TRANS INDIVIDUALS' PERCEPTIONS OF COUNSELOR EFFECTIVENESS: AN EXPERIMENTAL ANALOGUE STUDY

A DISSERTATION

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Abstract

The current study experimentally explores the effect of counselor characteristics on trans participants' perceptions of the therapist's general counseling competence. Specifically, this study utilizes an experimental analogue design in which participants were randomly assigned to a vignette in which counselor gender identity and connection to the trans community were manipulated. Gender identity was manipulated through the counselor disclosing whether they were 'trans' or 'cisgender.' Counselor connection to the trans community was manipulated by knowledge of and attendance of Transgender Day of Remembrance (TDOR). Additionally, participants' levels of Internalized Transphobia (IT) was explored as a possible moderator between counselor-client gender identity matching and participants' perceptions of the counselor's general counseling competence as measured by the Counselor Rating Form-Short (CRF-S). The hypothesis that counselor-client gender matching would increase participants' perceptions of general counseling competence was not supported in the current study. IT did not moderate the relationship between counselor-client gender matching and CRF-S scores. Counselor Connection to the trans community increased participants' perceptions of the counselor's general counseling competence. This finding highlights the importance of counselor connection and advocacy to culturally and advocacy related events when working with the trans community. Research, practice, and training and education implications are discussed.

Introduction

Trans people are at increased risk for discrimination and interpersonal violence, including but not limited to: physical, verbal, sexual assault, harassment and discrimination (Grant et al., 2011; The Trevor Project, 2020). Trans people are those whose internal experiences of gender are not consistent with their sex/gender assigned at birth; cisgender people are those whose gender identity aligns with their sex/gender assigned at birth (American Psychological Association, 2015; Hendrick & Testa, 2012). Because of their relatively low representation within the overall population, trans people have historically been marginalized, leading to experiences of discrimination and interpersonal violence based on their gender identity (Grant et al., 2011; The Trevor Project, 2020).

Discriminatory and violent experiences have been empirically linked to negative mental health outcomes within the transgender community (Bockting et al., 2013). Researchers often rely on the minority stress model (Hendricks & Testa, 2012; Meyer, 2003) to investigate the relationship between environmental stressors and negative health outcomes experienced by trans people and have uncovered direct links between minority stressors and a variety of negative health outcomes for trans people including increased symptoms of depression, anxiety, and somatization (Bockting et al., 2013) and suicide attempts (Grant et al., 2011; Haas et al., 2014). Of a national sample of 6,450 people who self-identified as trans, 41% have reportedly attempted suicide, compared to 4.6 percent of the total U.S. population (Grant et al., 2011). Haas et al. (2014) found that suicide attempts were related to discrimination experiences such as being refused treatment by a healthcare provider due to their gender identity; gender identity discrimination or harassment experiences at work; and harassment or bullying at school. Given these high rates of mental health concerns associated with minority stress, it is important that

trans people have access to appropriate culturally competent mental healthcare. Therapist factors have been shown to be an important element in the therapeutic relationship (Baldwin & Imel, 2013) and are linked to culturally competent care for trans clients (Hunt, 2014; McCullough et al., 2017). The impact of counselor-client gender matching is one factor that has been explored within the therapeutic context (Bellini, 2013). Additionally, feminist therapy and the field of Counseling Psychology has discussed the importance of advocacy and connection to the community of those with whom one is working with, especially clients from marginalized communities (Enns, 1993; Israeli & Santor, 2000; Singh & Burnes, 2011). There is currently a dearth of experimental literature exploring the effect of these factors on the counseling for trans clients. To address this need, the current study experimentally explored the effects of counselor gender identity, connection to the trans community and trans participants' levels of internalized transphobia on their perception of their hypothetical counselor's general counseling competencies.

Cultural Terminology

Trans is an umbrella term representing a multitude of gender identities (Moradi et al., 2016); some identities fall on the gender binary of 'man' or 'woman' such as trans men and trans women, while others do not fall within this binary such as 'genderqueer' or 'nonbinary' (APA, 2015). According to a recent study by Meerwijk and Sevelius (2017) approximately 390 out of 100,000 adults or .39% are transgender.

Multiculturally Competent Psychotherapy for Trans Clients

Receiving multiculturally competent psychotherapy could be one way for trans people to cope with their experiences of minority stress and thereby decrease associated negative health outcomes. However, there is a paucity of experimental literature exploring trans clients'

experiences in therapy (Blumer et al., 2012). In the marriage/couple and family therapy literature, a recent meta-analysis revealed that of 10,739 articles from the period of 1997-2009, only nine (.08%) focused on transgender concerns (Blumer et al., 2012). Furthermore, Moradi et al. (2016) conducted a content analysis specifically of trans research between the years 2002 and 2012 and concluded that an increased focus on factors that improve therapy for trans clients was needed. Given the dearth of literature on trans clients' experiences in therapy, it is not surprising that many trans people report that a barrier to appropriate healthcare is having to educate their provider about gender identity (The Joint Commission, 2011). Providing care professionals with empirical literature guided by the lived experiences of trans clients can increase their multicultural competence and decrease the educational burden currently experienced by trans clients.

While the literature is sparse regarding trans experiences in therapy, related studies regarding multicultural counseling competency can provide guidance on likely relevant variables to explore when studying MCC with trans clients. Using culturally adapted treatment approaches has been found to be more effective than treatment-as-usual (Smith et al., 2011) as has incorporating an understanding of the client's perception of the etiology of their concerns into treatment (Benish et al., 2011). A meta-analysis comparing culturally adapted psychotherapies revealed an effect size of $d = .32$ for culturally adapted psychotherapy compared to other bona-fide therapies, and a small but statistically significant effect size of $d = .21$ when a culturally adapted treatment included integrating the client's own etiological perspective of their disorder compared to culturally adapted treatments that did not incorporate the client's etiological perspective (Benish et al., 2011). For trans clients, this could indicate that a therapist's

connection to the trans community and adoption of a minority stress etiological model could be a beneficial cultural adaptation for positive therapeutic outcomes.

In support of the role of MCC on therapeutic outcomes, Bellini (2003) concluded that client-counselor racial matching and therapist MCC are statistically significant predictors of rehabilitation outcomes, but their effect sizes are small. Bellini's results exhibit support for the importance of therapist MCC on client rehabilitation rate at least for racial minority clients working with white counselors. They found that counselors from a majority group (European American counselors) with increased MCC had more positive impacts for their clients than did majority counselors with lower MCC scores. Specifically, racial majority counselors with increased MCC scores showed higher rates of rehabilitation for both racial majority and minority clients, and these effects were larger for racial minority clients. This finding could have implications for cisgender counselors working with trans clients. Soto et al.'s (2018) meta-analysis exploring the relationship between cultural adaptations and therapist multicultural competence revealed a medium effect size of d =. 50 for interventions that were culturally adapted. Although findings are mixed, the preponderance of evidence appears to support the notion that culturally adapted psychotherapies are more effective than treatment as usual (Benish et al., 2011; Griner & Smith, 2006; Smith et al., 2011; Soto et al., 2018).

Beyond having fundamental knowledge about trans issues and the ability to provide culturally adapted psychotherapy, multiculturally competent therapists must also have the skills necessary to build a therapeutic alliance with their trans clients, as therapeutic alliance has been shown to account for approximately 7.5% of the variance in treatment outcomes (Horvath et al., 2011). Successful therapeutic alliance (and therapy outcome as a result) is highly related to the client's perceptions of the therapist's MCC. For instance, Tao et al. (2015) found that not only

did clients' perception of their therapists MCC account for more than 8% of the variance in therapy outcomes, but also accounted for a considerable portion of the variance in therapeutic alliance, client satisfaction with counseling, and client perception of their counselor's general counseling abilities. Other researchers have concluded that both a weak therapeutic alliance and low ratings of therapist MCC were significant reasons for premature termination of treatment (Anderson et al., 2018). Lastly, Fuertes et al. (2006) study of perceived therapist MCC revealed clients' perceptions of therapist MCC were positively related to therapy alliance variables.

Although the working alliance has been measured in a litany of ways, Baldwin and Imel (2013) state that "measures of the working alliance involve patients, therapists or external raters indicating the degree to which patients and therapist agree on the tasks and goals of therapy as well as the quality of the therapeutic bond" (p. 282). As the working alliance is a combination of both therapist and client characteristics, a key aspect in this alliance is client perception of the therapist's general counseling competence. Tao et al. (2015) reviewed the literature and stated that client perceptions of therapist counseling competence include ratings of trustworthiness, attractiveness, and expertness, similar to Strong's (1968) original conceptualization of interpersonal influence for opinion change. Strong theorized multiple factors which contribute to the success of the therapeutic relationship including perceived counselor trustworthiness, attractiveness, and expertness. Counselor trustworthiness is defined as the perception of social role, reputation, sincerity, and lack of motivation for personal gain. Counselor attractiveness is defined as perception of the counselor as friendly, sociable, warm, and possessing similar characteristics with that of the client. Counselor expertness is defined as the perception of the counselor as having a degree and other credentials in a related field that signify mastery of the profession.

For therapists to be perceived by trans clients as competent, expert, trustworthy, and able to build an effective therapeutic alliance, there are specific factors to consider. Given the marginalization faced by the trans community both within and outside of healthcare settings (Grant et al., 2011), the importance of counselor characteristics might be especially salient for this community to build a trusting relationship. Nascent research points to the importance of therapist gender identity and therapist connection to the trans community as facilitative factors which might contribute to a positive therapeutic alliance and perception of therapist competence (Hunt, 2014; McCullough et al., 2017).

Gender and gender-identity matching is one possible route to enhance the working alliance for trans people. Specifically, Hunt (2014) found that 37% of trans clients selected their counselor based on their counselor's gender. Similarly, McCullough et al. (2017) found that almost every participant felt it was important to find a therapist with an identity similar to their own. While trans clients may express a preference for a therapist whose gender identity matches their own, the research is limited regarding whether the matching objectively improves treatment outcomes. Other research has studied the effects of client-therapist matching with mixed results, although matching has been described as an important factor for increasing treatment engagement for minority communities (Jones et al., 2003). Studies specifically exploring gender matching have historically done so using a binary, cisnormative lens, limiting their relevance for trans populations.

Of this research regarding gender matching, the results are unclear as to whether gender matching improves therapy alliance or outcomes (Bhati, 2014; Bowman et al., 2001). For example, Whaley (2006) conducted a quasi-experimental analogue design exploring how gender matching and racial self-labelling among male clients might affect symptoms of paranoia when

the participant was interviewed by Black male or Black female psychologists. Whaley found that male gender-matching reduced paranoia for participants. However, contrary to the study's hypothesis, participants who were gender matched also scored higher on a measure of cultural mistrust. Given the quasi-experimental nature of the study, one cannot draw causal conclusions, but these results appear to show that, for Black men with increased racial identity, even those matched on gender and race still exhibited high levels of cultural mistrust. Additionally, Bowman et al.'s (2001) meta-analysis (N = 64) found that therapist sex was a poor predictor of therapeutic outcome for both male and female identified clients. However, Bhati (2014) found that regardless of dyad-type, female identified therapists showed higher alliance ratings than male-identified therapists. These results point to the nuances involved in therapist demographic matching and points to the need for including other variables, especially identity development variables, that might moderate the relationship between client perceptions of their therapist and demographic matching.

Beyond matching variables, emerging literature supports the view that therapist connection to the trans community— that is, the therapist's knowledge about and attendance of trans-relevant activities— is an important factor for trans clients. Indeed, the American Psychological Association's (2015) Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (TGNC) specifies that trans-competent therapists should be actively involved with the TGNC community they serve, be involved with informing public policy, promoting social change, and with identifying and improving systems that promote violence toward TGNC people. As evidence of the importance of a therapist's connection with and advocacy for the trans community, Hunt (2014) reported that 34% of trans clients selected their counselor based on the counselor having a transaffirmative reputation within the trans

community. Likewise, Rachlin's (2002) qualitative survey of 93 trans participants found that participants viewed the therapist's connection to the transgender community as one of the four important factors in positive therapy experiences. A theme identified in McCullough et al.'s (2011) qualitative study of trans experiences in therapy was a trans affirmative approach (that is, one that affirms the identity of trans people and recognizes their unique experiences). This included overt therapist involvement with advocacy efforts, specifically demonstrating visibility within the TGNC community. Multiple participants reported that therapist visibility within and advocacy for TGNC communities led clients to feel better understood and supported by their therapist and increased trans client's positive feelings toward their therapist (McCollough et al., 2011).

Given the pronounced effects of minority stress on trans clients (Hendricks & Testa, 2012), social activism could be a helpful approach in addressing the cause of distress for many trans clients. This activism or therapist sociopolitical connection to the community in which they serve has been widely discussed within feminist therapy for years (Enns, 1993; Israeli & Santor, 2000; Singh & Burnes, 2011). In fact, social activism is a core tenant of feminist therapy and connection to community can be understood as one operationalization of that intervention. Israeli and Santor conceptualize social activism as an intervention that "extends(s) beyond individual therapy sessions in order to affect broader social changes" (p. 234). Israeli and Santor state that, at the time of their writing, this intervention had not yet been empirically studied. Indeed 14 years later, the need for an increased empirical literature linking "feminist therapy to activist practice" is still prevalent (Singh & Burnes, 2011, p. 139). Directly assessing the effect of therapist connection and activism to the trans community through attendance of a culturally significant event, Transgender Day of Remembrance, is one approach to answering the call for

continued empirical studies. To accurately identify the impact of therapist allyship (through connection and activism) to the trans community, it is essential that therapists receive feedback from this community to ensure the effectiveness of their interventions (Dillon et al., 2016).

Importance of Perspective

The focus of the variables of interest thus far have been from the perspective of the client rather than the therapist or outside observer, and for good reason. There is a need for the representation of trans clients' voices in describing what makes therapy most efficacious for this community; that is, what sorts of therapists do trans clients themselves find to be expert, trustworthy, and multiculturally competent? Rater perspective is subject to bias and has a demonstrable effect on the reporting of various therapeutic outcomes and processes. For instance, Dillon et al. (2016) conducted a study of 133 clients of color receiving psychotherapeutic services at a university counseling center. In accordance with other literature, therapists' assessment of their own MCC was not consistent with their clients' ratings of therapist MCC (Dillon et al., 2016). Soto et al. (2018) conducted a meta-analysis related to therapist MCC in which the results also differed by rater. When clients rated therapist MCC, there was a moderately strong positive correlation between MCC and treatment outcomes (r = .38). However, when therapists rated their own MCC, there was a much weaker correlation between MCC and treatment outcomes (r = .06). As such, clients' ratings of therapist MCC were more strongly related to treatment outcomes than were therapists' ratings of their own MCC. Therefore, it is essential to solicit the client perspective especially when assessing subjective factors related to therapy outcomes, such as MCC and counselor competence.

Moderating Variables- Minority Stress

Negative feelings about one's own community have been found to be negatively associated with mental well-being (Sanchez & Villain, 2009). Internalized transphobia, a proximal minority stressor, can be conceptualized as internalizing a system of oppression. Nascent research on this construct has demonstrated that Internalized Transphobia is positively related to psychological distress such as depressive symptomology (Bockting et al., 2020). Transphobia is conceptualized as an effect of the oppressive system of cisgenderism. Cisgenderism can be defined as an "ideology that delegitimizes people's own designation of their genders and bodies" (Ansara & Hegarty, 2014, p. 2). When an individual possesses internalized negativity about one or multiple personal identities, they integrate negative social messages about the groups to which they belong. For instance, they might internalize negative stereotypes about their group (Rood et al., 2017).

