutic relationship with a transgender client, they each responded similarity. Participant Three, urged that any therapist embarking on this type of work would have acquired a strong sense of where they are within the realm of transgenderism and that they would be very sure of who they are in this realm. She cautioned that if a therapist embarking on this work was anyway unsure of their
position or had not explored their own sense of self within the gender spectrum, they could be “set off” by the work.

Participant Two offered a similar caution to a would-be therapist of trans clients. She spoke about the necessary level of comfort required to do this work. If the therapist is not comfortable with getting into deep work with a transgender client, then she suggests that the client should be referred on to a therapist who is comfortable. She too suggested, that a lack of comfort with this type of subject matter could bring up unexpected issues for the therapist.

The data would suggest that a key outcome of the identification process between the therapist and client to be the therapist’s in-depth understanding of their trans client. The therapist is not expecting the client to educate them on trans issues or explain the day to day challenges faced by transgender people. The data would also suggest that transgender people are constantly educating others in their everyday life and they need the therapy space to be a place where they can let this education piece go.

Anne Marie Toole (2017) of Insight Matters makes the point that, “The world looks at transgender people from the outside in, the role of the therapist is to view their client’s gender from the inside out”. She continued by saying that, “the therapist requires an understanding of the developmental aspects of transgenderism and to recognize that a person’s gender identity develops before their sexual identity. A trans person’s felt sense of who they are can happen at any age and can present as a blend of gender identities”.

44
The therapists involved in this research identified with their trans clients and identified the complexity of gender identity. They did not try to simplify it into a binary model.

5.3 Theme Two: The Maternal / Paternal Countertransference

The second theme that emerged across each of the three interviews relates to the maternal / paternal countertransference experienced by the therapists. Each therapist acknowledged having maternal feelings towards their clients but they also spoke about their conscious effort to manage their countertransference and to remain within their role as therapist.

Despite their awareness of this countertransference and their wish for it not to impact the client’s process, the therapists reported that they do alter their therapeutic approach when working with trans clients. On a number of occasions during the interviews, the therapists presented as concerned and protective parents, when speaking about these clients.

Lothstein’s article (1977), talks about an awareness of the countertransference or the therapist’s emotional reactions to their client being a key part of the work. King (2012), speaks specifically about her maternal countertransference when she recalls wondering if she would become, in the transference, the client’s mother who wished to feminise her son.

Participant One, spoke about how she brought her concerns regarding her maternal countertransference to Christina Richards, whom she describes as a leading figure in the area of
transgender therapy. She described how Ms. Richards told her that her maternal fears about her client not fitting in once they transition, were not the therapist’s business. Participant One acknowledged that Richard’s response released her from her maternal anxiety.

Participant One, said that she realized “It was just for me to stay with them (clients) and stay out of that piece of the transference where “mother” is coming in. I suppose in a way that was a bit freeing to know that I’m just here to stay with them”

The LGBT Ireland Report (2016) states that, knowing they would be supported and accepted by family, friends and others has helped LGBTI youth to come out. These findings reflect the author’s interpretation of the therapists’ wish to provide an accepting parental experience for their clients.

In many cases, trans clients have not spoken with their parents about their gender identity, particularly in the cases of older clients. The therapists involved in this research, spoke of cases where they were the first person that their client had ever spoken to about their gender identity. So, the therapists’ response to the client’s disclosure is very important. If a care giver were to reject a fundamental aspect of a child’s persona it could have negative developmental and attachment implications for that child.

Participant Two, spoke of this type of situation when she said, “I think that a lot of the time when trans people come in, I may be the first person they have said this to. So, my reactions and how I
react matter hugely in that space because I may be the representative of what they are looking for and how they are going to proceed”. She also says that, the clients want the therapist to be the missing mother or father, or a mix of both. The therapist is the person that the client can be completely honest with, maybe for the first time ever.

Later in her interview, Participant Two, spoke about her experience of the maternal countertransference, she said “I have great empathy for them. The struggles that they go through on a daily basis. I think sometimes the thing is not wanting to be their mother. Making sure that I’m not being their mother. And, I think that’s where the challenge comes in sometimes”.

