

Therapeutic approaches to counselling trans and gender diverse clients during the 2017 Australian Marriage Law Postal Survey: A qualitative study of the effects of stigma

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Introduction

In the last decade, there has been a dramatic rise in the cultural visibility of people who identify as trans and gender diverse (TGD). This increased visibility is due to the advocacy of groups that represent and support TGD people as well as some high-profile individuals. Consequently, there is much deeper appreciation of TGD people's rights and the issues they face. Despite these advances, in Australia TGD people are three times as likely to be treated for a mental disorder as the general public and seven times as likely to attempt suicide (National LGBTI Health Alliance, 2016). The literature indicates that to a large extent these issues are rooted in the stress of social and relational stigmatisation and isolation (Blumer, Green, Knowles, & Williams, 2012). Access to psychological support that validates and respects TGD people's own understanding of their gender has been identified as a key factor in turning around the negative effects of discrimination and exclusion (Riggs, Ansara, & Treharne, 2015). In 2017, Australians were asked to vote on the question: "Should the law be changed to allow same-sex couples to marry?" In the lead up to the Australian Marriage Law Postal Survey (AMLPS), and during the 11 weeks in which voting took place, TGD people were subjected to increased levels of stigmatisation by some advocates of the "No" campaign. This study investigates the impact of stigma on TGD people during the period of the 2017 AMLPS. It enquires into the therapeutic approaches adopted by therapists working with this population and documents the resources they drew upon in response to the effects of stigma.

Terminology

In this paper the term "trans and gender diverse" (TGD) is used as an umbrella term for people whose gender identity is different from that normatively associated with their assigned sex at birth (von Doussa, Power, & Riggs, 2017). This includes people who identify with non-binary gender identities, such as genderqueer or gender-fluid, and binary gender identities such as trans man and trans woman or simply man and woman. *Cisgender* describes individuals whose given sex matches their body and gender identity.

The term “cisgender” is highly critiqued within the literature for maintaining the essentialist and binary practice of categorising people as either “cisgender or transgender”. This need to categorise and delegitimise people’s own designations of their genders and bodies is known as *cisgenderism* (Ansara & Hegarty, 2014). Within the multicultural Australian context, it is important to acknowledge that understandings of gender diversity are linked to cultural background. For example, Samoan culture is highly tolerant towards feminine males, who are addressed as *fa’afafine* (Vasey & Bartlett, 2007). Indigenous TGD Australians have adopted the terminology *sistergirl* and *brotherboy*, which is derived from traditional understanding of gender diversity and can have slightly differing meanings depending on the geographical location (Kerry, 2014).

Significance and Background to the Proposed Study

Despite diverse expressions of gender in Australian culture, there remains little understanding, knowledge, and acceptance of TGD people within the broader Australian society, resulting in widespread expression of transphobia and trans prejudice (Riggs, von Doussa, & Power, 2015). TGD individuals are at disproportionate risk of physical and sexual assault, homelessness, poverty, career-related discrimination, relationship losses, and refusal of medical services (McCullough et al., 2017). The largest study conducted on the mental health of TGD young people in Australia (Strauss et al, 2017) used a mixed-method, cross-sectional online format to talk with 859 TGD people aged between 14 and 25 years, as well as 194 of their parents or guardians. Respondents indicated high levels of mental illness: 76% had been diagnosed with depression, 79.7% had self-harmed, and 48.1% had attempted suicide. These young people also reported experiencing high levels of bullying, homelessness, abuse, unsafe educational environments, and lack of family support. There is increasing evidence that exposure to experiences of prejudice and discrimination increase the risk of adverse mental health outcomes such as suicide, depression, anxiety, substance abuse, and HIV/AIDS (Bess & Stabb, 2009; Klein & Golub, 2016; Lev, 2013; Meyer, 2003; Nadal, Skolnik, & Wong, 2012; National LGBTI Health Alliance, 2016; Pfeffer, 2016; Sanger, 2010; Sawyer, 2013; Schilt & Westbrook, 2009; Singh, Hays, & Watson, 2011; Strauss et al., 2017).

Context: The Australian Marriage Law Postal Survey

In 2017, the Australian government commissioned a national postal survey, conducted between 12 September and 7 November, to gather population-level public opinion on same-sex marriage. This postal vote was a “one of a kind” in Australian history and elicited intense public and political debate (Perales & Todd, 2018). Although TGD people were not the subject of the survey, issues that directly impacted a sense of inclusion and acceptance for this community were being publicly aired. In a discourse analysis study of campaign materials, Burns (2018) proposed that arguments grounded in essentialist views of gender and family were used to justify discrimination. One particular discourse was that same-sex marriage would inevitably lead to “radical gender theory” being taught in schools, and that this would pose a threat to children and disempower their parents to protect them. An article in *The Guardian* newspaper stated, “As the postal survey on same-sex marriage looms, conservatives looking to spook voters into selecting ‘no’ have

increasingly made scapegoats out of trans and gender nonconforming bodies” (Gallagher, 2017, p.1). The debate raged on the streets, on social media and mainstream media, in schools, in neighbourhoods, and in family homes. Trans academic Quinn Eades (2017) wrote, “I’m not thinking about outcomes, and neither are my friends—we’re too busy guarding our own edges. ...the fabric of my world has changed. ... the illusion of acceptance has vanished” (p. 4).