In a study exploring internalized sexual stigma, Herek et al. (2009) found that internalized stigma can lead to negative feelings about the self and others who also possess that stigmatized identity. These authors reason that the same oppressive systems which lead to homophobia in heterosexual people can also lead to internalized homophobia in sexual minority people. People high in internalized stigma may thus think negatively about themselves and others belonging to their stigmatized group. Bockting et al. (2020) studied the experiences of 430 trans individuals in their creation of a measure of internalized transphobia. The authors identified "alienation from other transgender people" as part of their four-factor model (p. 15). This factor was conceptualized as "feeling different from, and embarrassed by, other transgender individuals" (p. 22). As such, the PI hypothesizes that similar mechanisms might influence trans participants' perceptions of other trans people, including therapists. In the current study, possessing higher levels of internalized transphobia (IT) might serve to decrease trans

participants' perceptions of a transgender counselor's trustworthiness, expertness, and attractiveness while serving to increase their perception of these traits for cisgender therapists.

Current Study

The current study used an experimental analogue design to explore trans-identified participants' reactions to a hypothetical counseling scenario. Participants were randomly assigned to read a vignette in which counselor gender identity and connection to the trans community was manipulated. Trans participants' perceptions of counselor general counseling competence, participants' previous counseling experiences, and experiences with internalized transphobia was assessed.

Question/Hypotheses

Strong (1968) hypothesizes that therapist-client gender identity matching will lead to increased perceptions of the counselor's general counseling competence. The PI posits that counselor connection to the transgender community will also lead to increased participant perceptions of the trustworthiness, attractiveness and expertness of the counselor (as measured by the Counselor Rating Form-Revised). Given the aforementioned research, counselor connection, even in the absence of gender identity matching, will signal to the participant that the counselor might be multiculturally competent. It is expected that participants will perceive trans counselors who are connected to the transgender community as being most competent and thus rate them highest on the measures of trustworthiness, attractiveness, and expertness. It is hypothesized that participants will view these counselors as possessing both inside knowledge about what it means to be trans and effort related to connecting themselves to the transgender community. Lastly, those counselors who are not connected to the transgender community, nor are trans, are hypothesized to be rated lowest on these measures as there is no evidence to

suggest that they have knowledge or commitment to this community (at least in the current vignette). However, it is hypothesized that participant IT will moderate the relationship between counselor gender identity matching and the CRF-S. When IT is high, perceptions of the counselor as rated by the CRF-S will increase when the counselor is cisgender compared to when the counselor is transgender. However, when IT is low, perceptions of the counselor will decrease when the counselor is cisgender versus when the counselor is transgender. Thus, the PI will seek to answer the following questions in the current study.

Question 1: Is there an interaction between the effect of matching counselor and participant gender identity and counselor connection to the trans community on participants' perceptions of their counselor's attractiveness, trustworthiness, and expertness as measured by participant ratings of the CRF-S?

Hyp 1: There will be a significant interaction between counselor gender identity matching and connection.

Question 2: What is the effect of matching counselor and participant gender identity on trans participants' perceptions of their counselor's attractiveness, trustworthiness, and expertness as measured by participant ratings of the CRF-S?

Hyp 2: There will be a main effect of counselor gender identity matching on trans participants' perceptions of their counselor's attractiveness, trustworthiness, and expertness, as measured by participant ratings of the CRF-S. When counselor-participant gender identity matches, participant ratings of their counselor's attractiveness, trustworthiness, and expertness will be greater than when therapist-participant gender identity does not match.

Question 3: What is the effect of counselor connection to the transgender community on transgender participants' perceptions of their counselor's attractiveness, trustworthiness, and expertness as measured by participant ratings of the CRF-S?

Hyp 3: There will be a main effect of counselor connection to the trans community on trans participants' perceptions of their counselor's attractiveness, trustworthiness, and expertness as measured by participants' ratings of the CRF-S. When connection is present, participant satisfaction with their counselor's attractiveness, trustworthiness and expertness will be greater than when connection is absent.

Question 4: Internalized Transphobia (IT) will moderate the relationship between counselor-participant gender identity matching on participants' perceptions of their counselor's attractiveness, trustworthiness, and expertness as measured by participant ratings of the CRF-S.

Hyp 4: When internalized transphobia is higher, participants' perceptions of their counselor's attractiveness, trustworthiness, and expertness will be greater when counselor-participant gender identity does not match than when counselor-participant gender identity does match.

Method

Participants

According to an a priori power analysis, using the G* Power software, the current study required a sample of approximately 128 participants (Faul, Erdfelder, Buchner, & Lang, 2009) to achieve 80% of power in an independent group F-test with an alpha level of .05 to detect a medium effect. Out of the original 356 people who clicked on the Qualtrics link, the final sample consisted of 237 participants which yielded enough power for the current analyses. All participants self-identified on the trans spectrum. Specifically, participants indicated if they

"…identify as transgender, trans, gender nonconforming or some other identity under the transgender umbrella/spectrum AND (are) 18 years or older." Only participants that indicated in the affirmative were included in the current study. Participants ranged in age from 18 to 61 years old (M = 28.08, SD = 7.30). Besides age and gender identity, there were no additional exclusion criteria.

For the current study, participants were recruited via online venues. Specifically, convenience sampling was utilized. In order to increase the external validity of the current study, participants were recruited from organizations and community forums across the United States. Namely the Research Assistant (RA) and Principle Investigator (PI) contacted various Facebook groups, other online forums and community organizations that cater to LGBTQ people. An example of one such group is the Facebook group, Queer Exchange NYC. This group's focus is to connect queer-identifying people so that they can exchange goods and services to one another (essentially an online marketplace). This venue was particularly effective as, at the time of this writing, there are 31,071 members in this group, many of whom identify as a gender minority Although in-person formats were originally proposed, COVID-19 rendered this possibility impossible and unethical. As such, all participant data was collected remotely. To recruit from community-based organizations, the RA created a form letter which she distributed to various community-based organizations that serve LGBTQ individuals. Staff at some of these organizations indicated that they would send out the recruitment information to their members. For a full list of recruitment contacts, please refer to Appendix H.

Procedures

The study was conducted using the Qualtrics online platform. The study consisted of the experimental manipulation, the Counselor Rating Form -Short (CRF-S) scale, a detailed

demographic form, questions about participants' previous counseling experiences, and a subscale of the Gender Minority and Resilience Measure (GMSR)- Internalized Transphobia (IT). The measure of IT was included last in an attempt to limit order effects; specifically, this was done to limit its interaction with the experimental manipulation. The experimental manipulation is composed of an experimental analogue in which participants were randomly assigned to one of four vignette conditions. See Appendix A for an example vignette and Appendix D for a detailed example of the study questions and order of presentation.

A pilot study was conducted to measure the validity of the experimental manipulation prior to collecting data on the full sample. The pilot study was used to test the construct validity of the independent variables, psychometrics of the CRF-S for a trans sample, and study flow. The results of the pilot study indicated that the independent variables had good construct validity. Namely, participants perceived a counselor attending a Trans Day of Remembrance event as significantly more connected to the trans community than a counselor who was not knowledgeable about the event nor whom attended the event (p = .000). The CRF-S and its subscales yielded good reliability estimates and no concerns related to study flow were indicated (as per participants' free responses). The IT measure was added after the pilot study was conducted. For a full description of the pilot study and analyses, see Appendices E and F.

Manipulation and Design

The current study consisted of a 2 (Therapist Gender Identity Matching: Therapist identifies as a cisgender person vs. Therapist identifies as a transgender person) x 2 (Counselor Connection and knowledge about the Transgender Community: High (Counselor knows about and attended Transgender Day of Remembrance (TDOR), and Low (Counselor does not know about TDOR and did not attend TDOR) between subjects randomized factorial design with

perceptions of the counselor's general counseling competence (measured using the three subscales of the CRF-S (attractiveness, expertness, trustworthiness) as the dependent variables.

Instruments

Demographic Form. A demographic form assessed the following characteristics: sexual orientation, gender identity, sex assigned at birth, race/ethnicity, geographic location, age, highest current educational level, and current income. See Appendix D for a detailed description of the demographic form questions.

Previous Therapy Experiences. Participants reported their previous experiences with counseling. These questions included whether participants have ever been in counseling, whether they are currently in counseling, duration of their counseling experience, how they felt about their experience with their last therapist, their last therapist's gender identity, and whether their previous therapist was connected to the trans community.

Experimental Manipulation- Analogue Design. See Appendix A for a sample vignette that was presented to participants. The bolded, colored lines indicate where the independent variables are located and were varied according to condition. The PI's creation of this vignette was informed by research utilizing other experimental analogues. It was then pilot tested to ensure construct validity.

The Counselor Rating Form-Short (CRF-S; Corrigan & Schmidt, 1983). The CRF-S is a 12-item measure included to assess participants' perceptions of their therapist on a 7-point rating scale (Bettergarcia & Israel, 2018). Participants rate how they felt their therapist exhibited demonstrated various characteristics on a 1 (*not very*) to 7 (*very*) scale. This scale consists of three subscales measuring client perceptions of counselor's attractiveness (friendly, likable, sociable, warm), expertness (experienced, expert, prepared, skillful), and trustworthiness (honest,

reliable, sincere, trustworthy). For instance, participants read the following prompt: "Please imagine yourself as the client in the session you just read. The following characteristics are followed by a 7-point scale that ranges from *'not very* ' to *'very'*. Please select the point on the scale that best represents how you viewed the therapist." Participants then rated the therapist on the above adjectives. See Appendix C for a more detailed description of the question format.

Corrigan and Schmidt (1983) state that these scales, although independent, should be interpreted in conjunction with each other. The reliability estimates for this scale found in Bettergarcia and Israel's (2018) study are reported as opposed to the original Corrigan and Schmidt's (1983) estimates because their sample consisted of trans people. As this is the population of interest of the current study, these reliability estimates should have increased external validity. Bettergarcia and Israel found a Cronbach's Alpha of .98 for the total scale composite. The three dimensions or subscales yielded the following Cronbach's alpha estimates. Attractiveness yielded a Cronbach's alpha = .96, Expertness yielded a Cronbach's alpha = .97, and finally Trustworthiness yielded a Cronbach's alpha = .96. In the present study, the full CRF-S reliability estimate was high, Cronbach's alpha = .95. The Attractiveness subscale yielded a Cronbach's alpha = .91, Expertness yielded a Cronbach's alpha = .94, and the Trustworthiness subscale yielded a Cronbach's alpha =.90.

The Gender and Minority Stress and Resilience Measure (GMSR; Testa et al., 2015). This theory-derived measure was modeled after Meyer's (2003) Minority Stress Model. It assesses nine constructs related to minority stress. For the entire scale, Testa et al. (2015) reported good model fit, criterion, convergent, and discriminant validity. Specifically, Testa et al. utilized a sample of 1,414 participants. Testa et al. state that the nine subscales of the GMSR significantly correlated with additional measures of depression and social anxiety with effect

sizes ranging from .10 to .50 and thus conclude that the scale demonstrates adequate criterion validity. Convergent validity was mainly supported as evidenced by eight of the nine subscales of the GMSR correlating with a measure of perceived general life stress. Lastly, discriminant validity was indicated as correlations between the GMSR and other measures measuring related but distinct constructs were either at .60 or below. This was Testa et al.'s threshold for distinguishing between related constructs.

The GMSR subscale internalized transphobia is used in the current study. This 8-item subscale was measured on a 5-point Likert scale ranging from 0= *strongly disagree* to 4= *strongly agree*. Sample items include, "I resent my gender identity or expression," and "my gender identity or expression makes me feel like a freak." The authors reported internal reliability for this subscale, Cronbach's alpha=.89. See Appendix B for the full subscale. In the current study the Cronbach's Alpha was similar (alpha = .89).

Previous Counseling Experience. Lastly, participants' previous counseling experiences were assessed with a one-item measure, "Think back to your last therapist. How did you feel about your experience in counseling with them?" This item was a 7-point rating scale ranging from 1 (*Bad*) to 7 (*Good*) with 4 (*Neutral*) as a midpoint. This measure was included to control for previous counseling effects. It was not significantly related to any of the other measures in the current study.

Results

Analysis

An ANCOVA was conducted with Counselor Connection and Counselor Gender Matching as the independent variables, Internalized Transphobia as a covariate and the CRF-S subscales as the dependent variables. ANCOVA was selected as the method of analysis because

of the inclusion of a moderating variable and the finding that Previous Counseling Experience was not significantly related to any of the other variables (please refer to Table 3). Cell sizes were approximately even (see Table 3). The ANCOVA analysis was run three times with each of the individual subscales of the CRF-S (Trustworthiness, Expertness, and Attractiveness) as the dependent variables.

All assumptions of ANCOVA were tested: normality, homogeneity of variances, independence, scale of measurement, linearity of the covariate and dependent variable and homogeneity of regression slopes. The assumption of normality was met for all continuous variables (CRF-S subscales and IT). Kurtosis and skewness for Attractiveness was -.19 and -.28, respectively. For the Expertness subscale, kurtosis was -.81 and skewness was -.40, and for the Trustworthiness subscale, kurtosis was -.17 and skewness was -.57. The kurtosis for IT was -.28 and skewness was .74. Although IT's scores were also within normal limits for the assumption of normality, upon further investigation of its scores, as plotted on a histogram, there appeared to be a slightly positive skew, indicating that participants reported low IT scores (M = 1.23). To test the assumption of homogeneity of variances, Levene's test was run. With Attractiveness as the DV, this assumption was not violated as Levene's test was not significant, p = .229. With Trustworthiness as the DV, this assumption was not violated, p = .311. With Expertness as the DV, this assumption was violated as Levene's test was significant, p = .006. Independence was met given the randomized experimental design. Scale of measurement was met as all continuous variables were interval in nature. To test the linearity of the covariate, (IT with each of the DVs), a scatterplot was created, the results of which indicated that this assumption was met as a linear relationship was found. To test the assumption that there is homogeneity of regression slopes, the interaction between IT and the IV's were tested. As there was a non-significant interaction, this

assumption was not violated. See Table 3 for descriptive statistics for all scales and Tables 4-6 for means and standard deviations by condition.

To test Hypothesis 1, that there will be an interaction between Counselor Gender Matching and Counselor Connection, an ANCOVA was run with Counselor Gender Matching and Counselor Connection as the independent variables, IT as a covariate and each of the CRF-subscales as the dependent variables. No significant relationship was found for any of the dependent variables. Specifically, the relationship between Counselor Connection and Counselor Gender Matching was non-significant for Attractiveness, F (1, 236) = .99, p = .320, η^2 = .004, Expertness F (1, 236) = 3.24, p = .073, η^2 = .010, and Trustworthiness, F (1, 236) = 2.50, p = .115, η^2 = .010.

Hypothesis 2 predicted a main effect of Counselor Gender Matching on participants' ratings of the counselor as measured by the CRF-S subscales. Specifically, Hypothesis 2 stated that Counselor Gender Matching would increase participant ratings of the CRF-S. IT was controlled for in this analysis. This hypothesis was not supported, as there was no significant main effect of Counselor Gender Matching on Attractiveness, F (1, 236) =.16, p = .688 η^2 = .000, Expertness, F (1, 236) = .65, p = .422, η^2 = .002 or Trustworthiness, F (1, 236) = .02, p = .887, η^2 = .000.

Hypothesis 3 stated that Counselor Connection would lead to increases in participant ratings of the CRF-S subscales. IT was controlled for in this analysis. Hypothesis 3 was supported for all of the CRF-S subscales. Specifically, there was a significant main effect of Counselor Connection on Attractiveness, F (1, 236) = 4.42, p = .037, η^2 = .018. Participants rated the counselor significantly lower on the Attractiveness subscale when no connection was present, M = 4.61, SD = 1.09, than when connection was present, M= 4.98, SD = 1.31. Additionally,

participants rated the counselor significantly lower on the Expertness subscale when no connection was present, $M = 3.85$, $SD = 1.54$ than when connection was present, $M = 5.47$, $SD = 1.31$, F (1, 236) = 33.72, $p = .000$, $\eta^2 = .106$. Lastly, participants rated the counselor significantly lower on the Trustworthiness subscale, $M = 5.10$, $SD = 1.19$, when no connection was present than when connection was present, $M = 5.52$, $SD = 1.18$, F (1, 236) = 7.03, $p = .009$, $\eta^2 = .029$.

