RESEARCH ARTICLE

WILEY

Attending to gender in psychotherapy: Understanding and incorporating systems of power

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Abstract

This study reviews the research evidence on the effectiveness of attending to clients' gender identity and gender as a system of power in psychotherapy. We begin with definitions and measures of gender identity and provide clinical examples. Next, we summarize our search for studies to conduct two meta-analyses on: (a) randomized controlled trials (RCTs) of psychotherapy conducted with transgender clients, and (b) RCTs of the outcomes of psychotherapies that attend explicitly to gender as a system of power compared with another bona-fide psychotherapy. Our search did not yield studies that fit either search criteria; thus, meta-analyses were not conducted. Instead, we conducted a content analysis of the 10 qualitative and quantitative studies on psychotherapy with transgender individuals. We conclude by highlighting the limitations of the research base, describing diversity considerations, and recommending therapeutic practices that attend to gender, gendered systems of power, oppression, and privilege.

KEYWORDS
cisgender, gender affirmative therapy, gender identity, oppression, power, psychotherapy outcome, psychotherapy research, transgender

1 | INTRODUCTION

The social meanings tied to gender permeate societies around the world and often dictate how humans feel, think, and act (Gilbert & Scher, 2009). Gender is defined by systems of power that shape and are shaped by gender norms and hierarchies that intersect with other systems of power such as race, sexual orientation, and class. These norms and hierarchies disadvantage transgender people relative to cisgender people and disadvantage women relative to men (e.g., Bond & Allen, 2016; Moradi & Yoder, 2011; Serano, 2016).

This conceptualization of gender as power and social context contrasts with how gender is typically operationalized in psychotherapy research. In psychotherapy research, gender is often treated as a binary demographic variable whereby women or female clients are compared with men or male clients, and all clients are assumed to be cisgender. In this narrow approach, transgender clients with binary or nonbinary gender identities are rendered invisible, and gender as a dimension of power, including oppression and privilege, is not examined.

In its infancy, psychotherapy was dominated by gendered theories, such as Freudian theories focusing on gender (specifically in relation to one's parents) as the etiology of most presenting concerns (Brown, 1994; Burman, Gowrisunkur, & Sangha, 1998). In more modern theories, it is less clear what role gender plays in the effectiveness of psychotherapy. It might be reasonable to hypothesize that gender as a demographic variable does not play a large role in the overall process of change and effectiveness of treatments, given the evidence on common factors (Wampold & Imel, 2015) and meta-analyses suggesting gender similarities rather than significant differences across a multitude of psychosocial domains (Hyde, 2005). However, researchers have posited that gender may be associated with treatment outcomes due to differential rates of certain diagnoses (e.g., Felmingham & Bryant, 2012; Ogrodniczuk, 2006), or associated with treatment processes—for example, how therapists self-disclose or embed gender stereotypes within explanations for treatment (Haddock & Lyness, 2002; Heru, Strong, Price, & Recupero, 2006), or how long clients remain in therapy (Swift, Callahan, Ivanovic, & Kominiak, 2013).

Despite these speculations, research studies have yielded mixed results as to whether or not gender impacts psychotherapy outcomes (Clarkin & Levy, 2004; Ogrodniczuk, 2006; Owen, Wong, & Rodolfa, 2009). In this study, we review the research evidence on the effectiveness of attending to clients' gender identity and gender as a dimension of power in psychotherapy.

2 | DEFINITIONS AND MEASURES

Feminist scholars (e.g., Bem, 1993; West & Zimmerman, 1987) distinguish *sex* from *gender*. *Sex* reflects the biological and anatomical characteristics used to assign people at birth to sex categories (e.g., male, female, and intersex). *Gender* is the social meaning or collection of characteristics prescribed to sex categories in a given society or culture. *Gender identity* reflects one's sense of self and identification (e.g., gender nonbinary, genderqueer, male or man, and female or woman). *Gender expression* reflects the variety of ways in which people communicate their gender and gender identity in a given sociocultural context (e.g., hair, clothes, and voice). *Transgender* is an umbrella term that captures a variety of people whose gender identity is different from their assigned sex at birth. In addition, *nonbinary gender identities* describe individuals who identify outside of the man or woman binary or along a spectrum between man or woman. *Cisgender* is a term that describes individuals whose gender identity is the same as the sex they were assigned at birth.