In a survey study of 9,500 lesbian, gay, bisexual, trans, queer, and intersex (LGBTQI) Australians and their allies between 16 October and 14 November 2017, Ecker and Bennett (2018) report that: incidents of verbal and physical assaults more than doubled compared to the six months period prior; respondents reported experiencing negative messages about themselves at least daily, especially from online and television media; and, experiences of depression, anxiety, and stress increased. During this period, demand for counselling services for LGBT people surged by as much as 40% (Brown, 2017). These findings are in line with a United States’ survey of 1552 LGB adults following general elections where marriage law amendments were on the ballot (Rostosky, Riggle, Horne, & Miller, 2009). The authors reported significantly more *minority stress* due to exposure to negative media messages and negative conversations, and higher levels of psychological distress than among participants living in the other states. (Meyer [2003] defined minority stress as the high level of stress experienced by sexual minority groups.)

Identified Problems With Mental Health Services for TGD people

This study investigated the approaches adopted by therapists when working with TGD clients, in an environment when TGD identities were under heightened attack. Prior research indicates that TGD individuals often report reluctance to seek treatment due to fear of disapproving or culturally insensitive therapists (Whitman & Han, 2017). There is some justification for this fear in the literature. A study in the United States (Mizock & Lundquist, 2016) used a grounded theory approach to interview 45 TGD people who had received mental health services. This study identified specific missteps psychotherapists made in working with this group, including: therapists’ lack of knowledge of medical, cultural, historical aspects of TGD people’s lives and the systemic oppression they experience; focusing too much on gender or avoiding it completely; generalising trans experiences; pathologising gender variance as a disorder; and, experiences of gate-keeping, such as therapists controlling access to gender-affirming medical resources (McCullough et al., 2017; Mizock & Lundquist, 2016). In a phenomenological study, McCullough et al. (2017) reported the key negative experiences of TGD people seeking therapy as: therapists lack of knowledge of TGD issues; experiential invalidations, such as therapists *misgendering* clients by using incorrect pronouns or misidentifying them; and, *intersectional insensitivity*, where therapists fail to acknowledge that clients hold multiple marginalised identities, such as race or culture, that are also important aspects of their identity.

Trans-Affirmative Approaches

Investigating how therapists provide culturally relevant support which addresses the influence of social inequities on the lives of TGD people and enhances resilience and coping skills is an area where research and resources are urgently needed (Singh & Dickey, 2016). In 2015, the American Psychological Association (APA; 2015) endorsed the *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People*, which outlines an affirmative therapeutic approach to working with this population. This document comprises 15 key guidelines for therapists, beginning with an understanding that: "...gender is a non-binary construct that allows for a range of gender identities". (APA, 2015, p. 834). In response to these guidelines, there has been an increase in research into therapeutic practices from the United States. Most studies explore the experience of psychotherapy from the TGD clients' perspective (e.g., Bess & Stabb, 2009; Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016; Hines, 2007; Johnson, 2014; Lykens, LeBlanc, & Bockting, 2018; McCullough et al., 2017; Mizock & Lundquist, 2016; Nadal et al., 2012; Singh et al., 2011). The current study investigates trans-affirmative therapeutic approaches used by therapists with TGD clients, and as such, bridges a gap in the current research.

Addressing Trauma and Building Resilience and Coping Skills

Communities subjected to historical and structural violence are disproportionately afflicted by trauma and its effects (McKinnish, Burgess, & Sloan, 2019). Therefore, having a deep understanding of how trauma affects human beings and their relationships is essential for affirmative therapeutic practice with TGD people. The basic principles of a trauma-informed approach are: trauma understanding, cultural humility and responsiveness, safety and stability, compassion and dependability, collaboration and empowerment, and resilience and recovery (Kimberg & Wheeler, 2019).

Research suggests that therapists are developing approaches to support resilience and thriving for their TGD clients (Singh & Dickey, 2016). In a phenomenological enquiry, Singh et al. (2011) explored the lived experience of 21 TGD individuals. The authors identified five key resiliency themes for therapists to focus on: an evolving, self-generated definition of self; awareness of oppression; self-worth; connection with community; and, hope for the future.