In order to test Hypothesis 4 that IT moderated the relationship between Counselor Gender Matching and Participant Perceptions of the Counselor, a model was created via SPSS software in which IT was allowed to interact with the Gender Matching variable. IT did not moderate the relationship between Counselor Gender Matching and any of the CRF-S subscales. Specifically, IT did not moderate the relationship between Counselor Gender Matching and the Attractiveness subscale F (1, 236) = 1.19, $p = .277$, $\eta^2 = .005$, the relationship between Counselor Gender Matching and Expertness, F (1, 236) = .00, $p = .989$, $\eta^2 = .000$, nor the relationship between Counselor Gender Matching and Trustworthiness, F (1, 236) = .54, $p = .461$, $\eta^2 = .010$.

Discussion

The current study sought to explore the effect of Counselor Gender Matching and Counselor Connection to the trans community on trans participants' perceptions of counselor effectiveness as rated by the three subscales of the CRF-S, a measure of general counseling competence. This was done via an experimental analogue design. Additionally, the moderating role of IT on gender matching and the CRF-S was explored. Nascent qualitative research has begun to indicate that clients whom are trans-identified found aspects of their counselors' identity to be important. Specifically, clients found a stance towards activism or connection within the trans community during counseling to be important factors for the quality of the therapeutic experience (McCullough et al., 2017; Rachlin, 2002). Although demographic

matching studies have been conducted on various other sociopolitical identities (e.g. race/ethnicity, sexual orientation), research on gender matching has mostly rested on the implicit assumption that counselors and their clients were cisgender (Bhati, 2014; Strohmer et al., 2003; Whaley, 2006). As such, the current study explicitly explored the effects of matching trans participants with a trans-identified clinician on ratings of the CRF-S.

No interaction effects were found in the current study. As such, Hypotheses 1 and 4 were not supported. Hypothesis 1 stated that there will be an interaction between Counselor Gender Matching and Counselor Connection. Specifically, in Hypothesis 1, it was predicted that counselors who are trans and connected to the trans community will be rated highest on the CRF-S measures. However, no significant interaction was found between Counselor Gender Matching and Counselor Connection to the trans community for any of the CRF-S subscales. An interaction was hypothesized because it was conceivable that connection would have increased participants' perceptions of their cisgender counselors' ability to relate to them. In this way, participants would not see the cisgender counselor as part of the trans community and thus could have perceived them as having some deficits of knowledge, experience and possibly ability to relate. However, counselors' attendance of TDOR and thus their connection to the community could have assuaged some of these concerns. This did not appear to be the case in the current study. It is possible that there was no interaction effect because matching did not have an effect on participants' ratings of their counselor's general counseling competence. This finding might be because participants simply did not perceive the counselors' gender identity to be important. Alternatively, it is possible that that the way in which gender identity was operationalized was not specific enough for participants to perceive their counselor's gender identity as matching their own. If gender identity was more explicitly defined (as opposed to being denoted as either

"trans" or "cisgender"), and matched specifically according to the participants specific gender identity, then perhaps differing results would have been demonstrated.

Hypothesis 4 stated that when participants' Internalized Transphobia is higher, participants' perceptions of their counselor's Attractiveness, Trustworthiness, and Expertness would be greater when counselor-participant gender identity does not match than when counselor-participant gender identity does match. This conceptualization is based on the knowledge that internalized stigma can have deleterious effects on peoples' perceptions of their own minority status (Rood et al., 2017). Thus, the PI asked whether this internalized stigma could extend to participants' perceptions of others' abilities who shared the same marginalized status. It is possible that Hypothesis 4 was not supported due to the fact that average rating of IT across the entire sample was positively skewed. Many respondents did not report high levels of IT. IT was measured on a 0 to 4-point scale with higher scores indicating increased levels of Internalized Transphobia. The mean score for N=237 participants was 1.23, SD = .95. This mean score is lower than that found with the same measure in previous studies. In Testa et al.'s (2015) development of the Gender Minority Stress and Resilience Measure and Bockting et al.'s (2020) development of a measure of Internalized Transphobia, participants' mean rating of their IT was 3.3, and 3.57, respectively.

Hypothesis 2 stated that there will be a main effect of Counselor Gender Matching on participants ratings of the CRF-S. This hypothesis was not supported. These findings indicate that participants' perceptions of the counselor's Trustworthiness, Expertness and Attractiveness were not influenced by whether their counselor identified as transgender or cisgender. Although Strohmer et al. (2003) found that 30% of clients indicated a preference for gender matching, in the current sample, counselor-client gender matching did not appear to impact participants'

perceptions of the counselor's general competence as rated by the CRF-S. In the current study, Counselor Gender Matching was a dichotomous variable. The counselor in the vignette was either cisgender identified, or trans identified. As specific gender identities were not mentioned, it is possible that participants did not perceive their gender to be matching that of the counselor. The lack of gender specificity was intentionally included both due to pragmatic limitations and theoretical reasoning. Pragmatically, it would have been difficult to recruit the number of participants needed to reach adequate power if we assigned participants to more specific gender identities. Theoretically, within queer theory, gender is often described as an ideographic variable that is not easily quantified, nor should necessarily be (Wilchins, 2004). As such, the PI intentionally did not further specify the specific gender identity. Additionally, even a binary gender identity has differing meanings for various people. The idea of what being a "woman" is to one person can be markedly different from another person's conceptualization of their own gender. Thus, in order to increase the ecological validity of the current design, an unspecified gender identity, besides that which describes the counselor as trans or cis was employed. The demographic breakdown of the current study adds post hoc evidence in support of the decision to keep the operationalization of gender more ambiguous. In this sample, 46.4% (n = 110) of participants identified with an identity under the trans umbrella which does not fall under dichotomous gender labels and generally refer to a range of gender experiences (non-binary, gender queer). Language and its meaning is constantly evolving. This is especially true regarding language describing various gender identities. As such, it is especially important for quantitative researchers to balance the tension between specificity in order to increase internal validity with breadth to increase inclusivity and thus external validity.

Other studies of gender matching (Bess & Stabb, 2009; Bhati, 2014) indicate a trend towards clients (both cisgender and transgender), preferring woman-identified therapists. To the author's knowledge, no experimental study has yet to explicitly examine trans-identified clients' preferences regarding gender matching. As such, this null result bears significance. If this result generalizes to other trans people, it is possible that as a group, trans clients are not necessarily impacted by whether their therapist identifies as transgender or cisgender. Given the preponderance of cis identified therapists, this finding has implications for the provision of culturally competent care. Specifically, if clients are less concerned with the gender of their therapist matching their own, then there will be one less barrier to finding a therapist.

Hypothesis 3, that there will be a main effect of Counselor Connection to the trans community on trans participants' perceptions of their counselor's Attractiveness, Trustworthiness, and Expertness was supported. As a reminder, Counselor Connection to the trans community was operationalized by the counselor's attendance of a Trans Day of Remembrance (TDOR) event. Participants in the current study rated the counselor significantly higher on measures of Attractiveness, Trustworthiness and Expertness when Counselor Connection was present than when it was absent. This is in line with previous research indicating that counselor connection and/or activism is important for trans clients (McCullough et al., 2017; Rachlin, 2002). Interestingly, Counselor Connection yielded the largest effect size for expertness, $\eta^2 = .106$. It accounted for 10.6% of the variance in participants' perception of the counselor's Expertness, a small, but meaningful effect size. This in turn indicates that trans participants' perceive counselors to be more expert when they know about and attend a TDOR event than when they do not know about nor attend a TDOR event. Counselor Connection accounted for less variance in Trustworthiness (e.g. honesty), $\eta^2 = .029$, and Attractiveness (e.g.

liking), $\eta^2 = .018$ than for Expertness. These results are not surprising given Expertness has been conceptually defined in part by the possession of knowledge and Connection was operationalized as knowledge and attendance of TDOR. These findings also support long-held feminist therapists' notions regarding the importance of activism (Enns, 1993). Not only does activism promote systemic change which positively impacts our clients, these results indicate that it also improves aspects of the working alliance, which in turn is implicated in the promotion of therapeutic change and thus effectiveness (Lambert, 2013). TDOR is an activist activity based on the premise of "resisting violence against gender-variant persons" (Lamble, 2008, p. 24). As such, our current operationalization of Counselor Connection is explicitly related to social activism.

Overall, these results provide further empirical support answering Singh and Burnes' (2011) call for empirical literature connecting feminist therapy to advocacy and their call for therapists to be involved in street-level activism. Feminist therapists have long stated that the personal is political (Enns, 1993). This is true not only for clients, but for therapists. As the instruments of our work, our bodies, and the time and space we choose to occupy both within and outside the therapy room are inherently political-they matter. In Rogerian language, it is important for therapists to exhibit congruence (Kolden et al., 2011). Kolden et al. describe an aspect of congruence as "the therapist's personal integration in the relationship" (p.65). We as therapists need to ensure that our work/advocacy outside the therapy room is congruent with our work inside the therapy room. These results seem to indicate that clients are indeed affected by this congruence. Israeli and Santor (2000) describe the debate among feminist therapy regarding the role social activism or rather political advocacy plays in the therapeutic process. Therapists disagree regarding the necessity of political activism in feminist therapy (Enns, 1993). The

results of the current study support the notion that social activism does indeed produce positive effects within the therapeutic alliance through increasing participants' perceptions of their therapists' general counseling competence. In this way, social activism appears to have a direct relationship with aspects of the therapeutic alliance. Thus, we can assert that counselors' social activism not only has positive implications for the betterment of marginalized social groups at a macro level, but also positively impacts the client at the micro level.

This study utilized an experimental analogue design, which adds to the empirical base supporting therapist variables that yield higher satisfaction among trans clients in counseling. It is the PI's hope that this study, modeled after Bettergarcia's and Israel's (2018) experimental analogue exploring trans clients' perceptions of affirming/non-affirming therapist responses towards clients gender exploration, will continue to add to the mosaic of empirical literature depicting best practices for effectively working with trans clients.

Strengths

To the authors' knowledge, this is one of the few experimental designs conducted testing trans participants' perceptions of therapist factors that impact the working alliance. This adds further empirical support to the nascent body of counseling literature exploring factors that increase counseling effectiveness for trans clients. Additionally, the current study utilized a community sample which adds to the generalizability of the findings. To date, no experimental study has explicitly explored the variables of Gender Matching and Counselor Connection (Budge & Moradi, 2018; Moradi et al., 2016). As such, this study provides novel data concerning these therapist factors. These findings can help inform the direction of future research. For instance, given the finding that connection yields greater perception of general counseling competence, randomized controlled studies can be conducted in which this specific variable is

further explored. This study also utilizes the perspectives of trans participants. As stated earlier, research exploring counselors' perception of their own multicultural competencies demonstrates that counselors' perception of their own multicultural competence is unreliable. More research actively seeking feedback from the trans community in question is thus important.

Limitations

A limitation of the current study was the use of convenience sampling. There could have been differential factors impacting whether or not participants chose to engage in the current study. For instance, the title of the study was, *Trans Individuals Perceptions of Counselor Effectiveness.* Participants were shown this title in the informed consent prior to completing the study. Participants who completed the study may have self-selected based on the perception that this study only applied to them if they had been to counseling previously. In support of this possibility, all participants stated that they had previously engaged in counseling. The current results may have differed if the sample also consisted of participants who had not been to counseling before. This in turn could limit the generalizability of the current findings. Additionally, the global pandemic that occurred this year limited the recruitment that was possible; namely we were unable to conduct in-person recruitment and so had to rely entirely upon online recruitment due to safety considerations. However, internal validity was not threatened in the current study given the randomized design. Another limitation concerns the demographic make-up of the study which limits its generalizability. Specifically, 82.3% of the sample identified as white, and 62.5% had a fairly high level of education (bachelor's degree or higher). Additionally, the majority of the sample (85%) were between the ages of 18-33 which limits the generalizability of the current results. It is important to consider the unique intersections of race, education, age, and gender (Crenshaw, 1989). Further research should aim

to collect data from underrepresented racial groups. Psychosocial factors which impact the trans community varies depending on the intersections of these various identities. For example, Dino (2017), found that trans people of color (specifically Black and Latinx identified people) were more likely to be victims of homicide than were white trans people. Dino (2017) also reported that Black/ Latina transfeminine people between the ages of 15 to 34 were significantly more likely to be victims of homicide than Black/ Latina cisfeminine people. The increased racial and transphobic violence experienced by this population will certainly affect clients' specific needs in therapy. It is imperative that more racially, ethnically diverse samples be gathered for future research to capture the varied and unique experiences of those in the trans community. In addition, working alliance was assessed by a measure of general counseling competence, the Counselor Rating Form-Short. Although this is an important aspect of the working alliance, it is probable that this measure did not capture the full construct. Other measures of the therapeutic working alliance should be employed. Lastly, randomized controlled studies with real clients and counselors are needed to move this research paradigm forward.

Implications for Training, Research, and Practice

The current study has multiple implications for training, research, and practice.

Training. First, these findings contribute to the literature base for multicultural competence with trans clients. These findings transcend the ethical mandate to provide gender affirming therapy. The finding that connection, specifically in the context of social activism, positively impacts the working alliance is noteworthy. Clinicians should be trained about the importance of engaging in social activism in solidarity with the trans community (Singh & Burnes, 2011). Attendance of TDOR and other culturally relevant activities should increase counselor knowledge about the trans community. Such activities will enrich counselor training

through facilitating learning about specific minority stressors commonly experienced by this community in addition to learning about culturally relevant healing practices utilized to overcome said stressors. The impact of connection to the trans community on the working alliance can inform the way in which we educate and train clinicians entering the field, in addition to how we provide continuing education for those already practicing. Our training should center the goal of increasing connection through advocacy in solidarity with the trans community, specifically when training cisgender clinicians. Training should not only focus on the need and encouragement of social activism for eliminating cisnormative systems of oppression, but should directly address specific methods for engaging in social activism. For instance, training can consist of teaching clinicians methods for carrying out activism in a socially and ethically conscious way that decreases the risk of cisgender people colonizing trans spaces (Singh & Burnes, 2011). Clinicians who do not identify with the trans community should take great care to respect the space they are entering and ensure that they are centering the voices and needs of the trans community. Centering the voices of those who hold multiple marginalized identities is especially important (Singh & Burnes, 2011). It will be increasingly essential to continue to train clinicians on culturally humble practices for good allyship.

Research. The lack of finding regarding the impact of Gender Identity Matching and IT on trans participants' perceptions of their counselors' general counseling competence should not be ignored. Further research should further explicate specific reasons for why Gender Identity Matching did not influence perceptions of counselors' general counseling competence. Counselors should consider the low rate of IT found in the current sample. This has promising results for the mental health of the trans community; however, it is inconsistent with other literature demonstrating higher rates of IT (Bockting et al., 2020; Testa et al., 2015). Specific

attention should be paid to understanding the unique experiences of various segments of the trans community. Specifically, as previously mentioned, the current sample is largely composed (46.4%) of non-binary based gender identities. It is possible that lower rates of IT within the current sample is due to the specific gender identities represented. Further exploration is warranted to better understand how minority stressors (including IT) differ as a function of specific gender and other intersecting identities. Additionally, resilience has been previously shown to negatively correlate with psychological distress for trans participants (Breslow et al., 2015). Future research should continue to examine resilience demonstrated by the trans community in the form of the explicit rejection of cisnormative and other oppressive ideologies. This rejection could emanate from increased consciousness raising about the deleterious effects of cisnormative systems of oppression, thus decreasing internalized transphobia.