Participant One, demonstrates her maternal concerns when she expressed her annoyance about trans clients being exploited by others. She said, “But what makes me very annoyed, which I notice particularly in my MTF clients, is that they are taken advantage of because they are very vulnerable and people rip them off with services like wigs and dresses. I get very mad about that actually”.

At one stage, Participant One was so moved by the exploitation she witnessed, she had considered setting up a service for MTF clients where they could acquire, clothes, wigs and make-up services at a fair price. She later abandoned this idea, not wishing to be pigeon holed into such specific type of work.
Each of the therapists interviewed spoke of regular reviews with their clients. Taking time to explore exactly what point along their journey of transition the client was at any given time. The author experienced these reviews as reality checks and as very practical exercises that ran in tandem with the main therapeutic process. These reality checks gave the sense of a parent monitoring the safety and wellbeing of their child, as they progressed along a developmental journey.

Withers (2015) speaks about his castration anxiety and paternal countertransference prompting him to warn his MTF client of the dangers of surgery. He later realized that in doing this, he undermined the client’s psychotic system that was holding him together. His client has placed such faith in the ability of the gender reassignment surgery to solve his problems that when Withers warned against it, he sent his clients into psychotic anxiety.

Winogard (2014) also admits to struggling with her wish to slow down her client’s push toward sexual reassignment surgery. At times, she wondered if this delay was prolonging her client’s suffering. She highlights her difficulty when working with transgender adolescents, that sense of being rushed. She writes that “despite the fact that they have their whole lives ahead of them and usually feel immortal, there is often a sense of urgency in solving a problem or deciding something. It must be done now” (Winograd, 2014, p.73). The author interprets Winogard’s concerns about her client’s apparent haste, as emanating from her maternal countertransference.
Participant Three, spoke about this sense of urgency in the therapeutic space due to the various hormone treatments and transitional journey that is taking place outside the therapy room. She likens the practical element of the process to crisis pregnancy counselling and describes it as, “A lot of the time it’s not about waiting to see what evolves. It’s about, this is what we can be doing while we are doing the other therapeutic process”.

5.4 Theme Three: The Symptom of Confusion in the work with Transgender Clients

The third theme that emerged relates to the symptom of confusion being present in the therapeutic relationship with transgender clients. The therapists’ accounts of confusion within the therapeutic space were multidimensional. They included the client’s sense of confusion, the therapist’s sense of confusion and the infiltration into the therapeutic space of wider society’s confusion around transgender issues.

At times, the therapists were unclear about where the sense of confusion was emanating from. They asked themselves questions such as: Was it their own? Was it the client’s? Was it conscious or unconscious?

Initially, when considering the symptom of confusion, framed it in relation to wider society. As Mollenkott (2001) said, in many cultures and religious traditions, gender has been perceived as a binary construct, with mutually exclusive categories of male or female, boy or girl, man or woman. Bethea & McCollum (2013) add, that these mutually exclusive categories include an assumption that gender identity is always in alignment with sex assigned at birth.
These points illustrate how people are culturally gendered by society into a binary model despite the growing awareness that gender is not binary and it has always been fluid. In reality, the lived experience of trans people does not fit into this binary framework, causing them to experience confusion for an early age.

As Lev (2004) writes, psychotherapists are encouraged to adapt or modify their understanding of gender, broadening the range of variation viewed as healthy and normative. In doing so, the author believes that the therapist can affirm the complexity of gender and avoid simplifying it into a binary model. That if the therapist can hold the deeply confusing space for a trans client, then the client may be able to work with their own confusion.

Rachlin (2002), says that psychotherapy can support transgender clients in many ways. These supports include providing the client with a greater understanding of the meaning they afford to gender, as a construct in relation to themselves and society.

Participant Three, explained that working with trans clients is different to working with cis gender clients because with a trans client, one is working with someone who has an innate difference that they are trying to put into words. They are trying to express what is going on for them and how they feel about it. They have been socialized into being one person, yet they feel different. She describes the therapeutic process as involving questions around the client’s sense of self. She acknowledges the presence confusion and holds the question, as she too is a product of a binary society, is this confusion all the client’s or is some of it her own?