How Therapists Support Their Practice

Singh (2016) suggested that therapists need to examine their own understanding of cisgender privilege to become effective allies and advocates for their TGD clients. Whitman and Han (2017) reported that therapists who intentionally develop cultural competence and awareness of their personal biases and assumptions are less likely to perpetuate explicit or implicit forms of discrimination and stigma. This leads directly to stronger therapeutic alliance, providing the foundation to reduce disparities in mental health services for TGD individuals. As therapists develop cultural competence by becoming informed about the issues unique to their TGD clients, they can support their clients to explore their experiences of discrimination and begin to resolve internalised transphobic attitudes (Tebbe & Moradi, 2016). Singh (2016) quotes Gangulu woman and

Aboriginal land rights activist Lilla Watson (1985) to illustrate the potency of her call for therapists to examine their own experiences of oppression with regard to gender: “If you have come to help me, you are wasting your time. If you have come because your liberation is bound up with mine, then let us work together” (as cited in Singh, 2016, p. 756).

Methodology

This research enquires into the impact of stigma during the AMLPS on TGD clients, as reported by their therapists. The project was approved by the Torrens University Australia Human Research Ethics Committee. The research question was addressed using an exploratory qualitative phenomenological methodology. Qualitative research provides the framework for researchers to understand marginalised voices through the sharing of stories. Phenomenology was chosen as the methodology for this study because it has been shown to be useful when used by other similar studies (e.g., Bess & Stabb, 2009; Broadbent, 2013; Carrick, 2014; Moltu & Binder, 2014). The basis for the practice of psychotherapy is both phenomenological, with an open focus on experiences as they are lived, and hermeneutic, involved in the organisation and interpretation of experiences into meaningful wholes (Moltu & Binder, 2014). The methodology chosen for this study, a hermeneutic phenomenological theory of knowledge, matches the practice that is being studied.

Sample Recruitment

Six therapist participants were sourced for this study through purposive sampling (Denscombe, 2014). All participants were required to meet the following criteria: (a) experienced therapists registered with their professional body for at least five years, and (b) had at least two TGD clients between September and November 2017, the period of the AMLPS. Organisations that provide counselling services for TGD clients were contacted via email and asked to invite staff therapists to participate in the study. A promotional email was attached for them to forward to staff. An internal ethics review was required, and approval gained, in order for one particular organisation to support the project. Therapists in private practice were contacted through a support group for therapists who work with TGD clients. A promotional email was forwarded to therapists on their database, and those interested in participating in the study replied to the promotional email. An informed consent form was forwarded to each participant and a time and place to conduct the interview was arranged.

Participants

All participants were experienced therapists who have been registered with their professional body for between 10 and 30 years. Four of the six therapists were also supervisors to other therapists. All participants were seeing clients who identified as TGD during the period of the 2017 AMLPS. Table 1 below summarises the key features of each of the participants who were assigned a pseudonym to protect their identity.

Table 1: Key Features of Participants

Therapist	Professional background	Years of experience	Location & type of practice	Client base
Jo	Clinical psychologist	13	Major city; bulk billing practice	TGD
Karen	Psychotherapist	30	Major city; private practice	LGBTQI
Laura	Psychologist	30	Major city; private practice	LGBTQI
Ruby	Counsellor	10	Major city; community organisation	TGD
Michael	Counsellor	10	Regional city; community organisation	LGBTQI
Sally	Counsellor	20	Major city; private practice	TGD

Data Collection

Semi-structured, in-depth, one-on-one interviews of approximately 60 minutes were conducted with the participants to obtain rich and detailed accounts of their experiences (Flick, 2009). All interviews were conducted between July and August 2018.

Interview Questions

The following interview questions were used to guide the semi-structured interview:

- During the period of the marriage equality debate last year were there any significant changes in your TGD clients' presentations?
- How did you support your clients during this time?
- Did you modify or adapt your therapeutic approaches during this time?
- What supported you to meet the specific needs of your TGD clients? What resources did you draw upon?

Data Analysis

Data was analysed using the interpretative phenomenological analysis (IPA) framework as outlined by Pietkiewicz and Smith (2014). This method of analysis was chosen because, while meeting guidelines for rigour and validity, it emphasises the importance of individual accounts. The inclusion of detailed personal experiences is significant for the practice of psychotherapy (Pringle, Drummond, McLafferty, & Hendry, 2011). The process began with the author transcribing all interviews verbatim, before engaging in multiple readings of the transcripts and re-listening to the recordings to become familiar with the data. The next step involved analysis of each transcript in the form of notes summarising key ideas. This was followed by highlighting key phrases in the transcripts related to the research questions, and concepts and ideas in the literature. Through this iterative process of becoming more deeply familiar with the data, an extensive list of emergent themes was constructed. The themes were organised as sets of responses to each question and were represented by extracts from the transcripts. Further readings of the transcripts and themes led to grouping the concepts emerging from the data into the major sub-themes. The process of naming the sub-themes came from distilling the data and identifying the key messages. The author then wrote a narrative account of each theme and sub-theme.