Cisnormativity describes the collection of individual and systemic biases and assumptions that all people are and should be cisgender and binary (either man or woman), and by extension, that there is something wrong with people that do not fit within this standard. *Transphobia* is defined as prejudicial attitudes, behaviors, and systems that denigrate transgender individuals; it can span from subtle forms (microaggression) to overt forms (violence). *Internalized transphobia* is the internalization of such prejudice, such that societal bias is turned inward toward the self and results in shame, guilt, and internalized stigmatization. *Androcentrism* is centering men's (most often

cisgender men's) experiences as the normative, best, and focal experiences in defining human experience, in turn marginalizing the experiences of anyone who does not identify as a cisgender man as a suboptimal deviation of the norm. Relatedly, *sexism* describes prejudicial attitudes, behaviors, and systems that define women and femininity in restrictive ways, oppress women (transgender inclusive) relative to men, and are rooted in the notion that women are inferior to men.

Gender identity should be assessed separately from sex and sexual orientation variables. Specifically, the GenIUSS Group (2014) recommends separately assessing individuals' assigned sex at birth (male or female) and whether they are also intersex. These variables, in turn, can be assessed separately from gender identity and gender expression. Gender expression can be assessed to include separate masculine and feminine continua.

In the largest survey to assess a range of gender identities in the United States (James et al., 2016), researchers asked individuals to respond to the following question: "If you had to choose only one of the following terms, which best describes your current gender identity? (Please choose only one answer)" and offered the following options: Crossdresser, man, woman, trans woman (MTF), trans man (FTM), and nonbinary or genderqueer. Participants were also instructed to complete an open-response option to describe their gender identities in their own words. This open-ended description allows participants to have agency over how researchers quantify their gender identity (rather than researchers categorizing participants' gender identities) and also enables participants to describe their gender identity label(s) for research purposes.

Beyond assessing gender as identity and demographic variables, some measures assess feminist psychotherapy behaviors, which attend to gender as a system of power in psychotherapy and beyond. For example, the Feminist Family Therapist Behavior Checklist (FFTBC; Chaney & Piercy, 1988), and its subsequent versions, the Feminist Therapy Behaviors (FTB; Juntunen, Atkinson, Reyes, & Guitierrez, 1994) and the Feminist Therapy Behaviors-Revised (FTB-R; Moradi, Fischer, Hill, Jome, & Blum, 2000) are applicable across psychotherapy formats (e.g., individual, family) and assess use of feminist therapy behaviors with clients of all genders. Consistent with a focus on systems of power, an empirical study using the FTB-R found that strongly identified feminist therapists were differentiated from other therapists by engaging in more FTB-R behaviors that reflected attention to systems of oppression (e.g., sexism, racism, heterosexism) and socialization (Moradi et al., 2000). Similarly, the Therapy with Women Scale (TWS; Robinson & Worell, 1991) differentiates feminist therapy behaviors from other types of therapy, specifically by assessing the extent to which therapists share power in the therapeutic relationship (e.g., "I establish an egalitarian relationship with my client") and affirm women in therapy (e.g., "I support and value my female clients' relationships with other women").

Because it is not typical for psychotherapy researchers to go beyond assessing gender as a binary demographic variable, many measures have not been validated or adapted for use with people with a diversity of gender identities. Researchers have provided recommendations for using specific measures, which include: (a) Using well-established measures (such as the Center for Epidemiological Studies Depression Scale) that have been previously validated with transgender populations, (b) measures that focus on minority stress, and (c) re-evaluating measures that focus on gender, as it is likely that they are outdated (Budge, Israel, & Merrill, 2017).