In order to gain deeper appreciation of the symptom of confusion in the work with trans clients, narrowed the focus from the wider society down to an individual perspective. The LGBTIreland Report (2016) shows that transgender individuals face daily challenges, with approximately 60%
having had someone use the wrong pronoun to refer to their gender. Even within the therapeutic space, the therapist can slip up and use the wrong pronoun. Each of the participants interviewed, made reference to their conscious efforts to use the correct pronouns and the additional burden this added to the work.

Participant Three, described the brain disconnection of what she is physically seeing of the trans person sitting in front of her and the contradictory gender identity concealed within. She admits to her internal dialog asking; Is it a man? Is it a woman? Where am I with what they are telling? She explains her struggle in trying to work out what it must be like to be in a body that you feel you don’t belong in, yet society is telling you something very different.

Baird (2007) demonstrates how the symptom of confusion within the work can be compounded in situations where a trans client describes themselves as ‘male-to-male’ or ‘female to female’, reflecting their belief that they have always deep-down been the gender they feel themselves to be, regardless of social or biological assertions to the contrary. He also makes the point that many transgendered people, post-therapy or operation, are also gay or lesbian, which proves especially puzzling to the heterosexual mainstream.

On this point, Participant Two, spoke about avoiding heteronormative terms such as heterosexual, homosexual, gay or lesbian. She prefers to say, a “man who is attracted to men” or a “woman who is attracted to men”.

Both Participant Two and Participant Three, warn against making assumptions. They each recommended asking the client questions, rather than coming to one’s own conclusions. Participant Three, recalled an occasion when she made an assumption about a client based on their name and presentation, only to experience confusion later, when she realized that her assumption
was wrong. Participant One, shared her experience of how clients don’t know how to be in their new role and she describes it as an evolving process that can often be confusing for the client.

King (2012), writes about her struggles with conflicting feelings of empathy and revulsion towards her MTF client. She questioned where these feelings were coming from. Were they all her own? Or was she picking up her client’s disowned or disassociated feelings? Her client, Dawn, had shared her feelings of revulsion with her ‘male’ parts which she claimed did not belong to her.

In this instance, King demonstrates the multi-dimensional nature of the symptom of confusion, where the therapist is not only holding their own confusion but also holding the clients dissociated feelings of confusion. King describes their therapeutic journey together as “continuing to sit with uncomfortable ‘objects’ in the room” and as “a period of work that was filled with confusion, conflict, guilt, panic and a sense of Dawn purging herself from David” (King, 2012, p. 43).

Participant Three, spoke about her experience of the symptom of confusion within the erotic countertransference. She described occasions when her trans clients had dressed in role and she had found them to be sexually attractive. However, she knew that the body concealed beneath the presented gender identity, was not what she would normally find attractive. The author was struck by how such situations can create confusion and ambivalence for the therapist. Attracted to the client, yet not attracted to the client.

5.5 Benefits experienced by Therapists

Each of the participant therapists spoke of how they have benefited and grown as a result of working with transgender clients. They expressed how this type of work has broadened their awareness and has helped them to have a greater understanding of the complexity of life. They
acknowledged that this work encouraged self-reflection on their part, around how they view gender identity.

All three participants expressed how this work has increased their empathic capacity and their ability to sit with their clients in their confusion, their anxiety and their struggle to become the person they truly believe themselves to be. The participants spoke about how their trans clients have given them a greater understanding of how to accept a person for who they are, rather than how other people perceive them to be.

This chapter has reviewed the three main themes in light of the literature compiled in Chapter Two: Literature Review. The following chapter will present a brief conclusion to this research paper, acknowledge the strengths and limitations of this research, and make a suggestion for further research.
CHAPTER SIX: CONCLUSION

6.1 Conclusion

The primary aims of this research paper was to gain a deeper insight into the subjective experience of Irish psychotherapists working with transgender clients and to explore the challenges faced and benefits gained by the psychotherapists working with this minority group. The qualitative research methodology of Interpretative Phenomenological Analysis (IPA) delivered themes that were common across the three participants.