Validity

The credibility of this study is supported by the choice of experienced and professionally registered participants (Lincoln & Guba, 1985). The timing of the study to coincide with a period when TGD people are likely to have experienced increased mental health concerns requiring enhanced therapeutic responses from their therapists is evidence of the transferability of the study (Thomas & Maglivi, 2011). Thick, rich descriptions and the inclusion of the words of participants create vivid details for readers and enhance validity (Creswell & Miller, 2000).

Ethical Considerations

A research design was employed that would not expose TGD clients to harm by contributing to the pressure they experience to explain themselves. According to Connell (2012),

There is a great pressure on trans people to explain themselves: to family, to police, to psychiatrists, to endocrinologists and surgeons, to employers and workmates, to government officials, to border guards, and even to researchers. The demand for self-exposure is both wearing at a personal level, and tends to define trans people as bizarre, tabloid-fodder, craziness (p. 2).

Therapists were invited to participate in the study through a third party. Participants received information about the purpose of the study, measures of confidentiality and anonymity, and methods of data collection and storage. Participants were forwarded an informed consent form and told that they may withdraw from the study at any stage.

Results

Participants reported seeing TGD clients during the period of the 2017 AMLPS for trans-related concerns (e.g., affirming transition decisions), non trans-related concerns (e.g., anxiety, depression, trauma, or substance use), or, most often, a mixture of both types of concerns. Most of the therapeutic relationships were ongoing, that is, they existed prior to and following the period of the marriage equality debate.

Analysis of the data, as described in the methodology, led to grouping the results into three main themes: (a) *impact of the marriage equality debate on their clients*, (b) *therapeutic approaches utilised in working with the effects of stigma with TGD clients*, and (c) *support systems for therapists working with TGD clients*. Each of these main themes contained various sub-themes, which are outlined below.

Theme 1: Impact of the Marriage Equality Debate on Their Clients

Five of the six therapists reported that the majority of their TGD clients were impacted by the debate around the AMLPS and it became a major focus of their work with clients during the period of September to November 2017. All participants revealed that they thought TGD people were targeted in the debate. Several participants commented that the marriage equality debate came on the back of an attack on gender diversity, mounted by the Australian Christian Lobby, over the “Safe Schools program,” which was designed to support the creation of safe and inclusive learning environments for LGBTI students. The fear-mongering around gender diversity was carried over into the marriage equality debate. Laura shared: “There was a sense of TGD people being targeted again”. Karen added: “TGD people were marginalized in the nastiness of the campaign and this impacted the sense of belonging, that perhaps the gay community didn’t defend them”.

All participants reported that they had a few TGD clients who were not engaged with the debate. For example, Ruby reported: “Probably 80% of clients were on the pulse with it. So were being emotionally effected by advertising and conversations on social media around the campaign.” Sally, who mainly sees gender-questioning young people and their parents, reported that the debate came up in conversation a few times but was not the focus of her work: “It was just a passing comment usually because they wanted to focus on what they’re here for...people come to see me to transition”.

Data from the therapists who reported that their clients were impacted by the debate has been grouped into four sub-themes: (a) *lack of safety* (b) *family ruptures* (c) *expressions of distress*, and (c) *positive connections*.

Lack of safety.

Four of the therapists reported that clients had been verbally or physically assaulted during this period. One therapist reported a client had been victim to vandalism relating directly to the marriage equality debate.

All participants agreed that their clients, even those who were not emotionally distressed by the debate, experienced an increased sense of fear when they were in public and were being more vigilant about keeping themselves safe. Michael explained: “I found that

most of my clients... [were] sharing stories about being careful again, like careful on the streets, careful of identifying, feeling a bit more anxious and fearful of just being out in the world.” Participants reported that their clients experienced an increased sense of danger in being out in public, and that they felt like they were under the spotlight, scrutinised and judged for being TGD. Participants reported clients were getting “looks,” having abuse yelled at them, or being refused service in shops. Michael reported: “Conversations that they were hearing in cafés and on the streets were that people were asking, ‘do they have the right to do this?’”

Many people from the TGD community migrate to live in urban areas that are perceived as “safe” to benefit from lower structural and interpersonal stigma (Winston, 2017). During this period these “safe” areas became the sites of attacks. Several participants commented on this fact. Ruby said: “It turned what was considered to be a very safe area of Sydney into somewhere that wasn’t safe anymore”.