3 | CLINICAL EXAMPLES

Feminist therapy was developed in the 1970's to emphasize attention to power dynamics, including oppression and privilege associated with gender (Rader & Gilbert, 2005). Feminist psychotherapy is a constructivist approach that incorporates principles of person-centered therapies into eclectic treatment methods while focusing on the politics of clinical practice, critically addressing gender and other systems of power, and infusing the client's social location into all interventions (Brown, 2006). As such, feminist therapy is applicable to clients of all genders. A core aspect of feminist therapy also includes the power relationship between the therapist and the client (Worell & Remer, 2002).

Gender aware therapy (GAT) is another approach that infuses feminist principles into therapy (Good, Gilbert, & Scher, 1990). GAT employs five overarching principles: (a) Ensuring that gender is integral to the treatment plan, (b) using social context to understand a client's presenting concern, (c) infusing activism to change gender injustices into the therapeutic process, (d) working toward a collaborative therapeutic relationship, and (e) respecting clients' freedom to choose rather than be defined by gender scripts. Although feminist therapy and GAT are applicable to clients of all genders, explicit articulation of using these approaches with transgender people remains limited.

In influential analog research (Salierno, 2000), four clinical case examples were provided to 97 participants to determine if the type of therapy (feminist vs. cognitive behavioral) and client gender were related to the perception of effective outcome. The vignette provided below focused on a cisgender male therapist conducting feminist therapy with a cisgender male client (from Salierno, 2000, p. 129). The case history indicated that James (the client) had been seeing the therapist (Mr. Jones) for about 3 months. The presenting concern for James was primarily related to difficulties in his marriage and ensuing depression.

Dr. Jones: It sounds like career is very important to you.
James: Yes, I think career is, especially for a man. You can't really feel like a man unless you make your mark in your career.
Dr. Jones: So a man who stays at home to raise children while his wife works is not a real man. I think we could come up with a list of qualities that makes a man without even mentioning work, like...someone who is caring, strong, honest, and giving.
James: Well, maybe it's not so much about what I think, but we all have to live in the real world. It's about what people expect of you.
Dr. Jones: You know what we have discussed about this, just because society has unfair expectations about what a woman should be like or what a man should be like, doesn't mean we have to buy into it. We have to decide these things for ourselves.
James: I guess if it were totally up to me, I would rather come home earlier and spend more time with my family.
Dr. Jones: Perhaps then, that's what we should be working on.
James: You mean how to be able to not work so late all of the time. That would be difficult, because the boss is so unreasonable and intimidating. I'll just get yelled at and embarrassed in front of the whole company like the last person who tried to stand up to the boss.
Dr. Jones: Tell me, what kind of expectations do you think that working late will set up in your boss's mind?
James: I guess I'm showing that working late means I care about the job.
Dr. Jones: So if you ever try to stop working late...
James: They'll think I don't care anymore. So you're telling me that I'll be stuck working late forever unless I do something about it. I'm sure not looking forward to explaining this to my boss.
Dr. Jones: It's always difficult to confront someone who has power over you. Whenever there is such a difference in power in a relationship, it puts the less powerful person at a disadvantage and that person can easily be taken advantage of, just like the employees in your company. It's just like what we talk about in terms of differences between men and women. Women have less power, and they are paid less for the same work than men. But these are things we can do to help you deal with this situation. The first thing I want to discuss with you are some assertiveness training techniques...

In this excerpt, the therapist addresses gender role expectations and discusses power with the client, which are central aspects of feminist therapy. However, a feminist therapy lens also offers critical analysis of several additional points in this excerpt. First, the statement about a man who stays home and his wife who works outside the home communicates an implicit heteronormative assumption (i.e., men are heterosexual and have wives) that should be avoided. Instead, a more exploratory and open-ended response could be used to help the client deepen his understanding of social norms versus his own values; for example, "can you tell me more about what it means to feel like a man and what it means for you personally to feel good about yourself? I wonder how these things might be similar and different."

A second point of caution about this excerpt is that the therapist emphasizes individual agency without sufficient attention to the consequences of that agency in gendered systems of power. For example, a realistic consequence of assertiveness in this example might be that the client loses his job. Thus, while the therapeutic intervention may include assertiveness training, feminist therapy also includes deep empathy, full exploration of costs and benefits, and additional strategies to help mitigate potential costs of the client's assertiveness.