Further research should continue to test the effect of Counselor Gender Matching and Connection using actual therapeutic dyads. Randomized controlled studies are a logical next step to test these effects, especially given the effects of Connection in the current study. Additionally, further empirical research should explore the differences in variance that Connection accounted for among the various subscales of the CRF-S. Connection accounted for 2.9% and 1.8% of the Trustworthiness and Attractiveness subscales, respectively, compared to 10.6% of the variance in Expertness. Other therapist variables which might increase perceptions of counselor Trustworthiness and Attractiveness should be explored. Lastly, in the current study, the hypothetical therapist disclosed their gender identity and attendance of TDOR. Disclosure has long been used as a tool in feminist therapy to decrease the power differential between the clinician and client and increase collaboration (Chang & Singh, 2018). The effects of disclosure specifically regarding social activism activities warrants future attention. It will be important to

understand any possible unique variance that disclosure of activism contributes to trans clients' perceptions of their therapists' general counseling competencies.

Practice. Lastly, these results should inform the practice of clinicians. Counselors can improve the working alliance with trans clients by becoming invested allies/accomplices with the trans community. They can do so by attending various culturally relevant and/or activist events. The primary investigator cautions against cisgender clinicians engaging in virtue signaling, defined here as the practice of discussing socially desirable activities without the actual inclination to engage in real social activism in solidarity with the community they serve within the therapy room. As previously mentioned, congruence is a key tenant of therapeutic practice. Rather, genuine engagement with the community one serves can better orient the therapist to the needs of their client which in turn will make them a more effective clinician. Interestingly, Connection accounted for only 2.9 % of the variance in the Trustworthiness subscale of the CRF-S, as opposed to 10.6% for Expertness. Cisgender clinicians should heed this finding. Trust will need to be built through more than merely knowing about and attending culturally relevant events, though such attendance is a noteworthy step in the right direction. It is the author's hope that these results will serve as one building block towards building a more effective, multiculturally responsive, therapeutic practice for the trans community.

Conclusion

The current study explored the effects of Counselor Gender Identity Matching and Connection to the Trans community on trans participants' perceptions of clinicians' general counseling competence. This was done using a 2x2 factorial experimental analogue design. Findings indicate that Counselor Connection increases perceptions of general counseling competencies. There was no effect of Counselor Gender Identity Matching nor IT on participant

perceptions of general counseling competence. Further research should be conducted to further explicate these findings. However, the role of social advocacy through Connection to the community one serves can be headed by practitioners and educators, alike. It is the author's hope that these findings serve as an additional building block in increasing culturally responsive psychotherapy for the trans community.

Table 1. Participant Demographics

Characteristics	***n***	**(%)**
Age (*N* = 236)		
18-25	102	(43)
26-33	98	(42)
34-41	21	(8.9)
42-49	9	(3.8)
50-57	5	(2.1)
58-61	1	(0.4)
Sex Assigned at Birth (*N* = 235)		
Male	40	(17.0)
Female	195	(83.0)
Gender Identity (*N* = 237)		
Non Binary	82	(34.6)
Trans Man	47	(19.8)
Gender Queer	28	(11.8)
Man	20	(8.4)
Selected Other	20	(8.4)
Trans Woman	17	(7.2)
Agender	11	(4.6)
Woman	8	(3.4)
Trans	4	(1.7)
Sexual Orientation (*N* = 237)		
Queer	61	(25.7)
Pansexual	59	(24.9)
Bisexual	55	(23.2)
Lesbian	22	(9.3)
Gay	19	(8.0)
Asexual	7	(3.0)
Multiple Identities	7	(3.0)
Straight/Heterosexual	3	(1.3)
Demisexual	1	(0.4)
Same Gender Loving	1	(0.4)
Fluid	1	(0.4)
Selected Other	1	(0.4)
Race (*N* = 237)		
White/Caucasian	195	(82.3)
Selected Multiple Options	20	(8.4)
Multiracial	6	(2.5)
Black/African American	5	(2.1)
Asian American	5	(2.1)
Jewish	2	(0.8)
Latinx	1	(0.4)
Arab/Middle Eastern	1	(0.4)
Indian	1	(0.4)

Other	1	(0.4)
American Indian/Native American	0	(0.0)
Native Hawaiian/Pacific Islander	0	(0.0)
Latinx? (*N* = 236)		
Latinx	16	(7.0)
Not Latinx	220	(93.0)
Area of Residence (*N* = 237)		
Urban	137	(57.8)
Suburban	76	(32.1)
Rural	24	(10.1)
Education Level (*N* = 237)		
Less than High School	2	(0.8)
High School	8	(3.4)
Some College (some college, no degree)	66	(27.8)
Associates Degree (2-year)	13	(5.5)
Bachelors (4-year)	93	(39.2)
Masters	41	(17.3)
Doctoral	7	(3.0)
Professional Degree (JD, MD)	7	(3.0)
Income Level (*N* = 236)		
Less than 10,000	31	(13.1)
10,000-19,999	34	(14.4)
20,000-29,999	31	(13.1)
30,000-39,999	35	(14.8)
40,000-49,999	23	(9.7)
50,000-59,999	15	(6.4)
60,000-69,999	13	(5.5)
70,000-79,999	13	(5.5)
80,000-89,999	9	(3.8)
90,000-99,999	5	(2.1)
100,000-149,000	15	(6.4)
150,000 or more	12	(5.1)

Table 2.

Participant Previous Counseling Experiences

Characteristics	***n***	**(%)**
Been to Counseling Before? (*N* = 237)		
Yes	237	(100.0)
No	0	(0.00)
Currently in Counseling? (*N* = 237)		
Yes	153	(64.6)
No	84	(35.4)
Years in Counseling (*N* = 237)		
Less than one month	5	(2.1)
1-6 months	17	(7.2)
7 months-1 yr	12	(5.1)
1-2 years	35	(14.8)
3-4 years	56	(23.6)
5-6 years	37	(15.6)
More than 6 years	75	(31.6)
Was Your Previous Therapist Transgender? (*N* = 237)		
Yes	26	(11.0)
No	199	(84.0)
Unsure	12	(5.0)
Was Your Previous Therapist Connected to the Transgender Community? (*N* = 237)		
Yes	80	(33.8)
No	79	(33.3)
Unsure	78	(32.9)

Table 3. Correlations Between Counselor Rating Form-Short (CRF-S) Subscales (Attractiveness, Trustworthiness, Expertness), Internalized Transphobia, and Previous Counseling Experience

Variables	Mean	SD	1	2	3	4	5
1. CRF-S Attractiveness	4.80	1.22	---				
2. CRF-S Trustworthiness	5.32	1.20	.759**	---			
3.CRF-S Expertness	4.71	1.63	.688**	.753**	---		
4.Internalized Transphobia	1.23	0.946	-.127	-.098	-.131*	---	
5. Previous Counseling Experience (1-7point scale)	5.31	1.90	.050	.116	.049	-.080	---

**. Correlation is significant at the .01 level (2-tailed)

*. Correlation is significant at the .05 level (2-tailed)

Table 4.

Condition Means with Attractiveness as DV

	Mean	**Standard Deviation**	***n***
Condition			
Cisgender Counselor, Not Connected to Trans Community	4.4815	1.05715	54
Cisgender Counselor, Connected to Trans Community	5.0181	1.37153	69
Transgender Counselor, Not Connected to Trans Community	4.7412	1.12198	57
Transgender Counselor, Connected to Trans Community	4.9298	1.23270	57

Table 5.

Condition Means with Expertness as DV

Condition	**Mean**	**Standard Deviation**	***n***
Cisgender Counselor, Not Connected to Trans Community	3.5525	1.40280	54
Cisgender Counselor, Connected to Trans Community	5.5471	1.14907	69
Transgender Counselor, Not Connected to Trans Community	4.1272	1.61820	57
Transgender Counselor, Connected to Trans Community	5.3684	1.49187	57

Table 6.

Condition Means Table with Trustworthiness as DV

Condition	**Mean**	**Standard Deviation**	***n***
Cisgender Counselor, Not Connected to Trans Community	4.9738	1.17404	54
Cisgender Counselor, Connected to Trans Community	5.5507	1.12343	69
Transgender Counselor, Not Connected to Trans Community	5.2149	1.21232	57
Transgender Counselor, Connected to Trans Community	5.4737	1.24435	57

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Extended Literature Review

Need

Trans people are at increased risk for discrimination and interpersonal violence, including but not limited to: physical, verbal, sexual assault, harassment and discrimination (Grant et al., 2011). According to Grant et al.'s (2011) national survey of 6,450 transgender and gender nonconforming (TGNC) people from each of the 50 states including DC, Puerto Rico, Guam and the US Virgin Islands, 47% stated they experienced "an adverse job outcome" due to being transgender or gender nonconforming, "such as being fired, not hired or denied a promotion" (p. 3). Seventy-eight percent of respondents who stated that they expressed a TGNC identity while in grades K-12 experienced harassment, 35% experienced physical assault and 12% experienced sexual violence. Trans people have also experienced discrimination regarding accessing health care (Grant et al., 2011). Nineteen percent of Grant et al.'s sample reported being refused medical care due to being transgender or gender nonconforming, and 50% stated that they had to educate their providers about transgender care.

The minority stress model posits that there are unique environmental stressors (e.g. discrimination and violence) which affect the transgender community. As such this framework centers the origin of pathology in one's environment (Hendricks & Testa, 2012; Meyer, 2003). There is empirical support describing direct links between minority stress and mental health outcomes (Bockting et al., 2013). Minority stress has been shown to increase psychological distress, such as clinical depression, anxiety, and somatization (Bockting et al., 2013). Of a national sample of 6,450 people who self-identified as trans, 41% have attempted suicide, compared to 4.6 percent of the total U.S. population (Grant et al., 2011). Minority stressors have also been found to be associated with suicide attempts (Rodgers et al., 2014). Specifically,

Rodgers et al. found that suicide attempts were related to discrimination. These authors found that 60% of respondents who had experience with a doctor or other health care provider who refused to treat them had attempted suicide. Additionally, 50-59% who had experienced discrimination or harassment at work attempted suicide and 50-54% who had experienced harassment or bullying at school had attempted suicide. Given the high rate of mental health concerns associated with minority stress, it is important that trans people have access to appropriate culturally competent mental healthcare.

Cultural Terminology

Prior to reviewing factors implicated in increasing the efficacy of psychotherapy for trans clients, a brief review of specific terminology is provided to better orient the reader. 'Trans,' the shortened version of 'transgender,' tends to be more frequently used in common parlance today to describe a range of gender identities and expressions. Trans people are those who do not identify with their sex and associated gender assigned at birth; cisgender people are those whose gender identity aligns with their sex/gender assigned at birth (American Psychological Association, 2015; Hendrick & Testa, 2012). Trans is an umbrella term representing a multitude of gender identities (Moradi et al., 2016); some identities fall on the gender binary of 'man' or 'woman' such as trans man and trans women, while others do not fall within this binary such as 'genderqueer' or 'non binary' (APA, 2015). There is an important distinction between gender identity and gender expression. Gender identity refers to the label that one associates with their gender. Gender expression is how one presents themselves to the world (e.g. dress, mannerisms, speech, activities etc). According to a recent study by Meerwijk and Sevelius (2017) approximately 390 out of 100,000 adults or .39% are transgender.

Multiculturally Competent Psychotherapy for Trans Clients

Psychotherapy can be used as a tool to help trans people cope with these experiences of minority stress. However, there is a paucity of experimental literature exploring trans clients' experiences in therapy (Blumer et al., 2012). Among the family therapy literature, a recent meta-analysis revealed that of 10,739 articles from the period of 1997-2009, only nine focused on transgender concerns (Blumer et al., 2012). This means that in the field of marriage/couple and family therapy, only .08% of the literature focused on transgender issues. In addition, Moradi et al. (2016) conducted a content analysis of trans research between the years 2002 and 2012 and concluded that an increased focus on "identity related distress" was needed (p. 961). Given the dearth of literature on trans client's experiences, it is not surprising, that many trans people report having to educate their provider about their gender identity and appropriate healthcare (The Joint Commission, 2011). This is another burden that serves as a barrier for trans people to access appropriate care.

Trans clients are in need of counseling given the unique minority stress factors they face and the subsequent implications for decreased mental health. The question remains, what are the experiences of trans clients in counseling. Hunt (2014) conducted a qualitative study exploring transgender people's (N=74) experiences of seeking and engaging in counseling in the UK using both a survey instrument and interview. She found that fear of discrimination in addition to the fear of exploring gender for the first time were significant barriers to seeking help. Overall, 61 percent of clients in this study stated that they felt 'extremely or very accepted' by their counselor (p. 292). A large number of participants (43%) stated that their counselor wanted to explore transgender issues even when this was not the client's presenting concern. When gender concerns were actually discussed, about a third of participants (35%) stated their counselor had either an 'extremely good' or 'very good' awareness of gender identity issues. Thirty-six percent

of participants stated that therapists had 'only slight' or 'very little awareness' of gender identity issues. However, 51 percent stated that their therapists were 'very affirming' of their gender identity. This appears to indicate that although clients in this study perceived their therapists as having good intentions, they were benevolently uninformed. Hunt also conducted interviews with participants and the themes of discussing gender identity too much or too little was explored. Either end of this continuum were deemed as unhelpful in these interviews, possibly indicating the importance of striking a balance when creating a space to discuss gender identity. Bess and Stabb (2009) conducted a qualitative study exploring the therapeutic alliance and satisfaction among transgender clients (N=7). The authors concluded that clients reported affirming and supportive relationships with their therapists even though some had previously had negative experiences in therapy. Additionally, perhaps other factors, such aspects of the therapeutic alliance, could inform participants perceptions such a discussion.

Alliance, Multicultural Competence (MCC), and Outcome

Therapeutic outcome concerns treatment efficacy and effectiveness, that is, whether the therapy works and is effective outside clinical trials (Heppner et al., 2016). Horvath et al., (2011) conducted a meta-analysis exploring the relationship between alliance and psychotherapy outcomes. Their analysis consisted of 201 studies and revealed that alliance accounts for approximately 7.5% of the variance in treatment outcomes (psychological distress measured by the Beck Depression Inventory, dropout rate, etc.). Tao et al. (2015) found that clients' perceptions of their counselor's MCC accounted for more than 8.4% of the variance in therapy outcomes (e.g. anxiety and depression).

Anderson et al. (2019) conducted a study exploring premature termination (N = 278). Anderson et al. concluded that a weaker therapeutic alliance was one of the main reasons for

premature termination and found that clients' perception of therapist MCC was negatively associated with premature termination. Additionally, greater perceived MCC was found to be related to greater therapeutic alliance.

When exploring constructs that are similar, yet distinct, it is important to have measures sensitive enough to capture these unique elements. Constantine (2002) found that client rating of therapist MCC contributed significant variance to racial and ethnic clients' satisfaction with counseling. They found that the Counselor Rating Form-Short (CRF-S) and the Cross-Cultural Counseling Inventory-Revised (CCCI-R) had a large amount of shared variance (60%), however the CCCI-R added more variance than the CRF-S to overall counseling satisfaction. As such these authors conclude that MCC is a distinct construct from general counseling competence. Understanding the client's perception of the etiology of their concerns and incorporating this into treatment appears to have significant effects on treatment outcomes (Benish et al., 2011). Benish et al. conducted a meta-analysis comparing culturally adapted psychotherapy to other bona-fide therapies. Their test of relative efficacy revealed an effect size of d = .32 for culturally adapted psychotherapy.