Several of the therapists talked about the lack of safety in terms of the minority stress framework (Meyer, 2003). When exposed to external stressors such as public scrutiny or instances of violence and discrimination, members of the minority group under attack (in this case those who identify as TGD) then develop internal stressors, such as expectations of violence and internalised transphobia (Hendricks & Testa, 2012). Jo explained: “It’s being primed to feel the world is unsafe. Which is classic minority stress stuff where you experience an attack and then you internalise that and you become kind of hyper-vigilant and sometimes over-read neutral stimuli to think that’s an attack too”.

Family ruptures.

Therapists reported that one of the most significant impacts of the public nature of the debate was on family relationships. All participants reported that they had clients who had ruptures with family members. Ruby reported: “With all of this going on, people were starting to clash with their families in a new way”. Michael added: “I had some young people who were thrown out of home at this time”.

In some families where there had been a level of acceptance of the person’s gender expression, ruptures occurred when family members felt pressure from religious or community groups that gender diversity was not acceptable. Karen stated: “Some religious leaders just said you must vote no and this is how it is... that isolated them more from their families”.

The very public nature of the debate led to family members making their opinions known, as Ruby shared: “It forced people to play their hands”. For some clients, learning that their family members were voting against marriage equality opened up old wounds, as Karen reported: “A whole lot of distress would come up when they realised that a family member or the whole family was going to vote ‘no’. Then conflict that had just been pushed aside was right there in everyone’s faces.”

Some clients responded by going on the attack and others by retreating. Michael said: “I definitely had clients sitting in the chair saying, ‘Well, I’m no longer respectful of my father,’ or, ‘I no longer want to have a relationship with my mother, or grandmother, aunts, cousins’”.

Expressions of distress.

Participants reported a range of distress responses that they noticed in their clients during this period. These included increased tiredness, sadness, increase in tears, depression, fear, anger, and isolating. Jo reported:

Some people, I saw them crumbling in on themselves. And other people, I saw them flashing between being furiously angry then collapsing with it. So, the people going up and down with anger and distress, and other people who just got more depressed and worn down by it.

Participants described how their clients minimised their feelings of distress and were dismissive of their feelings, saying that they shouldn’t be feeling so stirred up by the debate. This response corresponds with the “minority stress” model, where external messages such as “you’re horrible, disgusting people” are internalised and to some extent believed (Bradford, Reisner, Honnold, & Xavier, 2013).

Michael talked about the impact on clients who were in the early stages of transition:

Some of the clients were reasonably confident in their transition, and we were working through it at fairly good pace – then this was like a big bump in the road, like a big obstacle in the road. It kind of threw them backwards and that just needed stabilizing.

Isolation and marginalisation were other issues most of the therapists talked about. People were feeling afraid to go out and this fear increased their tendency to withdraw from social contact. Those who did not have support networks during this time tended to become more isolated, as Jo reports:

People who didn’t have those connections: social support, biological family, created family. If you don’t have that, then it’s a really big risk factor for your wellbeing. And I was seeing that those people, who were probably already the most marginalised, were just feeling incredibly isolated.

Positive connections.

All of the therapists talked about the positive effect that a show of explicit support from family members had on some of their clients. Ruby explained: “Some people obviously had very supportive families in every respect, before, during, and after, and that really strengthened the relationships because people really felt like they had an advocate”.

The debate provided opportunities for community connection, which was a positive experience for some clients. The gender minority stress and resilience (GMSR) model (Testa, Habarth, Peta, Balsam, & Bockting, 2015) includes two resilience factors:

community connectedness and *pride*. Jo observed:

People who are connected with community, they were drawing together very strongly. So there were a lot more free dances, people having big group lunches together or having picnics in the park, you know, and really, I think, for the connection but also for the visibility—pulling together. And that was helping people who had those connections.

Theme 2: Therapeutic Approaches to Working With the Effects of Stigma With TGD Clients

Participants shared their insights and understanding about working with the effects of stigma on their TGD clients during this time. The therapists drew on a range of therapeutic modalities including; person centred counselling, gestalt therapy, existential therapy, and acceptance and commitment therapy (ACT). While they shared about interventions specific to these approaches, analysis of the data revealed three overarching common sub-themes in their approach: (a) *acknowledging the systems at play*, (b) *promoting self-care*, and (c) *working from a trauma-informed approach*.

Acknowledging the systems at play.

Participants stressed the importance of acknowledging the structural difficulties their clients face. This included knowing the history of the struggles faced by TGD people as well as the current inequities at play. Several participants talked about acknowledging their own privilege. Jo stated:

I think that part of affirmative practice is acknowledging the systems at play. Whether it's a woman, or a person of colour, or a person with a disability, or a trans person, or a gay person, it's really important to acknowledge the structural difficulties that people come up against. Because I think that if we don't, then I'm not acknowledging my privilege in the room.