The data compiled, illustrated a strong identification process between the participant therapists and the transgender community which appears to have acted as the catalyst that motivated these participants to engage in therapeutic work with transgender clients.

A strong maternal countertransference was apparent from the data, which appeared to influenced the therapeutic approach of the therapists and the nature of the engagement within the therapeutic relationship. A dual process consisting of a traditional humanistic approach and a more directive approach seems to be the preferred approach of these therapists when working with their trans clients.

The symptom of confusion was present within the therapeutic space. This sense of confusion is multi-dimensional, consisting of the client’s confusion associated with the gender identity issues, society’s confusion associated with the non-conformance of transgender people to a binary model and the therapists’ confusion associated with their own experienced in this type of work.

Despite the challenges associated with this very specific group of clients, each of the participants experienced the work as rewarding and expressed the benefits they have gained from engaging with this minority group.
6.2 Strengths and Limitations

**Strengths** – The qualitative approach of this research paper delivered rich data. In terms of achieving the aims of this paper, the semi-structured interviews worked well in allowing the participants to share their experiences of working with transgender clients. The sample group of therapists were well informed on trans issues and were willing to participate in this research.

**Limitations** – When interpreting the findings of this research paper, the following limitations require consideration. Firstly, with a sample size of three participant therapists is it impossible to determine how statistically representative the compiled data is with regard to the wider psychotherapy profession.

Secondly, as each of the participant therapists were females over the age of forty years, the data may be gender and age biased. Furthermore, as the data implies, the participant therapists strongly identify with transgender people and as such, their positive bias may impact the findings.

6.3 Suggestions for Further Research

The data compiled during this research shows evidence of the symptom of confusion within the therapeutic space when working with transgender clients. One of the participant therapists made reference to this element of confusion being present within the erotic countertransference she experienced.

She found the external presentation of her client, when dressed in role, to be sexually attractive. However, these feelings caused confusion and conflict for the therapist, as she knew that what lay beneath the external presentation of her client, was not what she would normally be attracted to.
Further research into the erotic countertransference experiences of therapists working with transgender clients would be recommended, in order to gain an understanding of this phenomenon within the work.
REFERENCES


APPENDIX 1 - INFORMATION FORM

My name is Kevin Harmon and I am currently undertaking an MA in Psychotherapy at Dublin Business School. I am inviting you to take part in my qualitative research project on the experience of psychotherapists working with transgender clients.

I am interviewing psychotherapists with at least 5 years’ practice experience post accreditation, who are interested in talking about their experiences of working with transgender clients.

What is involved?

If you agree to participate in this research, you will be invited to attend an interview with myself in a setting of your convenience, which should take no longer than an hour to complete. During this interview, I will ask you a series of questions relating to the research question and your own work. After completion of the interview, I may request to contact you by telephone or email if I have any follow-up questions.

Confidentiality

All information obtained from you during the research will be kept confidential. Notes about the research and any form you may fill in will be coded and stored in a locked file. The key to the code numbers will be kept in a separate locked file. This means that all data kept on you will be de-identified. All data that has been collected will be kept in this confidential manner and in the event, that it is used for future research, will be handled in the same way. Audio recordings and transcripts will be made of the interview but again these will be coded by number and kept in a secure location. Your participation in this research is voluntary. You are free to withdraw at any point of the study without any disadvantage.

DECLARATION

I have read this consent form and have had time to consider whether to take part in this study. I understand that my participation is voluntary (it is my choice) and that I am free to withdraw from the research at any time without disadvantage. I agree to take part in this research. I understand that, as part of this research project, notes of my participation in the research will be made. I understand that my name will not be identified in any use of these records. I am voluntarily agreeing that any notes may be studied by the researcher for use in the research project and used in scientific publications.