In greater support of the role of MCC on therapeutic outcomes, Smith et al. (2011) conducted a meta-analysis of 65 studies of culturally-adapted treatments and found an effect size of d = .46, a medium effect size, between clients in culturally adapted treatments as opposed to control groups. Bellini (2003) explored the effects of client-therapist racial matching and therapist multicultural competency on vocational outcomes and concluded that, although client-counselor racial matching, and counselor multicultural competency are not, "highly influential determinants" of outcomes in rehabilitation, they have a "measurable impact" (p.172). Bellini's (2003) study exhibits support for the importance of therapist MCC on client rehabilitation rate at

least for clients working with white counselors. Their finding that counselors from a majority group (white racial identity) with increased MCC had positive impacts on their clients could have implications for cisgender counselors working with trans clients. Additionally, Soto et al.'s (2018) meta-analysis exploring the relationship between cultural adaptations and therapist multicultural competence, revealed a medium effect size of d =. 50 for interventions that were culturally adapted. Although findings are mixed, the preponderance of evidence appears to support the notion that culturally adapted psychotherapies are more effective than treatment as usual (Benish et al., 2011; Griner & Smith, 2006; Smith et al., 2011; Soto et al., 2018).

Relationship between Multicultural Competence and Alliance

There is emerging empirical literature demonstrating the link between MCC and the therapeutic alliance. One such study that explores this relationship is a meta-analysis by Tao et al. (2015) in which the linkage between MCC, therapeutic alliance and outcome was explored. They found that clients' perceptions of their therapists' MCC accounted for a considerable portion of the variance in working alliance, their satisfaction with counseling and their perception of their counselors general counseling abilities. Specifically, Tao et al. found that client ratings of their therapists' multicultural competence accounted for approximately 37% of the variance in working alliance, 52% of the variance in client satisfaction and 38% of the variance in General Counseling Competencies. Fuertes et al. (2006) study of perceived therapist MCC revealed that MCC was significantly associated with positive relationships between clients' perceptions of therapist MCC and alliance variables. Based on their findings, Tao et al. call for an increased focus on the effects of clients' intersecting sociopolitical identities.

The Working Alliance and Perceptions of General Counseling Competence

Given the above findings, it appears that clients' perceptions of therapists' MCC is an important factor in the working alliance. Tao et al. (2015) define the working alliance as a partnership between therapist and client and the agency with which they both direct the course of therapy. Although the working alliance has been measured in a litany of ways, Baldwin and Imel (2013) state that "measures of the working alliance involve patients, therapists or external raters indicating the degree to which patients and therapist agree on the tasks and goals of therapy as well as the quality of the therapeutic bond" (p. 282). As the working alliance is a combination of both therapist and client characteristics, a key aspect in this alliance are client perceptions of the therapist's general counseling competence. Tao et al. reviewed the literature and stated that this refers to therapist trustworthiness, attractiveness, and expertness, similar to Strong's (1968) original conceptualization of interpersonal influence for opinion change.

Strong's Interpersonal Influence Theory states that there are multiple factors which contribute to the success of the therapeutic relationship. Among these factors include perceived counselor trustworthiness, attractiveness, and expertness (Strong, 1968). Counselor trustworthiness is defined as social role, reputation, sincerity, and lack of motivation for personal gain. Counselor attractiveness is defined as perception of the counselor as friendly, socialable, warm, and possessing similar characteristics with that of the client. Counselor expertness is defined as having a degree and other credentials in one's related field that signify mastery of the profession.

Measuring the Working Alliance Using the Counselor Rating Form. Given Tao et al.'s (2015) definition of the working alliance, a key aspect in this alliance are client perceptions of therapist variables. The Counselor Rating Form (CRF), based off of Strong's (1968) Interpersonal Influence Theory, and created by Barak and LaCrosse (1975) has been used in

multiple studies and shows good validity and reliability (Cabral & Smith, 2011; Moran, 1992). This scale is a 36-item list of bipolar adjective pairs with three subscales (12 items each), counselor expertness, counselor attractiveness and counselor trustworthiness. Another version of this scale is the Counselor Rating Form Short Version (CRF-S) (Corrigan & Schmidt, 1983). This scale improves upon the original version in multiple ways. The CRF and CRF-S have been tested in both analogue studies and with real patient-counselor relationships. Corrigan and Schmidt (1983) conducted an extension study in addition to a replication of Barak and LaCrosse's (1975) original study in which participants used the form to rate Perls, Ellis and Rogers after watching them in psychotherapy tapes. The number of items was decreased from 36 to 12, however, the reliabilities of the three subscales (attractiveness, expertness, and trustworthiness) were reported to have stayed equal or to have improved in comparison to the original version (CRF). Corrigan and Schmidt's extension study recruited clients from outpatient community mental health agencies. They reported the following reliability estimates for the attractiveness, expertness and trustworthiness subscales, .91, .85, and .91, respectively. Another strength of the CRF-S relative to the CRF, concerns the reading level of various items. The reading level of multiple items was decreased from that of a 10^{th} grade (18% of items) to an 8^{th} grade reading level. This will increase the validity of the scale for use with populations that have a lower educational background or with participants who struggle with distraction. One limitation reported by Corrigan and Schmidt regarding their revised scale concerns their inability to increase the variance obtained on the individual items. These authors eliminated negative adjectives. As such, they modified the scale from a bipolar adjective scale to one in which participants rated the counselor using just the positive adjective on a scale ranging from 1 (*not very*) – 7 (*very*). They found that there continued to be a skew towards the higher end of the 1-7

point scale in their clinical sample. Specifically, Corrigan and Schmidt were able to increase the variance on the 7-point scale in their replication study where participants viewed Ellis, Rogers and Perls engaging in psychotherapy in the film *Three Approaches to Psychotherapy* (Shostrom, 1966). However for their community sample, in which clients were rating their real counselors, they continued to find a restriction of range. Participants rated their counselors using the fifth point or higher on the 7-point scale. Using confirmatory factor analysis, Corrigan and Schmidt also found that given the intercorrelations of the subscales, all factors (attractiveness, expertness and trustworthiness) should be measured and accounted for when used for research purposes. However, the subscales are measuring unique aspect of general counseling competence.

Recently, the CRF-S has been used in previous analogue studies exploring perceptions of the therapeutic relationship with trans participants (Bettergarcia & Israel, 2018). The authors reported this measure to have good reliability in their sample. As such, the current study will also utilize the CRF-S in order to measure this aspect of the therapeutic alliance.

Who Decides What is Multiculturally Competent- The Importance of Rater Perspective

There is a need for the representation of trans clients' voices in describing what makes therapy most efficacious for this community. Rater perspective has a demonstrable effect on the reporting of various therapeutic outcomes and processes. For instance, Dillon et al. (2016) conducted a study of 133 clients of color receiving psychotherapeutic services at a university counseling center. In accordance with other literature, therapists' assessment of their own multicultural competence was not consistent with their clients' rating of their MCC (Dillon et al., 2016). Soto et al. (2018) conducted a meta-analysis (N =15) related to therapist cultural competence in which the results also differed by rater. When clients rated therapist MCC, there was a moderately strong relationship between treatment outcomes (r = .38). However, when

therapists rated their own MCC, there was a much weaker relationship between MCC and treatment outcomes (r = .06). As such, clients' ratings of therapist MCC was a stronger predictor of treatment outcomes than were therapists' ratings of their own MCC. In the current study, we sought to center trans peoples' perspectives through the use of participant ratings of their counselor's general counseling competence. As such, general counseling competence served as the current dependent variable.

Culturally competent care is an ethical mandate (APA, 2015). However, the field of psychology does not yet have enough evidence to support the most effective form of culturally competent care for the trans community. We currently do not know very much about counseling with trans clients. Most of the literature is conceptual in nature and there is a dearth of empirical studies (McCullough et al., 2017). Empirical studies that do exist tend to be descriptive in nature (Wanta & Unger, 2017). There are no published randomized controlled studies and few analogue studies have been conducted to date. Additionally, there are currently multiple articles on working with trans client using different forms of therapy modalities, such as cognitive behavioral therapy, person centered therapy, and therapy using an ecological framework (Austin & Craig, 2015; Edwards, Goodwin, & Neumann, 2018; Knutson & Koch, 2018). However, these are conceptual in nature and are written from clinician's perspectives.

Therapist Factors Which Might Increase the Working Alliance

Nascent research points to the importance of counselor connection to the trans community and counselor identity as facilitative factors which might contribute to a positive working alliance (Hunt, 2014; McCullough et al., 2017). Baldwin et al. (2007) explored the relationship between therapeutic alliance and outcome. They found a statistically significant and positive relationship between therapists' ability to form a strong alliance and decrease in client

psychological distress. Therapists who formed stronger alliances on average also had stronger outcomes; alliance is not an artifact of decreased symptomology, instead alliance appears to be associated with greater symptom reduction. Given vast amounts of marginalization faced by the trans community both within and outside of healthcare settings (Grant et al., 2011), the importance of counselor characteristics might be especially salient for this community in order to build a trusting relationship. As such the current study explores therapist contributions to the working alliance by measuring participants' perception of the therapists' general counseling competence.

Bettergarcia & Israel (2018) conducted a 3 (affirmation; transition affirming, non-binary affirming or non-affirming therapist response) x 3 (plan to transition; plan to transition in the process of transitioning, no plan to transition). This author found that there was a statistically significant difference in perception of the therapist and session based on the type of video condition viewed. Post hoc tests revealed that there was statistically significant difference between the transition affirming and non-affirming video across conditions across all dependent variables and a significant difference between the two affirming conditions and the dependent variables.. Interestingly, there were no significant differences in perception of therapist and the session based off of the interaction between the therapists' affirmation and participants' plans to transition. Rachlin (2002) conducted a survey design where 93 trans participants reported on their previous experience with psychotherapy. Rachlin stated that participants, listed the following four categories as most helpful: acceptance, respect for the person's gender identity, flexibility in the treatment approach, and connection to the transgender community.

Connection to the Trans Community

Guideline 7 of the Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (TGNC) states that "Psychologists understand the need to promote social change that reduces the negative effects of stigma on the health and well-being of TGNC people" (APA, 2015, p. 841). Included in this guideline are the tenants of: Informing public policy to reduce negative systemic impact on TGNC people, promoting positive social change, and identifying and improving systems that promote violence. The emerging literature indicates that therapist connection and advocacy are important factors for trans clients. Perhaps perceived trustworthiness, attractiveness, and expertness can be achieved through the variable of connection to the trans community. As such, counselor connection is defined here as: knowledge about and attendance of activities seen as culturally and socially relevant to the trans community. McCullough et al.'s (2017) stated that trans clients' positive feelings towards their counselor increased when they saw them as being advocates within the trans community. McCullough et al. found that multiple participants stated that when counselors engaged in social activism within TGNC communities, TGNC clients felt increasingly supported. Therapist connection to larger sociopolitical movements affecting their clients also has been described theoretically within the feminist therapy literature (Israeli & Santor, 2000). Social activism is a core tenant of feminist therapy and connection to community can be understood as one operationalization of that intervention. Israeli and Santor conceptualize social activism as an intervention that, "extends(s) beyond individual therapy sessions in order to affect broader social changes" (p. 234). Israeli and Santor state that at the time of their writing this intervention had not yet been empirically studied. As such, the current study sought to empirically examine counselor connection or activism as a therapeutic intervention. A theme identified by McCullough et al. was a transaffirmative approach, broken into two subthemes, one of which was advocacy. One part of

this advocacy was the visibility of the counselor within TGNC communities. The authors stated that multiple participants reported that visibility in TGNC communities led clients to feel better understood and supported by their counselor. Lastly, Hunt (2014) reported that 34% of trans clients selected their counselor based on the counselor having a transaffirmative reputation. In the current study, connection to the trans community was explored as a variable that might increase participant perceptions of therapist general counseling competencies.

Therapist Matching

Previous research has shown that demographic matching is one route to enhance the working alliance. Specifically, Hunt (2014) found that 37% of trans clients selected their counselor based on their counselor's gender. Similarly, McCullough et al. (2017) found that almost every participant discussed that their counselor selection was informed by the practitioner's personal identity and the importance of finding a counselor with an identity participants felt was similar to their own. In the current study, counselor-client gender identity matching was explored as a variable that might increase participant perceptions of therapist general counseling competencies.

Gender matching is one demographic that has been studied. Strohmer, et al. (2003) found that 30% of clients expressed a preference for gender matching, which was the greatest preference in comparison to the other identities that were assessed. Despite that matching therapists to clients based on various demographic variables has been researched for some time, the research on gender inclusive matching for trans clients in counseling is quite limited. Although the literature is far from definitive, matching has been described as an important factor for increasing treatment engagement for minority communities (Jones et al., 2003). Studies exploring gender matching have historically done so using a binary, cisnormative lens. These

studies explore the effects of gender matching based on a cisgender man/woman dichotomy. In other words, as far as one can tell, all of these studies explored matching of cisgender women or cisgender men. The PI was unable to locate a meta-analysis on therapist gender matching effects.

Although there are mixed findings regarding the effects of gender matching, the finding that female therapists are generally rated higher on measures of therapeutic alliance has been documented. Specifically, the finding that clients prefer female therapists is supported by the work of Bhati (2014) who found that, regardless of client gender, female therapists were rated higher on various measures of therapeutic bond. Bhati measured therapeutic alliance with the therapeutic bond subscale of the Therapy Session Report, a significant main effect was found for dyad type. Female-client, Female-therapist (FF) dyads reported higher therapeutic bond than Female-client, Male-Therapist (FM) and Male-Client, Male-Therapist (MM) dyads, but not Male-client, Female-therapist (MF) dyads. For the Collaborative Role Enactment and Empathetic Resonance subscales of the Therapy Session Report, FF dyads were found to have significantly higher scores than FM dyads and MM dyads but not MF dyads. Lastly, for the mutual affirmation subscale, FF dyads reported significantly higher scores than all other combinations. Thus, it appears that regardless of client gender, female therapists appear to form closer relationships with their clients regardless of client gender.

Whaley (2006) conducted a quasi-experimental analogue design exploring the effects of gender matching and racial self-labelling among male clients interviewed by black male or black female psychologists. Whaley explored whether participant self-labelling as either African American, Black or Negro/other would interact with psychologist gender match to have an effect on paranoia symptoms. Whaley found a significant main effect for male gender-matching on a measure of paranoia, such that males in the gender-matched group scored lower on this measure.

However, contrary to the study's hypothesis, participants who were gender matched also scored higher on a measure of cultural mistrust. Given the quasi-experimental nature of the study, one cannot draw causal conclusions, but these results appear to show that, for African American men with increased racial identity, even those matched on gender and race still exhibited high levels of cultural mistrust. These results point to the nuances involved in therapist demographic matching and points to the need for including other variables, especially identity development variables, that might moderate the relationship between client perceptions of their therapist and demographic matching. One factor that has been used in matching has been gender.

Given vast amounts of marginalization faced by the trans community both within and outside of healthcare settings (Grant, et al. 2011), the importance of counselor characteristics might be especially salient for this community in order to build a trusting relationship. Below is a review of other matching studies which explore therapist matching for differing marginalized communities.

Racial Matching

A meta-analysis by Cabral and Smith (2011) of 154 studies reviewed three variables used to explore racial/ethnic matching. The first variable was client's preference for a therapist of their own racial/ethnic identity (n = 52 studies). The second was client's perceptions of therapist across racial/ethnic match (n = 81). The third was therapeutic outcome across racial/ethnic match (n = 53). Cabral and Smith found that client's preference for having a counselor with the same racial identity was moderately strong (d = .63). Client perceptions of therapist as measured by the counselor effectiveness rating scale and counselor rating scale indicated a slightly positive perception of the counselor based off of racial matching (d = .32). Finally, therapeutic outcome

(as measured by the OQ-45 and Global Assessment of Functioning) yielded almost no difference in symptom reduction as a function of counselor racial identity matching (d = .09).