Several participants talked about creating a safe place for their clients to talk about what was going on and for them to be heard and validated. They stressed the importance of asking directly about how people were coping with the marriage equality debate. For some clients, it was front and centre as a topic for discussion, but for a lot of clients, it wasn't until they were asked directly that the floodgates opened. Jo remarked:

I would give them space to talk about whatever seemed front of mind for them. But then I would say, "Do you think that the marriage equality debate is having an impact?", and then I would get this flood. Because they hadn't had the opportunity to talk about it with anyone. And it was really quite powerful to see how without asking that question they would have just held it.

Michael shared a similar experience:

The little things that they would not always share, that came out with a little bit of deeper asking. “Are you OK? Have you experienced any harassment or discrimination?” And then they would say... “Well, yes, I suppose, there was the guy who yelled at me from the car when I was crossing at the intersection”.

Therapists reported that many clients were dismissive of their own feelings. Jo stressed that for this reason it was important to be active in raising the issue of the marriage equality debate, because it sends the message that it is perfectly reasonable to have feelings about it. She also stressed the importance of giving clients permission to really open up about how they are feeling about it, and letting them know that they were not alone, that this is a difficult time for a lot of people. Karen made it clear to her clients that this is a cultural issue:

There are political gains for some people in keeping certain groups repressed. That whatever someone’s feeling through that whole “yes” and “no” campaign that it’s also beyond them as well as within them—to contextualise it within the culture they’re within. It impacts you when you’re hearing negative messages.

Several participants commented that it was not a time for deep, analytical therapy or for addressing issues of internalised transphobia in any depth. Michael commented: “I think it was a time of just holding people and keeping people safe. We knew that there was going to be an end to the debate and that we would be able to move on after the debate”.

Promoting self-care.

Keeping people safe and promoting self-care was another theme. The volatility of the debate brought out destructive behaviours in some clients. Some were very angry and wanting to fight back, while others turned to distracting behaviours like drugs or other addictions. The therapists worked to develop resilience and coping strategies with their clients through developing protective factors, such as keeping connected with family and community, keeping themselves safe, managing difficult feelings, and regulating how they were engaging with the debate.

All participants agreed that a strong support network of family and friends is a protective factor for their clients. Those who have the full support of their family and friends thrive (Austin & Goodman, 2017). Therapists were checking what supports their clients had and encouraging them to be making use of them. Jo commented: “Clients, who were too vulnerable to attend events or connect with groups face-to-face were directed to online chat groups and support lines”.

Another area of self-care was how people were engaging with the debate. Ruby commented: “Some people were reading Facebook and Twitter day in and day out and just reading all the negativity... So I worked with people to make choices around their involvement, limit the time they spent online.”

Jo works with the client's set of values as a way of helping them work out how to protect themselves, while still acting in line with their values: "So if something like compassion and kindness is important in someone's value set... they don't need to punch someone in the nose... instead they might write something or say something and not get pulled into a destructive discussion". Working with values was also a way of guiding clients' toward showing compassion and kindness towards themselves.

Trauma-informed approach.

Overwhelmingly, previous data suggests that experiences of trauma are all-too-common for TGD people (McKinnish et al., 2019). Many TGD clients come with some form of trauma already embedded in their lived experiences. Four of the six therapists interviewed talked about working from a trauma-informed approach during this period to help regulate their clients' emotional states. A lack of safety and the sense of public scrutiny and judgement was taking some clients back into past traumatic experiences. Michael stated:

Whether it was abuse or neglect or being thrown out of home or homeless. So just being conscious that that's already sitting there, and now there's something else that's going to elevate that past experience and possibly put them back in it.

Participants used mindfulness practices such as body awareness, breathing techniques, and physical games to help clients regulate their emotional states. Michael shared: "I found myself working during that time—keeping in mind that trauma model to stabilise and steady people so that they could actually react more calmly to things". As Jo reports: "I think that it's a real struggle sometimes when everyone is hurting and lots of people have traumas so the front of their brain, their frontal cortex is a bit offline because they are triggered and in their instinctive reactions, so it's really hard for everyone to be very gentle with each other."

Laura observed that some of her younger clients were not as personally impacted by the transphobic messages they were hearing as her older clients. She understood this in terms of the trauma model: "It's because it didn't trigger anything for them," she explained:

"They had largely been raised by parents who have tended to be, if not progressive, at least were fairly open, and surrounded by peers too who were fairly open... so their concerns around the debate were more conceptual... as opposed to feeling really emotionally churned up by it."

Theme 3: How Therapists Support Their Practice With TGD Clients

All of the participants talked of this as a time when they were particularly concerned for their clients. Some talked of the frustration they felt that a political process was at the root of the increased suffering they were seeing in their clients. Ruby shared: "I held a lot of frustration on behalf of my clients". Several of the participants shared about managing their own responses to the negative messages and hate speech they were hearing during

this time. Michael shared: “Personally it was really impactful. I was quite surprised, being a confident gay man who’s been out in the world for a long time. I was even surprised at my own reaction to the brutality and the impact that it had on me”.