Name of Participant (in block letters)________________________________________

Signature_________________________________________________________________

Date / /
APPENDIX 2 – INTERVIEW QUESTIONS

1. I would like to start by hearing about what brought you into psychotherapy work?
2. Can you tell me about the type of clients you tend to see?
3. Can you tell me about your transgender clients? MTF, FTM, Pre-op, Post-op, #, %.
4. How would you describe your experience of working with these trans clients?
5. What is your sense/understanding of the specific needs of trans clients?
6. How can the therapist meet these needs in the therapeutic relationship?
7. What challenges have you encountered that are specific to working with trans clients?
8. Can you recall a time when you may have felt uneasy working with a trans client?
9. Can you say a little about the transference / countertransference issues you have encountered while working with trans clients?
10. Do you feel the clients make sense of the work?
11. How have you grown or changed from working with trans clients?
12. What is any, specific training did you undertake to support your work with trans clients?
13. How would you evaluate your core training in terms of preparing you to work with trans clients?
14. Do you feel that the current field of psychotherapy in Ireland is adequately trained and equipped to support trans clients?
15. What advice would you offer a fellow therapist commencing work with a trans client?
16. What supports are there for a therapist working with trans clients? Have you tapped into these? (Supervision – is your supervisor experienced with trans clients?)
17. Is there anything you would like to add that I have not asked you about?
## APPENDIX 3 – Sample of Transcript Analysis

<table>
<thead>
<tr>
<th>Original Transcript</th>
<th>Line by line analysis</th>
<th>My thoughts</th>
<th>Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do they themselves feel that they are passing well enough? So, really high levels of anxiety. Some levels of depression and loss. Fear. Everything comes into the room, really.</td>
<td>Self-doubt, self-critical, Fear, depression, loss.</td>
<td>Self-doubt around their choices and their appearance. Massive impact on the client’s mental well-being.</td>
<td>Society – shame (mental health)</td>
</tr>
<tr>
<td>I suppose, by being with them. Accepting them. Psycho-educational work, I think is very important. Being able to tap into the tool bag of the training that we get and use little bits of everything. So, being in contact with their body. Being in contact with their feelings. Sitting with it, being with them in it</td>
<td>Acceptance, psycho-educational work, integrative approach, emotional awareness, somatic awareness, holding the space</td>
<td>There is a dual process required, an integrative approach which looks at the client’s emotions, feelings and bodily sensations. But also, a psycho-educational aspect where the therapist is educating and resourcing the client.</td>
<td>Approach – psychodynamic and integrative</td>
</tr>
<tr>
<td>Also, challenging them. The challenge isn’t about somebody.... I don’t know how to explain this. Sometimes went we hear you are going to challenge someone, it’s as if you are trying to get them to change their mind. It’s not about getting them to change their mind, it’s about challenging them to say, “No, I can do this. And I’m right to do this. This is good for me”. And get them to accept what they are doing and how they are doing.</td>
<td>Challenging the client to look at the choices they are making and to believe that they are doing the right thing</td>
<td>Challenging the client to believe in themselves, that they are worth it and deserve to be happy. The choices they are making are the right choices for them. Encouraging them to have confidence in what they are doing</td>
<td>Approach – encouragement Society – putting themselves first</td>
</tr>
<tr>
<td><strong>So, it nearly sounds like you are trying to empower them?</strong></td>
<td><strong>Empowering the client to put their needs and their wants first.</strong></td>
<td><strong>The therapist work to strengthen the clients sense of self-worth, encouraging them to put their own needs above everyone else’s for once. They are worth it and they deserve to be happy.</strong></td>
<td><strong>Approach – empowerment, encouragement, self-worth, self-first</strong></td>
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<tr>
<td>Yes, that sounds a better way of putting it, rather than challenging them. It’s not about getting them to change their mind or getting them to do something differently. Or, maybe they will do something differently as part of it. But to get them to see that putting themselves first, with their wants and their needs is important. It’s not always about everybody else out there.</td>
<td>Empowering the client to put their needs and their wants first. Strengthening the self-worth. Not always putting others needs before their own</td>
<td></td>
<td>Society - shame</td>
</tr>
</tbody>
</table>