Therapist Matching, Sexual Orientation

Although people who are sexual minorities face unique challenges to those who are gender minorities, both gender and sexual minority people belong to the LGBT community. To date, there has been considerably more research done on the experiences of sexual minority peoples. Exploring the effects of sexual minorities might be fruitful in exploring issues that might be important for both groups of people. Having said this, it is important to distinguish between the unique needs and experiences of gender and sexual minority peoples so as not to conflate their experiences. Jones et al. (2003) explored sexual orientation matching among other factors with a sample of 600 LGB clients who are either current or former mental health patients. Jones et al. found that therapist characteristics accounted for 2% of the variance in therapeutic benefit. Gender and sexual orientation of the therapist remained significant predictors of benefit, with female therapists. Specifically, gender of the therapist was a significant predictor only for the female respondents and therapists' sexual orientation was only a predictor for the male clients. A limitation to this study was the sample composition. Specifically, two thirds of the sample identified as women, and 9 out of 10 were highly educated and white. This thus limits the generalizability of these authors' findings.

Moran (1992) studied sexual orientation matching and counselor experience on gay men's and lesbian women's perceptions of counselors using an experimental analogue design. This design consisted of a 15-minute taped mock therapy sessions. Counselor gender for gay men and lesbian women were matched and held constant (counselor was a man for gay men and a woman for lesbian women). Moran tested both level of experience and counselor sexual

orientation and measured ratings of the counselor using the Counselor Rating form. He found a significant main effect for experience level on the expertness subscale for lesbian women only. No other effects were found. No comparison was made between lesbian and gay people because they were exposed to different video tapes and thus different experimental manipulations. A large limitation of the current study was the small sample size. There were only 40 participants within each analysis.

Moderating Variables- Minority Stress

As stated previously, minority stress plays a large role in the lives of trans people (Hendricks & Testa, 2012). This is a multifaceted construct that consists of both external and internal experiences of stress due to possessing marginalized sociopolitical identities. One internal stressor is internalized stigma, or the internalization of a negative perception about one's sociopolitical identity (Testa et al., 2015). These stressors occur in the form of discrimination, stigma, and prejudice. Specifically, minority stress encompasses the following elements: distal stressors, proximal stressors, and resilience. Distal stressors are defined as overt forms of discrimination such as physical, verbal or sexual assault, verbal and emotional abuse, and other forms of violence enacted towards an individual by another. These are termed distal because these sources of stress are outside of the individual or are distal to them. Proximal stressors describe the anticipation and expectation of future negative external events, and internalized stigma about one's trans identity. Proximal stressors function within the individual as a result of external stressors. For instance, the fear that is associated with disclosing one's trans identity to another due to the anticipation of negative interactions is a form of proximal stressor. Likewise, keeping one's identity a secret to avoid violence or negative interactions can also be stressful to the individual and is thus another form of proximal stressor. Hypervigilance occurs when one is

expecting negative events to occur and is thus primed to search for possible sources of threat within one's environment. Resilience is the act of coping with negative environmental stressors. Resilience has been theorized to decrease the deleterious mental health consequences of minority stress. Hendricks and Testa's conceptual article describes the link between minority stress and negative mental health consequences. There has since been empirical support which describes the direct links between minority stress and mental health outcomes (Bockting et al., 2013). Before describing this research, a review of various documented distal and proximal stressors will help provide context for the minority stress paradigm.

Minority stress has been shown to increase psychological distress, such as clinical depression, anxiety, and somatization (Bockting et al., 2013). Bockting et al. conducted a cross-sectional online study exploring the effects of minority stress and resilience on mental health outcomes on trans people. Their sample consisted of 1093 people with multiple trans identities from 48 out of the 50 U.S. states. The authors state that the sample from the 15 largest states was proportional to the size of that state. This sample was a convenience sample not originally designed to test Meyer's (2003) minority stress model and thus these results are derived from a secondary data-analysis. Originally this study was used to examine the relationship between gender identity and HIV risk. One distal measure used for analysis included, a 10-item discrimination scale, an example item includes, "have you ever been verbally abused or harassed and thought it was because of your transgender identity or gender presentation?" Another measure used was the Stigma Consciousness Scale- a measure of proximal stress. An example question included, "most people have a lot more transphobic thoughts than they actually express." Mental health was assessed using the Brief Symptom Inventory (BSI-18), which contains a global measure of distress and subscales of depression, anxiety and somatization. The

authors also assessed gender dysphoria with a 7-point Likert type scale with the question of "how comfortable are you currently with the sex you were assigned at birth?" Bockting et al. used hierarchal linear modeling and regressed BSI-18 on measure of gender dysphoria and found that gender dysphoria was not significantly associated with BSI-18. This finding has large implications as it provides evidence for the minority stress model. Specifically, it is a common stereotype that pathology lies within transgender people due to their gender dysphoria and not in environmental stressors. This finding demonstrates that gender dysphoria is not the cause of mental health discrepancies. Additionally, compared with the Brief Symptom Inventory community norms, trans participants had disproportionately high rates of depression (44.1%), anxiety (33.2%) and somatization (27.5%). A limitation of this finding is that the authors neglected to report what the community norms for the Brief Symptom Inventory were. Overall, after regressing distal stigma (termed enacted stigma in the current article) and proximal stigma (termed felt stigma in the current article) onto the Brief Symptom Inventory. Bockting et al. found that enacted stigma and felt stigma were positively associated with psychological distress. It was also found that identity pride, family support and peer support were negatively associated with psychological distress. These authors concluded that family and peer support in addition to identity pride were all protective factors against psychological distress as they were negatively associated with psychological distress. Another proximal stressor, discussed next, is internalized stigma.

Negative feelings about one's own community have been found to be negatively associated with mental well-being (Sanchez & Villain, 2009). Internalized transphobia, a proximal stressor, can be conceptualized as internalizing a system of oppression. Transphobia is conceptualized as an effect of the oppressive system of cisgenderism. Cisgenderism can be

defined as an "ideology that delegitimizes people's own designation of their genders and bodies" (Ansara & Hegarty, 2014, p. 2). When an individual possesses internalized negativity about one or multiple personal identities, they integrate negative social messages about the groups to which they belong. For instance, they might internalize negative stereotypes about their group (Rood et al., 2017).

In a study exploring internalized sexual stigma, Herek et al. (2009) found that internalized stigma can lead to negative feelings about the self and others who also possess that stigmatized identity. These authors reason that the same oppressive systems which lead to homophobia in heterosexual people can also lead to internalized sexual stigma in sexual minority people. People high in internalized stigma may thus think negatively about themselves and others belonging to their stigmatized group. As such, the PI hypothesizes that similar mechanisms might influence trans participants' perceptions of other trans people, including therapists. In the current study, possessing internalized transphobia (IT) might serve to decrease trans participants' perceptions of a transgender counselor's trustworthiness, expertness, and attractiveness while serving to increase their perception of these traits for cisgender therapists.

Current Study

The current study used an experimental analogue design to explore trans-identified participants' reactions to a hypothetical counseling scenario. Participants were randomly assigned to read a vignette in which counselor gender identity and connection to the trans community was manipulated. Trans participants' perceptions of counselor general counseling competence, participants' previous counseling experiences, and experiences with internalized transphobia was assessed.

Question/Hypotheses

Strong (1968) hypothesizes that therapist-client gender identity matching will lead to increased perceptions of the counselor's general counseling competence. The PI posits that counselor connection to the transgender community will also lead to increased participant perceptions of the trustworthiness, attractiveness and expertness of the counselor (as measured by the Counselor Rating Form-Revised). Given the aforementioned research, counselor connection, even in the absence of gender identity matching, will signal to the participant that the counselor might be multiculturally competent. It is expected that participants will perceive trans counselors who are connected to the transgender community as being most competent and thus rate them highest on the measures of trustworthiness, attractiveness, and expertness. It is hypothesized that participants will view these counselors as possessing both inside knowledge about what it means to be transgender and effort related to connecting themselves to the transgender community. Lastly those counselors who are not connected to the transgender community, nor are trans, are hypothesized to be rated lowest on these measures as there is no evidence to suggest that they have knowledge or commitment to this community (at least in the current vignette). However, it is hypothesized that participant IT will moderate the relationship between counselor gender identity matching and the CRF-S. When IT is high, perceptions of the counselor as rated by the CRF-S will increase when the counselor is cisgender compared to when the counselor is transgender. However, when IT is low, perceptions of the counselor will decrease when the counselor is cisgender versus when the counselor is transgender.

Conclusion

The literature on client-counselor demographic matching demonstrates mixed findings regarding the impact of this effect on therapy process/outcomes. The current review reveals that demographic matching has not been experimentally tested with a trans population. As such, the

current study seeks to fill this gap. Additionally, counselor advocacy and connection to the community they serve has long been encouraged by feminist therapists. Furthermore, qualitative literature supports this as an important aspect of therapy for trans clients. However, there has yet to be an experimental design testing the effect of counselor advocacy on clients' perception of the therapeutic alliance. Lastly, internalized stigma has been shown to deleteriously affect marginalized peoples' sense of self and community. The effect of Internalized Transphobia is thus considered here as well. The current study seeks to answer the gaps identified in the current literature review through conducting an experimental analogue design testing the effects of counselor gender identity matching and connection on trans participants' perceptions of the general working alliance, an aspect of the therapeutic alliance.

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Appendix A

Experimental Manipulation Vignette

Prior to deciding if you would like to work with the following therapist, you receive a hypothetical clip of their work with a client. Please read the following example of the counselor's work and try to put yourself in the client's perspective.

Counselor: So how has your week been?

Client: Counselor Gender ID Matching: Uh, fine. A lot has happened and there are some things I want to talk about. I remember you saying that you are trans. /

Counselor Gender ID NON-Matching: Uh, fine. A lot has happened and there are some things I want to talk about. I remember you saying that you are cisgender.

Counselor: That's right. Can I ask why you ask?

Client: …I'm not sure if I've told you yet, but I'm trans. And, well the other day I wanted to go to a Trans Day of Remembrance event. And well, some stuff happened. Do you know what that is?

Counselor: The Trans Day of Remembrance?

Client: Yes.

Counselor: High Connection: Mmmhmm, a day to remember trans people who have fallen due to transphobic violence in addition to celebrate the strength this community possesses. I went to one this year as well. /

Low Connection: You know I am not familiar with it, but my colleague gave me a flyer for it and I've been meaning to take a look. Ah, here it is (picks it up off desk), it is a day to remember trans people who have fallen due to transphobic violence in addition to celebrate the strength this community possesses.

Client: Yes well, my anxiety was super bad this week and I really didn't want to go, but my friends made me. So I drank a lot to take the edge off of all the people there and at first that helped, but then I ended up getting sick and my friend got really pissed because she was taking care of me the whole time.

Counselor: Mmm.

Client: So what do you think?

Counselor: Well, there is a lot there. I heard multiple things that perhaps we could talk about? I heard that you had a lot of anxiety throughout the entire week. In order to attend the event you were trying to use this alcohol to lower some of your anxiety, but instead of helping, it seems to have actually led to a fight with your friend. I also heard that you identify as trans; this is something we have not talked about before. Did I get that right?

Client: Yep, it is a lot.

Counselor: Is there something in particular you would like to focus on?

Client: I mean, I think the anxiety is annoying and I'd like to figure out ways to be able to do things to avoid feeling this way.

Counselor: Sure

Counselor then begins to talk to client about their anxiety.

Appendix B

Gender Minority Stress and Resilience Measure (GMSR) -Internalized Transphobia Subscale

Please indicate how much you agree with the following statements:

I resent my gender identity or expression.
0 (Strongly Disagree) 1 2 3 4(Strongly Agree)

My gender identity or expression makes me feel like a freak.
0 (Strongly Disagree) 1 2 3 4(Strongly Agree)

When I think of my gender identity or expression, I feel depressed.
0 (Strongly Disagree) 1 2 3 4(Strongly Agree)

When I think about my gender identity or expression, I feel unhappy.
0 (Strongly Disagree) 1 2 3 4(Strongly Agree)

Because of my gender identity or expression, I feel like an outcast.
0 (Strongly Disagree) 1 2 3 4(Strongly Agree)

I often ask myself: why can't my gender identity or expression just be normal?
0 (Strongly Disagree) 1 2 3 4(Strongly Agree)

I feel that my gender identity or expression is embarrassing.
0 (Strongly Disagree) 1 2 3 4(Strongly Agree)

I envy people who do not have a gender identity or expression like mine.
0 (Strongly Disagree) 1 2 3 4(Strongly Agree)

Appendix C

Counselor Rating Form -Short

Please select the point on the scale that best represents how you viewed the therapist

Friendly

1	2	3	4	5	6	7
(not very)						(very)

Likeable

1	2	3	4	5	6	7
(not very)						(very)

Sociable

1	2	3	4	5	6	7
(not very)						(very)

Warm

1	2	3	4	5	6	7
(not very)						(very)

Experienced

1	2	3	4	5	6	7
(not very)						(very)

Expert

1	2	3	4	5	6	7
(not very)						(very)

Prepared

1	2	3	4	5	6	7

(not very) (very)

Skillful

1 2 3 4 5 6 7

(not very) (very)

Honest

1 2 3 4 5 6 7

(not very) (very)

Reliable

1 2 3 4 5 6 7

(not very) (very)

Sincere

1 2 3 4 5 6 7

(not very) (very)

Trustworthy

1 2 3 4 5 6 7

(not very) (very)

Appendix D

Trans Individuals' Perceptions of Counselor Effectiveness

Study Title ***(Trans Individuals' Perceptions of Counselor Effectiveness)***

IRB Protocol Number: 1546470

Study Purpose and Rationale

The purpose of this study is to explore what factors make counseling more effective for trans clients.

Inclusion/Exclusion Criteria

To be eligible to participate in this study, you must be at least 18 years of age and identify on the trans spectrum.

Participation Procedures and Duration

For this project you will be asked to read a hypothetical vignette, answer questions about your experience relating to the vignette, answer demographic questions, and answer questions about your own gender identity and experiences with counseling. The study should take approximately 15 minutes to complete.

Data Confidentiality or Anonymity

All data will be maintained as anonymous and no identifying information such as names will appear in any publication or presentation of the data.

Storage of Data and Data Retention Period

Digital Data will be stored in a password protected box online account. The data will also be entered into a software program and stored on the researcher's password-protected computer for five years and then deleted. Only members of the research team will have access to the data.

Risks or Discomforts

Some participants might perceive some of the questions asked to be sensitive in nature and might induce some discomfort or emotional distress. If you feel uncomfortable or upset in any way, please call The National Suicide Prevention Hotline, 1-800-273-8255, or visit their website for more information, https://suicidepreventionlifeline.org/ This is a 24-7 free and confidential

resource in which you can speak with counselors who can assist you whether you are experiencing emotional distress, suicidal crisis or need emotional support.

Benefits

There are no perceived benefits for participating in this study.

Voluntary Participation

Your participation in this study is completely voluntary and you are free to withdraw your permission at anytime for any reason without penalty or prejudice from the investigator. If you do not finish the entirety of the study, your data might be retained and used for research purposes. Please feel free to ask any questions of the investigator before signing this form and at any time during the study.

IRB Contact Information

For questions about your rights as a research subject, please contact the Office of Research Integrity, Ball State University, Muncie, IN 47306, (765) 285-5052 or at orihelp@bsu.edu.

Study Title ***(Trans Individuals' Perceptions of Counselor Effectiveness)***

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Researcher Contact Information

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Consent

I agree to participate in this research project entitled, ***(Trans Individuals' Perceptions of Counselor Effectiveness).***

I have had the study explained to me and my questions have been answered to my satisfaction. I have read the description of this project and give my consent to participate. I understand that I can print a copy of this informed consent form to keep for future reference.

To the best of my knowledge, I meet the inclusion/exclusion criteria for participation (described on the previous page) in this study.

Please check the option below that pertains to you:

- ○ I agree
- ○ I do not agree & will not take this study
- ○

Q122 I identify as transgender, trans, gender nonconforming or some other identity under the transgender umbrella/spectrum AND am 18 years or older.