Participants’ discussion about how they support their practice is divided into the following sub-themes: (a) *keeping informed and connected*, (b) *becoming an advocate*, and (c) *reflections on gender, power, and privilege*.

Keeping informed and connected.

All participants emphasised the importance of keeping informed and up to date with current research and literature. They felt that it is important to be well informed about the changes happening with trans health care and any legislation or policy developments that might impact their clients. They attend conferences and stay connected with the peak bodies that provide services for TGD people. Ruby said: “ACON put out a poster on how to stay strong during the marriage equality debate. It was a really useful resource to share with my clients.”

All of the participants regularly attend supervision to support their practice. Karen shared: “It can be difficult to find [a supervisor] who understands, in a non-prejudiced way, what people are doing when they transition. So the therapist has a slightly parallel process to her client in that way.”

Participants also talked about the importance of connecting with other therapists to stay up to date with current practices and build professional connections. Several are members of a support and referral group for therapists who see TGD clients. Jo said: “It can feel really isolated working in this area and through this group we have peer supervision and we’re actually able to talk our struggles through with other people”. Two of the therapists who work in organisations shared about how much they value having TGD colleagues and being part of an organisation focused on best practices for TGD clients.

Becoming an advocate.

All participants talked about their roles as advocates for the TGD community. Several participants take voluntary leadership roles in organisations that provide services for TGD people. They talked about the importance of being connected into the network of community events so that they can share resources with clients and also have some visibility within the community. Michael shared: “I keep connected with what’s happening in the trans community... I attend trans pride. I show my allegiance and support for trans people through that”. Jo reported:

I actually have a big crossover with a lot of my clients, even socially, which is usually an absolute “no no”. So we talk about it and figure out how to deal with it... The feedback that I get is that they actually feel safer for me being there.

Some therapists spoke of participating in direct action such as protest marches during this time. This ties in with the writing of Vikki Reynolds (2011) who suggests that in order to avoid burnout, therapists need to participate in transforming the social context of oppression through various activist traditions, in conjunction with doing the work of helping their clients to adjust to the impact of oppression.

Reflections on gender, power, and privilege.

All of the therapists were passionate about their work with TGD clients. One participant identified as genderqueer, and several others stated they are cisgender. Reflecting on gender, Laura shared:

I try to be really careful and respectful of people's lived experiences, given that I don't have it, and arguably someone who is trans who's a practicing therapist or psychologist is almost always better placed to speak to this stuff than I am. I try to be careful with that because I am cisgendered and that is a privilege in this society.

Reflecting on their understanding of gender, Michael shared:

I'm not married to any kind of binary gender ideas. There's a lot more young people coming out now non-binary, or having a real mix of gender identities in their body. So just being open to that and letting people be whatever they are without them needing to conform in any way... there are as many ways of being transgender as there are transgender people.

And Ruby reflected on the way she works:

It's about helping clients figure out who they are authentically and what will best help them to present that to the world. Because the important thing about gender is that we are social creatures and we need to see ourselves reflected in other people. We need to know that people see us the way that we see ourselves.

When talking about the way feminism informs her understanding of power and privilege, Karen reflected, "I find that the most important thing is not to make any assumption or judgement. Not to assume anything, but to ask; to really get to know someone's world view of how they see themselves".

Discussion

The goal of this study was to better understand the counselling experiences of six experienced therapists in their work with TGD clients during a period of intense public focus on this client group. Using an IPA qualitative approach to analyse semi-structured, in-depth interviews with the participants, the findings reveal a high level of commonality in the participant's experiences during this time. Overall findings reveal that working with the effects of the AMLPS on their clients was the focus of a large part of their work during this time. Participants reported that their clients experienced increased levels of distress, increased levels of fear for their personal safety, increased reports of family ruptures, and

re-triggering of past traumas. They also reported on their clients' positive connections with family and community. Therapeutic approaches utilized during this time were primarily focused on keeping people safe and stabilising difficult emotional states.

Structural and Interpersonal Stigma

The results of this study can be understood in relation to research which seeks to distinguish between structural and interpersonal stigma (Hatzenbuehler, 2014). Structural stigma is defined as discrimination exercised through societal-level conditions, institutional policies, and cultural norms (Hughto, Reisner, & Pachankis, 2015), while interpersonal stigma occurs between people. Results from this study indicate clients were exposed to both structural and interpersonal stigma directly resulting from the AMLPS.

On a structural level, the political process of the "postal survey" allowed for the distribution and broadcast of campaign material that attacked the legitimacy of gender diversity and put this minority group "under the spotlight," making TGD people the subject of negative discourse. Interpersonal stigma was experienced in the form of physical and verbal abuse, refusal of services, and family ruptures.