Focusing specifically on therapy with transgender clients, a recent case study described the process and outcome of psychotherapy with a client seeking a letter for hormones (Budge, 2015). In this exchange (from Budge, 2015, p. 289), the therapist (Stephanie) and the client (Lia, a pseudonym) are discussing the possible rupture on the relationship due to the therapist's gatekeeping role:

Stephanie: Lia, I'd like to talk to you about some of the information that I need to put in the letter. The university health services requires that transgender patients receive a diagnosis of gender dysphoria to receive hormones—how do you feel about this?

Lia: Um, well, I guess you need to do what you need to do.

Stephanie: I thought it would be important to bring this up, because I want you to know that I do not believe that being trans means you have a mental disorder. Instead, in the letter, I will indicate that you meet criteria for the diagnosis, since you have given me information that fits enough of the criteria to provide this diagnosis.

Lia: No, I get it. It makes me pretty mad to think that someone would think that I have some type of mental disorder, but I understand that it is part of the process.

Stephanie: I definitely understand how that could make you mad. How do you feel about working with me after I have given you this diagnosis as part of the letter?

Lia: Oh, it's okay—I know that you are writing the letter to help me get hormones and it helps to know how you see the diagnosis. I'm not mad at you, more mad that it even exists in the first place.

This part of the exchange illustrates key principles of feminist therapy, including acknowledging and critically analyzing the underlying system of power in psychotherapy, in this case, the necessity of a pathologizing diagnosis to receive care and the potential impact of this on the client and on the client-therapist dyad.

The next part of the exchange (pp. 289–290) examines the process of the client reading the letter:

Stephanie: So, what was it like to read your letter?

Lia: It was weird.

Stephanie: Weird.

Lia: Yeah. I've never actually seen a document that was written about me that uses my name—Lia—or female pronouns [appears a little tearful]. It feels good … what's the word? Empowering. But I'm having a lot of feelings I'm not sure how to talk about. More than good, but also weird. Maybe a little overwhelming.

Stephanie: That makes sense—a lot of trans people tell me they feel the same way when they read their letters for the first time. How are you feeling about our relationship after reading through the letter?

Lia: Oh, I feel good. I feel like you really advocated for me and that you understood the things I told you. It was funny to read the letter because I could see the things I told you written down. I feel like you really get it.

In one of the final exchanges (pp. 292), the therapist and client discuss the client's perception of how therapy interacted with her taking hormones:

Stephanie: How do you feel like taking hormones has impacted your mood?

Lia: Greatly. I used to be all types of crazy and wild and my moods would just pop up. During the first month or so of hormones it was worse, but now I just feel like, since I'm living my life as a woman, everything is just chill now. It just feels right.

Stephanie: How much of that do you attribute to the hormones?

Lia: A lot. Because I can see my progress through hormones, like getting boobs.

Stephanie: How do you think therapy interacted with the hormones?

Lia: Well, it helped me notice how different my moods actually were and how I'm much more open now than I was before. I attribute that to hormones, because I do not think I would have done it if I hadn't started hormones. I do not know where I would be...

Stephanie: Where do you think you would be?

Lia: Well, I would still be that quiet do-not-want-to-talk-about-anything type of person.

Stephanie: So not wanting to open up to others or show who you are?

Lia: Yeah.

Here, the therapist and the client were able to connect the client's gender transition process to her ability to be a more authentic individual with others in her life. Although the client attributes much of her change to external factors (e.g., hormones), with the assistance of her therapist, she is able to internalize that she is more open with others as a result of engaging in psychotherapy.

4 | META-ANALYTIC REVIEWS

We aimed to conduct two separate meta-analyses, one of the outcomes of transgender affirmative psychotherapies or psychotherapies with transgender people and another of the outcomes of psychotherapies that attend explicitly to gender as a system of power. We conducted keyword searches in the PsycINFO database, since it is linked to other databases (e.g., Academic Search Premier, PubMed, and ISI Web of Science).