- ○ yes (1)
- ○ no (2)

Skip To: End of Survey If I identify as transgender, trans, gender nonconforming or some other identity under the transgend... = no

End of Block: Informed Consent

Start of Block: Directions & Definitions

Q116 Different people use different language to refer to people of varying gender identities.

The current study uses the term 'trans' to describe someone who does not identify with the sex/gender they were assigned at birth (that was put on their birth certificate). You might have heard this term referred to as transgender. Trans is used in this study to describe the various identities that fall under the transgender umbrella.

The current study uses the term, 'cisgender' to describe someone who does identify with the sex/gender

they were assigned at birth (that was put on their birth certificate).

Additionally, there are different terms used to describe mental health treatment. The current study will use the terms counseling and therapy interchangeably. Additionally, therapist and counselor will be used interchangeably.

End of Block: Directions & Definitions

Start of Block: (Counselor Gender Match (transgender) & (High Counselor Connection)

Q65 Prior to deciding if you would like to work with the following therapist, you receive a hypothetical clip of their work with a client. Please read the following example of the counselor's work and try to put yourself in the client's perspective.

Vignette varied depending on condition (Please see Appendix A)

End of Block: (Counselor Non-Gender Match (cisgender) & High Counselor Connection

Start of Block: (Counselor NON-Gender Match (cisgender) & (No Counselor Connection)

Start of Block: Counselor Rating Form Scale -Short Form (CRS-S), From Corrigan & Schmidt (1983)

Q29 Again, please imagine yourself as the client in the session you just read. The following characteristics are followed by a 7-point scale that ranges from 'not very ' to 'very'. **Please select the point on the scale that best represents how you viewed the therapist.**

(CRS-S)Attractivene1 Friendly

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Attractivene2 Likeable

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Attractivene3 Sociable

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Attractivene4 Warm

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Expertness5 Experienced

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Expertness6 Expert

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Expertness7 Prepared

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Expertness8 Skillful

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Trustworthy9 Honest

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Trustworthy10 Reliable

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Trustworthy11 Sincere

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

(CRS-S)Trustworthy12 Trustworthy

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

End of Block: Counselor Rating Form Scale -Short Form (CRS-S), From Corrigan & Schmidt (1983)

Start of Block: Demographics

Q82 What is your age?

_____

Q83 What was the sex you were assigned at birth?

- Male (1)
- Female (2)

Q85 Do you identify as intersex?

- Yes (1)
- No (0)

Q84 What is your gender identity?

- ○ Woman (1)
- ○ Man (2)
- ○ Trans Man (3)
- ○ Trans Woman (4)
- ○ Trans (5)
- ○ Non Binary (6)
- ○ Gender Queer (7)
- ○ Gender Neutral (8)
- ○ Agender (9)
- ○ Other not listed here (10) _____

Q108 What are your pronouns?

_____

Q92 What is your sexual orientation?

- ○ Straight/Heterosexual (1)
- ○ Lesbian (2)
- ○ Gay (3)
- ○ Bisexual (4)
- ○ Pansexual (5)
- ○ Asexual (6)
- ○ Other (7) _____

Q90 Choose one or more races that you consider yourself to be:

- ☐ White or Caucasian (1)
- ☐ Black or African American (2)
- ☐ American Indian or Alaska Native (3)
- ☐ Asian American (4)
- ☐ Native Hawaiian or Pacific Islander (5)
- ☐ Multiracial (6)
- ☐ Other (7) _____

Q100 Are you Spanish, Hispanic, or Latino or none of these?

- ○ Yes (1)
- ○ None of these (2)

Q93 Do you consider the area you live to be...

- ○ Rural (1)
- ○ Suburban (e.g. in-between a rural area and an urban area) (2)
- ○ Urban (e.g. a city) (3)

Q98 What is the highest level of school you have completed or the highest degree you have received?

- ○ Less than high school degree (1)
- ○ High school graduate (high school diploma or equivalent including GED) (2)
- ○ Some college but no degree (3)
- ○ Associate degree in college (2-year) (4)
- ○ Bachelor's degree in college (4-year) (5)
- ○ Master's degree (6)
- ○ Doctoral degree (7)
- ○ Professional degree (JD, MD) (8)

Q102 Information about income is very important to understand. Would you please give your best guess?Please indicate the answer that includes your entire household income in (previous year) before taxes.

- ○ Less than $10,000 (1)
- ○ $10,000 to $19,999 (2)
- ○ $20,000 to $29,999 (3)
- ○ $30,000 to $39,999 (4)
- ○ $40,000 to $49,999 (5)
- ○ $50,000 to $59,999 (6)
- ○ $60,000 to $69,999 (7)
- ○ $70,000 to $79,999 (8)
- ○ $80,000 to $89,999 (9)
- ○ $90,000 to $99,999 (10)
- ○ $100,000 to $149,999 (11)
- ○ $150,000 or more (12)

Q134 What is your occupation?

_____

End of Block: Demographics

Start of Block: Previous Therapy Experience

X→

Q99 Have you been to counseling/therapy/ or psychotherapy before?

- yes (1)
- no (0)

Skip To: End of Survey If Have you been to counseling/therapy/ or psychotherapy before? = no

Q100 Are you currently in counseling?

- yes (1)
- no (0)

Q121 How long have you been in counseling all together (include previous and current experience)?

- Less than one month (1)
- 1-6 months (2)
- 7 months- a year (3)
- 1 -2 years (4)
- 3-4 years (5)
- 5-6 years (6)
- More than 6 years (7)

Q101 Think back to your last therapist. How did you feel about your experience in counseling with them?

- 1 Bad (1)
- 2 (2)
- 3 (3)
- 4 Neutral (4)
- 5 (5)
- 6 (6)
- 7 Good (7)

Q102 Think back to your last therapist. Was therapy...

- 1 Unsafe (1)
- 2 (2)
- 3 (3)
- 4 Neutral (4)
- 5 (5)
- 6 (6)
- 7 Safe (7)

Q103 Think back to your last therapist, was your previous therapist transgender?

- yes (1)
- no (2)
- Unsure (3)

X→

Q136 What was the gender identity of your last therapist?

- Cis Woman (1)
- Cis Man (2)
- Woman (3)
- Man (4)
- Trans Man (5)
- Trans Woman (6)
- Trans (7)
- Non Binary (8)
- Gender Queer (9)
- Gender Neutral (10)
- Agender (11)
- Other not listed here (12) _____

Q104 Think back to your last therapist, was your previous therapist connected to the transgender community (attended various transgender community activities)?

- yes (1)
- no (2)
- unsure (3)

End of Block: Previous Therapy Experience

Start of Block: Gender Minority Stress and Resilience Measure (GMSR) -Internalized Transphobia S

Q123 *Please indicate how much you agree with the following statements:*

Q124 I resent my gender identity or expression.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

Q131 My gender identity or expression makes me feel like a freak.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

Q132 When I think of my gender identity or expression, I feel depressed.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

Q125 When I think about my gender identity or expression, I feel unhappy.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

Q128 Because of my gender identity or expression, I feel like an outcast.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

Q129 I often ask myself: why can't my gender identity or expression just be normal?

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

X→

Q130 I feel that my gender identity or expression is embarrassing.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

X→

Q133 I envy people who do not have a gender identity or expression like mine.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

End of Block: Gender Minority Stress and Resilience Measure (GMSR) -Internalized Transphobia S

Start of Block: Block 10

Q137 Have you participated in this study before?

- Yes (1)
- No (2)

End of Block: Block 10

Start of Block: Manipulation Check Trans Pilot

Q138 On a scale from 1-7 (7= definitely agree) how strongly do you agree with the following statements concerning the clip you read earlier?

Q140
How connected to the transgender community is this counselor?

- 1 Not at all (1)
- 2 (2)
- 3 (3)
- 4 Neutral (4)
- 5 (5)
- 6 (6)
- 7 Very much (7)

Q141
This is a realistic example of what counseling is like.

- 1 Definitely Disagree (1)
- 2 (2)
- 3 (3)
- 4 Neither Agree Nor Disagree (4)
- 5 (5)
- 6 (6)
- 7 Definitely Agree (7)

Q143 Before reading this clip, have you heard about Transgender Day of Remembrance?

- yes (1)
- no (0)

Q146 How important to you is it that your counselor is connected to the trans community?

- 1 Not at all important (1)
- 2 Slightly important (2)
- 3 Somewhat important (3)
- 4 Very important (4)
- 5 Extremely important (5)

Q148 How important to you is it to have a counselor who identifies as transgender?

- 1 Not at all Important (1)
- 2 Slightly important (2)
- 3 Somewhat Important (3)
- 4 Very important (4)
- 5 Extremely important (5)

End of Block: Manipulation Check Trans Pilot

Appendix E

Experiences of Trans Clients in Counseling-Pilot Study

Start of Block: Informed Consent

Informed Consent Form will be presented in the main study. It was retracted here for space concerns.

Consent I agree to participate in this research project entitled, (The Experiences of Trans Clients in Counseling). I have had the study explained to me and my questions have been answered to my satisfaction. I have read the description of this project and give my consent to participate. I understand that I can print a copy of this informed consent form to keep for future reference. To the best of my knowledge, I meet the inclusion/exclusion criteria for participation (described on the previous page) in this study. Please check the option below that pertains to you:

- ○ I agree (1)
- ○ I do not agree & will not take this study (2)

Page Break

Q122 I identify as transgender, trans, gender nonconforming or some other identity under the transgender umbrella/spectrum.

- ○ yes (1)
- ○ no (2)

End of Block: Informed Consent

Start of Block: Directions & Definitions

Q116 Different people use different language to refer to people of varying gender identities.

The current study uses the term 'trans' to describe someone who does not identify with the sex/gender they were assigned at birth (that was put on their birth certificate). You might have heard this term referred to as transgender. Trans is used in this study to describe the various identities that fall under the transgender umbrella.

The current study uses the term, 'cisgender' to describe someone who does identify with the sex/gender they were assigned at birth (that was put on their birth certificate).

Additionally, there are different terms used to describe mental health treatment. The current study will use the terms counseling and therapy interchangeably. Additionally, therapist and counselor will be used interchangeably.

End of Block: Directions & Definitions

Varying vignette conditions will be presented in the main study.

Start of Block: Counselor Rating Form Scale -Short Form (CRS-S), From Corrigan & Schmidt (1983)

Q29 Again, please imagine yourself as the client in the session you just read. The following characteristics is followed by a 7-point scale that ranges from 'not very ' to 'very'. Please select the point on the scale that best represents how you viewed the therapist.

X→

(CRS-S)Attractivene1 Friendly

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Attractivene2 Likeable

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Attractivene3 Sociable

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Attractivene4 Warm

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Expertness5 Experienced

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

(CRS-S)Expertness6 Expert

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

(CRS-S)Expertness7 Prepared

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

X→

(CRS-S)Expertness8 Skillful

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

(CRS-S)Trustworthy9 Honest

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

(CRS-S)Trustworthy10 Reliable

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

(CRS-S)Trustworthy11 Sincere

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

(CRS-S)Trustworthy12 Trustworthy

- 1 not very (1)
- 2 (2)
- 3 (3)
- 4 (4)
- 5 (5)
- 6 (6)
- 7 very (7)

End of Block: Counselor Rating Form Scale -Short Form (CRS-S), From Corrigan & Schmidt (1983)

Start of Block: Demographics 1

Q82 What is your age?

_____

Q83 What was the sex you were assigned at birth?

- Male (1)
- Female (2)

Q85 Do you identify as intersex?

- ○ Yes (1)
- ○ No (0)

Q84 What is your gender identity?

- ○ Woman (1)
- ○ Man (2)
- ○ Trans Man (3)
- ○ Trans Woman (4)
- ○ Trans (5)
- ○ Non Binary (6)
- ○ Gender Queer (7)
- ○ Gender Neutral (8)
- ○ Agender (9)
- ○ Other not listed here (10) _____

Q108 What are your pronouns?

_____

Q92 What is your sexual orientation?

- ○ Straight/Heterosexual (1)
- ○ Lesbian (2)
- ○ Gay (3)
- ○ Bisexual (4)
- ○ Pansexual (5)
- ○ Asexual (6)
- ○ Other (7) _____

Q90 Choose one or more races that you consider yourself to be:

- ☐ White or Caucasian (1)
- ☐ Black or African American (2)
- ☐ American Indian or Alaska Native (3)
- ☐ Asian American (4)
- ☐ Native Hawaiian or Pacific Islander (5)
- ☐ Multiracial (6)
- ☐ Other (7) _____

Q100 Are you Spanish, Hispanic, or Latino or none of these?

- Yes (1)
- None of these (2)

Q93 Do you consider the area you live to be...

- Rural (1)
- Suburban (e.g. in-between a rural area and an urban area) (2)
- Urban (e.g. a city) (3)

Q98 What is the highest level of school you have completed or the highest degree you have received?

- ○ Less than high school degree (1)
- ○ High school graduate (high school diploma or equivalent including GED) (2)
- ○ Some college but no degree (3)
- ○ Associate degree in college (2-year) (4)
- ○ Bachelor's degree in college (4-year) (5)
- ○ Master's degree (6)
- ○ Doctoral degree (7)
- ○ Professional degree (JD, MD) (8)

Q102 Information about income is very important to understand. Would you please give your best guess? Please indicate the answer that includes your entire household income in (previous year) before taxes.

- ○ Less than $10,000 (1)
- ○ $10,000 to $19,999 (2)
- ○ $20,000 to $29,999 (3)
- ○ $30,000 to $39,999 (4)
- ○ $40,000 to $49,999 (5)
- ○ $50,000 to $59,999 (6)
- ○ $60,000 to $69,999 (7)
- ○ $70,000 to $79,999 (8)
- ○ $80,000 to $89,999 (9)
- ○ $90,000 to $99,999 (10)
- ○ $100,000 to $149,999 (11)
- ○ $150,000 or more (12)

End of Block: Demographics 1

Start of Block: Previous Therapy Experience D3

Q99 Have you been to counseling/therapy/ or psychotherapy before?

- yes (1)
- no (0)

Q100 Are you currently in counseling?

- yes (1)
- no (0)

Q121 How long have you been in counseling all together (include previous and current experience)?

- Less than one month (1)
- 1-6 months (2)
- 7 months- a year (3)
- 1 -2 years (4)
- 3-4 years (5)
- 5-6 years (6)
- More than 6 years (7)

Q101 Think back to your last therapist. How did you feel about your experience in counseling with them?

- 1 Bad (1)
- 2 (2)
- 3 (3)
- 4 Neutral (4)
- 5 (5)
- 6 (6)
- 7 Good (7)

Q102 Think back to your last therapist. Was therapy...

- 1 Unsafe (1)
- 2 (2)
- 3 (3)
- 4 Neutral (4)
- 5 (5)
- 6 (6)
- 7 Safe (7)

Q103 Think back to your last therapist, was your previous therapist transgender?

- ○ yes (1)
- ○ no (2)
- ○ Unsure (3)

Q136 What was the gender identity of your last therapist?

- ○ Woman (1)
- ○ Man (2)
- ○ Trans Man (3)
- ○ Trans Woman (4)
- ○ Trans (5)
- ○ Non Binary (6)
- ○ Gender Queer (7)
- ○ Gender Neutral (8)
- ○ Agender (9)
- ○ Other not listed here (10) _____

Q104 Think back to your last therapist, was your previous therapist connected to the transgender community (attended various transgender community activities)?

- yes (1)
- no (2)
- unsure (3)

End of Block: Previous Therapy Experience D3

Q123 *Please indicate how much you agree with the following statements:*

Q124 I resent my gender identity or expression.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

Q131 My gender identity or expression makes me feel like a freak.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

Q132 When I think of my gender identity or expression, I feel depressed.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

Q125 When I think about my gender identity or expression, I feel unhappy.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

Q128 Because of my gender identity or expression, I feel like an outcast.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

Q129 I often ask myself: why can't my gender identity or expression just be normal?