These experiences of structural and interpersonal stigma led to expressions of distress in the form of increased tiredness, sadness, increase in tears, depression, fear, anger, and isolating. These findings are consistent with current research, which suggests poor health outcomes for TGD people are associated with the experience of structural and interpersonal stigma (Bradford et al., 2013; Goldblum et al., 2012; Reisner, Gamarel, Nemoto, & Operario, 2014; Tebbe & Moradi, 2016).

How Results Relate to Existing Research

These results add to the small body of research on the impact of the AMLPS. Perales and Todd (2018), in their analysis of data from the AMLPS, link the experience of structural stigma and negative life outcomes for LGB people. In a survey study of 9,500 LGBTQI people during the AMLPS, Ecker et al. (2018) reported an increase in experiences of violence and negative mental health outcomes during this time. Results from this study also point to an increase in family ruptures. This is an important finding because literature indicates that support from family is a key protective factor for people who identify as TGD (Austin & Goodman, 2017; Pfeffer, 2016; Riggs, von Doussa, et al., 2015; Tebbe & Moradi, 2016; Testa et al., 2017). Rejection by family is known to have negative effects on mental health, making young people economically vulnerable and depriving them of the protective factors of social support from close others (Klein & Golub, 2016).

Another model that helps understand these results is the gender minority stress and resilience (GMSR) model (Hendricks & Testa, 2012). It suggests that exposure to a hostile and stressful social environment leads to three types of internal stressors: negative expectations for future events, internalised transphobia, and non-disclosure of one's identity (Testa et al., 2017). This is consistent with reports of clients increased expectation of danger, tendency to minimise their negative experiences and feelings, and increased tendency to isolate.

Exceptions

Not all TGD clients experienced distress during this period. This was understood by some participants to be the result of strong family and social support systems, and the absence of past traumas related to discrimination and exclusion. It was also noted that some TGD people do not identify with the LGBTQI community, some conceal their transgender identity, and some have strong heteronormative identities. Some people from these groups were less engaged with the debate. It is also worth considering that these people who do not have community support around them and who work hard to conceal their trans identities may be highly engaged with the negativity of the debate and may be at high risk.

Therapeutic Approaches

In a qualitative study of counselling experiences of TGD clients, McCullough et al. (2017) concluded that after encountering challenging experiences, what mattered most to their participants was having a caring, supportive, and respectful mental health practitioner. All therapists reported that validation and respect for clients' gender expression was fundamental to their approach. The participants drew on a range of modalities, including: acceptance and commitment therapy, gestalt, existential and person-centred approaches. The key approaches when working with the effects of stigma were concerned with creating safety, fostering self-care, and working from a trauma-informed approach.

Research into affirmative therapeutic practices suggests therapists address the influence of social inequities on the lives of their clients (Singh, 2016). A key point that emerged from the current research is the importance of acknowledging the political and cultural systems at play. One therapist of the six interviewed reported that talk about the marriage equality debate didn't really come up because it wasn't why clients came to see them. This may be correct, but it is a stark contrast to reports from the other therapists interviewed. Nearly 20 years ago, Carroll, Gilroy, and Ryan (2002) encouraged therapists to consider how the experiences of stigma and prejudice impact mental health outcomes for transgender people and to include these issues in the therapeutic conversation.

Implications

This study contributes to a small body of research informing therapists of the many ways that TGD clients express the effects of stigma and discrimination. Some of the findings may also be applicable to members of other minority groups who are subject to public scrutiny and discrimination.

In the Australian context, the AMLPS followed on from the "safe schools" debate, where negative discourse around gender diversity was publicly expressed. The Australian Government's review of religious freedoms is another political process, which will place this vulnerable group under the spotlight yet again.

Limitations

The results of this research should be regarded in light of several limitations. Firstly, as a small-scale qualitative study, there is the inherent limitation that the six therapist participants cannot represent the experiences of all the therapists around Australia who were working with TGD clients during this time. Another limitation is that although one participant was based in a regional city, five of the participants were based in major cities. Therefore, the results do not include the experiences of participants from remote and rural settings.

Conclusion

The findings reported here contribute to a growing body of research showing evidence of the negative impacts of structural and interpersonal stigma on the wellbeing of people who identify as TGD. This study looks specifically at the impact of the AMLPS on this group. The results speak to the need for structural level intervention to acknowledge the harm and to prevent future political processes and policies which foster negative discourse and lead to stigmatisation and discrimination of vulnerable community members. Therapists working with those subject to stigma need to be active in acknowledging the systems at play and creating an environment of safety for their clients to explore the effects of stigma. Further research into therapist's experiences working with TGD clients, particularly in the Australian context, is much needed.

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