4.1 | Search results for transgender affirmative psychotherapies

For the first meta-analysis, relevant studies were identified by using keyword searches that focused on psychotherapy trials and LGBTQ+ populations; we used keywords to capture transgender as well as LGBQ+ populations because studies often collapse across these groups. In addition, we distributed a call for unpublished data to the following professional listserves: American Psychological Association's Divisions 12, 29, 17, 44, 35, 49, 51, and POWR-L (feminist psychology list). We received one email in response that provided a literature review of some data that were thought to fit our inclusion criteria. This call yielded no unpublished psychotherapy outcome studies about transgender people.

To be included in this meta-analysis, multiple criteria needed to be met, including: (a) English language publications from 1990 or later; (b) two treatment conditions, with at least one bona-fide psychotherapy condition and an additional treatment condition in which participants engaged in some type of intervention (i.e., not a waitlist); (c) treatment conditions would either have to compare transgender and cisgender individuals or have a focus on treatments adapted or designed for transgender individuals; and (d) statistics necessary to calculate effect sizes. Ideally, we were also hoping to have an inclusion criterion that focused primarily on transgender affirmative psychotherapy; however, given that the search yielded no comparison studies specific to transgender individuals, we were open to including studies that were broader in scope.

The initial search on June 1, 2017 for psychotherapy trials and LGBTQ+ studies resulted in $k = 2,257$. After all duplicates were deleted, the search resulted in 2,189 studies. All abstracts were downloaded and coded into the following categories: (a) Meets inclusion for meta-analysis, (b) addresses psychotherapy and LGBTQ+ people without data, (c) includes data on psychotherapy with LGBTQ+ people, (d) addresses nonpsychotherapy interventions with LGBTQ+ people, and (e) discard. We also included an extra coding category to identify publications that specifically addressed transgender people or issues. The results focusing on LGBQ+ populations are reported in Moradi & Budge (this issue). A total of 108 articles were retrieved for full-text evaluation. However, no studies met the inclusion criteria for this meta-analysis. Therefore, we conducted a content analysis, coding the

TABLE 1 Empirical articles on psychotherapy with transgender clients

Authors	Method	Sample	Purpose	Main findings
Applegarth and Nuttall (2016)	Qualitative	N = 6	Explore transgender clients' previous experiences of psychotherapy	Described fear as a barrier in therapy, mainly due to anxiety about how to talk about gender or about talking about deep emotions in psychotherapy Described the importance of a good working alliance, but also described complicated feelings about their therapists (e.g., feeling deeply connected but also managing therapy boundaries) Indicated personal growth related to gender (clients learned new gender identity labels and gained a greater sense of humanity) Psychotherapy helped participants think long term about how to handle problems when therapy concluded
Bess and Stabb (2009)	Qualitative	N = 7	Explore transgender clients' perspectives on the therapeutic alliance and satisfaction with previous experiences of psychotherapy	Rejected a DSM diagnosis Reported that many therapists provided explicit transition-related support Appreciated a lack of rigidity in gender expectations Stated that the primary aspects of therapeutic alliance were support and empathy Indicated mixed feelings about the Standards of Care All felt that their therapists helped with self-acceptance, self-definition, validation, and normalization Found it helpful to have therapists who identified as women Found group therapy to be "particularly beneficial" Two found therapy not to be helpful (e.g., lack of therapist competence, therapist expression of hostility)
Blumer, Green, Knowles, and Williams (2012)	Quantitative (content analysis)	K = 9	Conduct a content analysis of family therapy journals to determine focus on transgender clients	Of 10,739 articles reviewed from journals that publish family therapy content, only nine (0.0008%) focused on transgender issues. Of the nine articles, five focused on therapy with transgender clients, two focused on family-of-origin issues, one focused on transgender identity, and one focused on "other."
Elder (2016)	Qualitative	N = 10	Gain understanding of older transgender clients' perspectives on psychotherapy	Nine described transgender affirmative and healing experiences All described negative first therapy experiences All said they have seen improvement over the years in how therapy is conducted with transgender clients

(Continues)

TABLE 1 (Continued)