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

Q130 I feel that my gender identity or expression is embarrassing.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

Q133 I envy people who do not have a gender identity or expression like mine.

- 0 (Strongly Disagree) (0)
- 1 (1)
- 2 (2)
- 3 (3)
- 4 (Strongly Agree) (4)

Q137 Have you participated in this study before?

- Yes (1)
- No (2)

Start of Block: Manipulation Check Trans Pilot

Q138 On a scale from 1-7 (7= definitely agree) how strongly do you agree with the following statements concerning the clip you read earlier?

X→

Q140
How connected to the transgender community is this counselor?

- 1 Not at all (1)
- 2 (2)
- 3 (3)
- 4 Neutral (4)
- 5 (5)
- 6 (6)
- 7 Very much (7)

Q141
This is a realistic example of what counseling is like.

- 1 Definitely Disagree (1)
- 2 (2)
- 3 (3)
- 4 Neither Agree Nor Disagree (4)
- 5 (5)
- 6 (6)
- 7 Definitely Agree (7)

Q143 Before reading this clip, have you heard about Transgender Day of Remembrance?

- yes (1)
- no (0)

Q146 How important to you is it that your counselor is connected to the trans community?

- 1 Not at all important (1)
- 2 Slightly important (2)
- 3 Somewhat important (3)
- 4 Very important (4)
- 5 Extremely important (5)

Q148 How important to you is it to have a counselor who identifies as transgender?

- 1 Not at all Important (1)
- 2 Slightly important (2)
- 3 Somewhat Important (3)
- 4 Very important (4)
- 5 Extremely important (5)

End of Block: Manipulation Check Trans Pilot

Appendix F

Pilot Study Results

The PI designed a pilot study to test whether the current experimental analogue demonstrates good construct validity. The pilot study was also used to test the flow of the current study.

Participants. After obtaining IRB approval, participants were recruited via snowball sampling. Specifically, participants were recruited via a Ball State Student LGBTQ organization of which the RA is the president. Additionally, participants were recruited through a local LGBT organization. The RA sent out the study link via repeated email and social media correspondence. A total of 36 participants originally clicked on the link. Three people identified as cisgender and so were automatically directed to the end of the study. One person did not answer the gender identity question and did not take the rest of the study and nine people stopped taking the study after being randomly assigned to condition. As such, the total sample consisted of 23 trans-identified participants. Participants ranged in age from 18-61 years old, with a mean age of 27 years (SD = 10.15). All participants self-identified as possessing a gender identity on the trans spectrum. Of the current sample, two self-identified as a man, seven identified as a transman, two identified as a transwoman, one identified as non-binary, one identified as trans, five identified as non-binary, one identified as genderqueer, and six identified as other. Responses for the other gender category included: "agender/trans/nonbinary, gender fluid, genderqueer and nonbinary, my gender expression is feminine, but my gender identity is masculine, nonbinary woman, transfeminine, what is your gender identity?" Participants were also asked about their gender pronouns. Nine participants stated they used some variation of

'he/him/his' pronouns, five used a version of "she/her/hers," eight participants used they/them pronouns, one participant stated, "all of them" and another participant asked, "what are your pronouns?" Multiple participants (*n*=5) stated they used a combination of pronouns (e.g. they/them and he/him). Twenty-five percent of the sample was assigned the sex of male at birth, and 70.8 percent were assigned the sex of female at birth. Participants self-identified their sexual orientation as: straight (*n*=1, 4.3%), lesbian (*n*=4, 17.4%), gay (3, 13%), bisexual (*n*=7, 30.4%), pansexual (*n*=2, 8.7%), asexual (*n*=1, 4.3%), or other (*n*=5, 21.7%). Participants wrote in the following sexual identities in the 'other' category: Biromantic Asexual (*n*=1), and Queer (*n*=4). Self-identified race/ethnicity included: white (*n*=19, 82.6%), black (*n*=4, 17.4%), Asian (*n*=1, 4.3%), and other (*n*=1, 4.3%). The participant who selected the 'other' category self-identified as "multiracial." Two participants (8.7%) identified as "Spanish, Hispanic or Latino." When asked about the type of location in which participants resided, five (21.7%) stated they lived in a rural setting, seven (30.4%) stated they lived in a suburban setting and 11(47.8%) stated they lived in an urban setting. Participants responded to the question "What is the highest level of school you have completed or the highest degree you have received?" with the following responses: one had a high school degree, 12 indicated some college, two had an associate's degree, four had a bachelor's degree, three had a master's degree and one had a professional degree (e.g., MD, JD). When asked about income level, 73.9% indicated that they earned between 30-39,999 in the previous year and 17.4% earned between 40,000 to 59,999, and 8.6% earned between 80,000-149,999.

Participants provided informed consent, were provided with directions and definitions and then were randomly assigned to condition. Participants read a vignette which only varied based on the independent variables of interest (gender identity matching and counselor

connection level). Participants then completed a manipulation check. This measure included attention checks in addition to questions assessing perceived realism of the vignette and key questions assessing the validity of the manipulation. General questions assessing the validity of the vignette were followed by more specific questions about specific variables.

Specifically, participants indicated whether TDOR was a good indicator of counselor connection to the trans community, whether they have heard about TDOR, and whether they felt the counselor in the condition to which they were assigned was connected to the trans community. Additionally, participants rated the importance of having a counselor who is connected to the trans community and the importance of having a counselor who identifies as transgender. Participants were then given the Counselor Rating Form-Short (Corrigan & Schmidt,1983), a demographic questionnaire, another scale not used in the current study, and questions assessing participants' previous therapeutic experiences. Please see the attached study (Appendix D) for specific questions.

Pilot Manipulation Check

The pilot study was conducted to assess the construct validity of the above manipulation (therapist gender identity matching and therapist connection to the transgender community). The first question this pilot study was designed to assess was whether or not TDOR was a valid manipulation to test connection to the trans community. One of the PI's concerns was that TDOR may not have been known to participants or that participants may not have perceived a counselor's knowledge/ attendance of this event as indicative of being connected to the trans community. Overall the pilot study appeared to reveal promising results as to the validity of the current experimental manipulation. All participants (N=23) reported having previously heard of TDOR. Twenty-two of the 23 participants stated that TDOR was "a good example of an event a

counselor who is connected to the trans community might attend." To assess whether participants thought being connected to the trans community was an important characteristic they looked for within a counselor, we asked the question, "How important to you is it that your counselor is connected to the trans community?" Answers ranged from 1 (*not at all important*) to 5 (*extremely important*). The majority of respondents stated that this was an important aspect of counseling (n=15, 65.2%). Six respondents (26.1%) indicated that it was "somewhat important." Two respondents stated that it was either "slightly or not at all important."

The second construct we sought to test was the variable of counselor-client gender identity matching. Specifically, we sought to examine participants' perceived importance of counselor-client gender identity matching. This was assessed with the question, "How important to you is it to have a counselor who identifies as transgender?" Possible answers ranged on a scale from 1 (*not at all important*) to 5 (*extremely important*). Fourteen respondents (60.8%) indicated that this was "not at all important" or "slightly important to them" and 9 participants (39.1%) indicated that this was "somewhat important" or "very important" to them. Given that 60% of participants found matching important and the fact that this is the first study to assess counselor matching with a trans population, it appears that matching client and counselor based on gender identity might be an important variable to consider.

Lastly, we tested whether participants differentiated between the three levels of the independent variable of counselor connection (low, medium, high). Using a one-way ANOVA, we tested the question "How connected to the transgender community is this counselor?" Participants rated this question on a 1 (*Not at all*) to 7 (*Very much*) rating scale. Four (neutral) was used as a middle anchor. Results indicated that there was a significant difference between these groups $F(2, 22) = 14.2$, $p = .000$. Bonferroni Post hoc mean analysis revealed that although

Low Connection was statistically different from Medium and High Connection (p=.001, p=.000, respectively), Medium and High Connection were not significantly different from one another. The reader should be cautioned that this finding might be an artifact of unequal cell sizes, given that Low and High Connection had nine and ten participants, respectively, while Medium Connection had four participants. Given these results, the PI decided to remove the middle condition and conduct an Independent Samples t-test to explore whether there is a difference between the Low and High Connection Condition. The PI found that participants in the low connection condition (M =3.67, SD = .87) rated their counselor significantly lower on the question of "how connected to the transgender community is this counselor?" than the high condition (M = 5.60, SD = .84), t (17) = -4.92, p =.000. This provides evidence that participants perceived a difference in the intended directions. The PI plans to use this finding to inform the main study. Only the High and Low Condition will be used. Please see Appendix A for more details.

A two-way ANOVA was used to analyze the results of the current study. Therapist Gender Identity-Matching and Therapist Connection to the Transgender Community served as the independent variables and participants' perception of the therapist (measured by the CRF-S) served as the dependent variable. The two-way ANOVA was not significant in the pilot study, ostensibly due to the low sample size. After removing the four participants assigned to the middle connection condition, we were left with a total sample of 19 and were thus underpowered to detect significant differences.

All procedures and measures will remain similar to that used in the pilot study sans the edited experimental manipulation and manipulation check portion of the pilot study.

Conclusion and Implications

The current study has implications for theory, research, and practice. Specifically, this study utilizes the minority stress model and Strong's Interpersonal Influence model to test the effects of varying interpersonal psychotherapeutic processes. On a more concrete note, to the author's knowledge, this study will only be the second analogue study to assess specific mechanisms of the counseling process with trans participants. This will be one of the most rigorous tests of internal validity to date given that other studies which explore trans clients' experiences in counseling are largely either descriptive or qualitative in nature. The findings of this study can inform both current and future standards of care for working with trans clients and have the potential for impacting policy. For instance, if there is a positive effect found for connection to the trans community and the therapeutic alliance, perhaps more programs will institute various incentives for counselors to become involved with the trans community through attending pride events, Trans Day or Remembrance events etc. Additionally, if it is found that matching is a particularly important characteristic for trans participants, then this can have implications for hiring policies. Counselors who wish to work with the trans community but do not identify as trans themselves may feel a lack of cultural capital in regards to trans people's experiences. Understanding the effects of connection to the trans community might empower some clinicians to feel more confident in working with this community and might encourage their participation in doing so.

Appendix G

Office of Research Integrity
Institutional Review Board (IRB)
2000 University Avenue
Muncie, IN 47306-0155
Phone: 765-285-5052
Email: orihelp@bsu.edu
DATE: June 4, 2019
TO: Samuel Colbert, MA
FROM: Ball State University IRB
RE: IRB protocol # 1446838-1
TITLE: The Experiences of Trans Clients in Counseling
SUBMISSION TYPE: New Project
DECISION: APPROVED
PROJECT STATUS: EXEMPT
DECISION DATE: June 4, 2019
REVIEW TYPE: Exempt Review
The designated reviewer for the Institutional Review Board (IRB) reviewed your protocol and determined the procedures you have proposed are appropriate for exemption under the federal regulations. As such, there will be no further review of your protocol, and you are cleared to proceed with the procedures outlined in your protocol. As an exempt study, there is no requirement for continuing review. Your protocol will remain on file with the IRB as a matter of record. All research under this protocol must be conducted in accordance with the approved submission and in accordance with the principles of the Belmont Report.
Exempt Categories:
Category 1: Research conducted in established or commonly accepted educational settings, that specifically involves normal educations practices that are not likely to adversely impact students' opportunity to learn required educational content or the assessment of educators who provide instruction. This includes most research on regular and special education instructional strategies, and research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.
X
Category 2: Research that only includes interactions involving educational test (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior (including visual or auditory recording) if at least one of the following criteria is met: (i) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects cannot readily be ascertained, directly or through identifiers linked to the subjects; (ii) Any disclosure of the human subjects' responses outside

the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or (iii) The information obtained is recorded by the investigator in such a manner that the identity of the humans subjects can readily be ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by 46.111(a)(7).
Category 3: Research involving benign behavioral interventions in conjunction with the collection of information from an adult subject through verbal or written responses (including data entry) or audiovisual recording if the subject prospectively agrees to the intervention and information collection and at least one of the following criteria is met: (A) The information obtained is recorded by the investigator in such a manner that the identity of human subjects cannot be readily ascertained, directly or through identifiers linked to the subjects; (B) Any

disclosure of the human subjects' responses outside the research would not reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, educational advancement, or reputation; or (C) The information obtained is recorded by the investigator in such a manner that the identity of the human subjects can be readily ascertained, directly or through identifiers linked to the subjects, and an IRB conducts a limited IRB review to make the determination required by 46.111(a)(7).

Category 4: Secondary research for which consent is not required.

Category 5: Research and demonstration projects that are conducted or supported by a Federal department or agency, or otherwise subject to the approval of department or agency heads, and that are designed to study, evaluate, improve, or otherwise examine public benefit or service programs, including procedures for obtaining benefits or services under those programs, possible changes in or alternatives to those programs or procedures, or possible changes in methods or levels of payment for benefits or services under those programs.

Category 6: Taste and food quality evaluation and consumer acceptance studies, (i) if wholesome foods without additives are consumed or (ii) if a food is consumed that contains a food ingredient at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

Category 7: Storage or maintenance for secondary research for which broad consent is required: Storage or maintenance of identifiable private information or identifiable biospecimens for potential secondary research use if an IRB conducts a limited IRB review and makes the determinations required by 46.111(a)(8).

Category 8: Secondary research for which broad consent is required: Research involving the use of identifiable private information or identifiable biospecimens for secondary research use, if the following criteria are met: (1)Broad consent for the storage, maintenance, and secondary research use of the identifiable private information or identifiable biospecimens was obtained in accordance with §46.116(a)(1) through (4), (a)(6), and (d); (2) Documentation of informed consent or waiver of documentation of consent was obtained in accordance with §46.117; and (3) An IRB conducts a limited IRB review and makes the determination required by §46.111(a)(7) and makes the determination that the research to be conducted is within the scope of the broad consent referenced in paragraph (d)(8)(i) of this section; and (iv) The investigator does not include returning individual research results to participants as part of the study plan. Note: This provision does not prevent an investigator from abiding by any legal requirements to return individual research results.

Ball State Specific Exempt Categories

Category 9: Research involving publicly observable online behavior. Any online behavior that requires a person's permission to access is considered private and does not fall under this category. Information that cannot be accessed by the general population would also be considered private.

Category 10: Research involving BSU students who are under 18 but have legal authority over their FERPA protected information. Only studies that fall into another exempt category except for sampling from BSU students who are under 18 can be considered exempt in this category.

While your project does not require continuing review, it is the responsibility of the P.I. (and, if applicable, faculty supervisor) to inform the IRB if the procedures presented in this protocol are to be modified or if problems related to human research participants arise in connection with this project. **Any procedural modifications must be evaluated by the IRB before being implemented, as some modifications may change the review status of this project.** Please contact Grace Yoder at (765) 285-5034 or gmyoder@bsu.edu if you are unsure whether your proposed modification requires review or have any questions. Proposed modifications should be addressed in writing and submitted electronically to the IRBNet as a "Modification/Amendment" for review. Please reference your IRB protocol number 1446838-1 in any communication to the IRB regarding this project.

In the case of an adverse event and/or unanticipated problem, you will need to submit written documentation of the event to IRBNet under this protocol number and you will need to directly notify the Office of Research Integrity (http://www.bsu.edu/irb) **within 5 business days.** If you have questions, please contact Grace Yoder at (765) 285-5034 or gmyoder@bsu.edu.

Reminder: Even though your study is exempt from the relevant federal regulations of the Common Rule (45 CFR 46, subpart A), Ball State has elected to hold you accountable to these regulations to encourage best research practices. You and your research team are not exempt from ethical research practices and should therefore employ all protections for your participants and their data which are appropriate to your project.