Authors	Method	Sample	Purpose	Main findings
				All provided recommendations for therapists, including becoming more educated about transgender issues, providing better ground rules in groups, having more affordable rates, and offering gender-specific spaces for groups
Hunt (2014)	Mixed method	N = 74 (quant)	Explore transgender clients' experiences of seeking and experiencing therapy	Found counseling through their general practitioners (48%), the internet (24%), personal recommendation (18%), or transgender community (16%)
				74% received therapy two or more times, with 75% of the sample attending 1–12 sessions
				Most sought therapy when coming out or seeking medical interventions (only 8% and 9% sought therapy "post-transition" or "surgery")
				Most reported feeling accepted by their therapist and trusted them, but the number who felt understood by their therapist was lower
		N = 5 (qual)		Some thought that therapists ignored gender too much; some clients thought that therapists focused on gender when that was not the primary concern
Kanamori and Cornelius-White (2017)	Quantitative	N = 95	Determine therapists' and therapists-in-training's attitudes toward transgender clients	Examined three attitudes toward transgender people: Interpersonal comfort (how much empathy and interpersonal closeness one feels toward transgender people), sex or gender beliefs (e.g., connection between mental illness and transgender identity), and human value (transgender people should be treated with dignity and treated similarly to cisgender people)
				Means for all three attitudes were all above 5 (somewhat agree) on a seven-point scale, indicating positive attitudes toward transgender clients
				Group mean for women was higher than the group mean for men on all three attitudes
				Group mean for LGBQ+ individuals was higher than the group mean for heterosexual participants on all three attitudes
				Therapists who reported more personal contact with transgender clients reported less comfort with and less human value of transgender clients
				Therapists who reported more training in transgender issues reported less human value of TGNC clients

(Continues)

TABLE 1 (Continued)

Authors	Method	Sample	Purpose	Main findings
Mathy (2002)	Quantitative	N = 73	Determine how transgender clients compare to cisgender/heterosexual and cisgender/LGBQ+ individuals on seeking psychotherapy	Reported greater use of psychiatric medication and psychotherapy than cisgender and heterosexual or lesbian and gay comparison groups
Mizock and Lundquist (2016)	Qualitative	N = 45	Explore therapist missteps from the perspectives of transgender clients	Eight themes of therapist missteps emerged: (a) Relying on clients to educate them about transgender issues, (b) overfocusing on gender, (c) stereotyping gender, (d) avoiding topics related to gender, (e) acting as though gender identity needs to be fixed, (f) pathologizing gender identity, and (g) controlling therapy as a gatekeeper
Yuksel, Kulaksizoglu, Turksoy, and Sahin (2000)	Mixed methods	N = 25 (for the therapy portion of the study)	Provide demographic information and outcomes from group psychotherapy with transgender women	Depression was the most frequent diagnosis Over the course of the 3 years, four participants (16%) dropped out of therapy Themes from the group were: (a) Clients experienced relationship difficulties with families, work, and partner, (b) the group facilitated a way to meet other transgender individuals, (c) clients felt they could share their difficulties with others who understood them and receive support, (d) the group was established as a "self-help resource," and (e) the group facilitated making decisions about gender affirming treatments
Rachlin (2002)	Quantitative	N = 93	Quantify transgender clients' experiences with therapists (e.g., number of therapists, reasons for seeking therapy)	Two primary reasons emerged for seeking therapy: personal growth, and help with gender affirming treatments and gender identity processes Clients in treatment longer indicated that they were in therapy for personal growth, rather than to discuss gender identity Therapist expertize with gender was correlated positively with rapport and correlated negatively with the length of therapy 15% of the sample reported that they were actively harmed by their therapist

articles into categories, with further analysis of the 10 articles that provided empirical data on psychotherapy with transgender people (see Table 1).

Of these 10 empirical studies that focused on psychotherapy with transgender people, eight focused on transgender individuals' experiences of psychotherapy, one focused on therapist competence with and attitudes toward transgender clients, and one was a content analysis of family therapy journal articles published on transgender issues. Multiple themes emerged from the findings of these studies. First, clients experienced anxiety and uncertainly when they discussed gender or deep emotions with their psychotherapists. Second, results from several of the studies suggested that clients uniformly rejected DSM/ICD diagnoses focused on gender identity. Third, participants indicated the value and need for a strong working relationship, characterized by empathy, validation, and safety; they also indicated that this was important in general, as well as specifically to assist with a social and/or medical transition. Fourth, participants indicated the importance of having knowledgeable and affirming psychotherapists and that psychotherapists can err by either ignoring gender too much or overemphasizing gender when it is not relevant. Fifth, while some psychological treatments may prove beneficial, clients indicated harm from some psychotherapy experiences as well; for example, in one study, 9 of 10 participants described transgender affirmative and healing experiences in psychotherapy, and at the same time, all 10 participants described negative first therapy experiences. Finally, there was consensus among clients, practitioners, and researchers that psychotherapy competence and using a transgender affirmative approach is essential in conducting therapy with transgender clients.

4.2 | Search results for psychotherapies attending to gender as a system of power

For the second meta-analysis, we focused the search on psychotherapies that attend to gender as a system of power. Again, we conducted a search via ProQuest's PsycINFO by using keywords to capture psychotherapy trials comparing two bona-fide psychotherapy treatments, where at least one of the treatments focused on gender as a system of power (e.g., feminist therapy, GAT). The search was conducted on July 31, 2017. The search yielded 331 articles that had been published between 1974 and 2017. There were no articles that matched the inclusion criteria for the meta-analysis.

5 | LIMITATIONS OF THE RESEARCH

The first obvious limitation of available research is the paucity of studies on the outcomes of psychotherapy with transgender clients, the outcomes of transgender affirmative psychotherapies, and the outcomes of therapies that attend explicitly to gender as a system of power. The lack of studies that evaluate treatments that attend to gender beyond a demographic variable and empower individuals from a gendered perspective (e.g., transgender affirmative therapy, feminist therapy) is particularly problematic given that such therapies might be key to addressing gendered disparities in mental health. Specifically, cisgender women and transgender people seek therapy and are diagnosed with some mental health concerns at higher rates than cisgender men (e.g., Addis & Mahalik, 2003; Kessler, Petukhova, Sampson, Zaslavsky, & Wittchen, 2012; Salk, Hyde, & Abramson, 2017); gendered systems of power are posited to contribute to such disparities (Meyer, 2003; Testa, Habarth, Peta, Balsam, & Bockting, 2015). The present content analysis also revealed that most research on psychotherapy with transgender clients is retrospective; if clients were currently in psychotherapy, they were not asked about changes or processes specific to how psychotherapy was assisting them to grow, adapt, and change. Researchers should conduct psychotherapy trials that focus on how treatments work, specifically focusing on gender dynamics (e.g., systems of power related to gender) and transgender individuals.

Second, feminist therapists have been vocal in critiquing research methods that are unrepresentative of clinical reality (Brown, 2006). We recommend that researchers track psychotherapy outcomes with all clients in

naturalistic settings and that therapists administer outcome measures to their clients. The benefit of publishing data from naturalistic settings is that such findings will be more generalizable to how therapy is conducted with clients in the "real world."

Third, a limitation across many studies in this review was the minimal attention given to the therapeutic relationship. We recommend that all psychotherapy studies focusing on gender identity measure the complex therapeutic relationship. A recurrent theme in the studies focusing on transgender clients' experiences concerned their relationship with the therapist. The alliance is particularly important to explore because many medical providers and clients may believe (erroneously) that psychotherapy is mandated for gender affirming treatments and this assumption may have a negative impact on therapeutic alliance (Budge, 2015; Budge et al., 2017).

6 | DIVERSITY CONSIDERATIONS

There is a diversity of gender identities, and gender identity is inherently connected with power dynamics, oppression, and privilege. As such, all of the considerations discussed in this study thus far are "diversity considerations." As well, there are implications for how gender identities relate to other systems of power organized around identity variables (e.g., class, ethnicity, race, and sexual orientation). For example, psychotherapy in the United States with an incarcerated white cisgender man compared to therapy conducted with an incarcerated African American cisgender woman will involve careful thinking and conversations about race, gender, and other systems of power within the United States (Mulay, Kelly, & Cain, 2017).

7 | THERAPEUTIC PRACTICES

Based on the present literature review and content analysis, we offer suggestions for improving psychotherapy outcomes by attending to gender-based systems of power, oppression, and privilege.

1. *Address gender dynamics and gender topics explicitly in session*. Gender can and should be addressed as a system of power in clients' lives and in the psychotherapy process. The clinical challenge is to know when and how to bring gender into the therapeutic space. Therapists should follow feminist therapy principles of collaborative gender analysis to integrate gender in psychotherapy based on accurate information (rather than stereotypes) and with a spirit of curiosity and collaborative exploration.
2. *Privilege clients' experiences and avoid assumptions*. The error of making assumptions based on both gender and sexual orientation was evident in a therapist's account of seeing a cisgender man who identified as heterosexual and came to treatment wanting to address his pornography usage (Walters & Spengler, 2016). The therapist never asked about the gender identity of the individuals in the pornography his client was watching because he made assumptions from his client's disclosures and gender presentation. However, once he determined that the client was watching cisgender men in pornography, the content of the sessions changed and focused on masculinity and shame, which ultimately led to a better outcome. As this example illustrates, therapists can check in with clients to determine if the clinician missed the mark or put "too much" emphasis on gender. Transgender clients want their therapists to bring up gender, but not when it is stereotyped or not relevant to the content (Mizock & Lundquist, 2016). Here, we reiterate the recommendation above; qualitative studies suggest that more damage can be done from not bringing up gender than bringing it up when it is not relevant. The spirit of collaboration and privileging clients' experiences can be helpful in this regard.
3. *Consider transgender affirmative methods and methods that focus on systems of power in psychotherapy*. A benefit of affirmative psychotherapies from a gendered lens is that they are applicable to all individuals, since all individuals have a relationship to gender identity. Information gleaned about the effectiveness of affirmative

psychotherapy could benefit all clients. Although there is a paucity of evidence from randomized controlled trials, other research evidence from the perspectives of transgender clients supports the use of affirmative psychotherapy (e.g., Bess & Stabb, 2009; Elder, 2016).

4. *Use a social justice framework for interventions within systems.* Feminist therapies and transgender affirmative therapies suggest a social justice orientation to psychotherapy. Because gender-based oppression is not internal to the client, addressing it requires pushing beyond traditional conceptualization of psychotherapy to include advocacy and activism. Therapists can assist clients with coping mechanisms, but in the broader context of continuing oppression, it is unlikely that coping alone will be sufficient. Therapists can advocate for and with clients, without compromising confidentiality; for example, intervening with institutions, finding lists of transgender affirming housing and groups, serving on local committees, working within the system to ensure better policies and trainings, and advocating in political structures for equal rights for people with all gender identities. Collaborating with clients on such efforts can also empower clients and serve as a social justice-focused therapeutic intervention.

5. *Stay informed on gender and language.* Frequently, mental health practitioners worry that the information is changing "too fast to keep up with the language." When we hear this concern from colleagues, we often wonder what is behind this fear. One hypothesis is that therapists are afraid of making mistakes and the defense of "I do not have time" or "It happens too fast to keep up with it" covers their worries. We recommend that practitioners search blogs, social media pages, and websites that post gender-specific definitions and terms about once every 6 months to remain updated on language and gender. This may take approximately 15 min, which should be feasible for all practitioners.

6. *Use an intersectional approach when focusing on gender and gender identity.* We draw attention to the importance of understanding that people who use the same gender identity labels are not homogenous. Clients should be approached with humility and curiosity, and understood with their full humanity, salient experiences, and identities. This humble approach should be paired with therapists' understanding of the sociopolitical climate for transgender individuals. Clients' experiences should be understood within the context of intersecting systems of power around gender, race/ethnicity, sexual orientation, and other inequalities (Hook, Davis, Owen, Worthington, & Utsey, 2013).

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