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Walden University

College of Counselor Education & Supervision

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Macie Stead

has been found to be complete and satisfactory in all respects,
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Walden University
2019

Abstract

Transgender and Gender Nonconforming Persons' Experiences With Counseling

Assessments

by

Macie Stead

MS, Walden University, 2013

BA, Whitworth University, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Counselor Education and Supervision

Walden University

May 2019

Abstract

Counselors sometimes use counseling assessments with transgender and gender nonconforming (TGNC) persons without understanding the experiences individuals have with those assessments. The American Counseling Association and the World Professional Association of Transgender Health identified that attention is needed with the practice of counseling assessments to ensure that helpful, ethical, and culturally sensitive services are available. The purpose of this study was to explore TGNC adults' experiences with counseling assessments. Gadamer's hermeneutics provided a framework to examine qualitative data as truth and validate the individuals' experiences with counseling assessments. Participants included 12 TGNC persons 18 years or older who had a counseling assessment provided by a mental health professional. Data were collected from questionnaires, a focus group, and individual interviews. Results from coding analysis revealed 6 themes: motivation, positive outcomes, barriers to participation, mental health professional, cultural sensitivity, and impact. Findings validated TGNC participants' experiences with counseling assessments and may be used to improve counseling assessment practices for TGNC persons.

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Dedication

This dissertation is dedicated to my loving and beautiful sisters, CeCe David, Danielle Hunt, and Kristin David. I also want to dedicate this work to my father, Scott Stead; my mom, Kathy David; and Robert David. I have spent family time writing papers, reading articles, and completing discussion posts and you have loved me anyway. Thank you. It means the world.

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I would like to acknowledge Dr. Dupkoski for her dedication and support throughout the dissertation process. She is a dependable and caring professor who has encouraged me to use my strengths. Dr. Dupkoski's guidance helped me grow as a scholar in the field of counselor education and supervision.

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Chapter 1: Introduction to the Study

Counseling Assessments for Transgender or Gender Non-Conforming Persons

The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, the American Counseling Association (ACA), and the World Professional Association of Transgender Health (WPATH) have called for ethical and culturally appropriate assessments for transgender and gender nonconforming (TGNC) persons who enter counseling (ACA, 2010; WPATH, 2011). The literature review indicated a lack of information on how TGNC persons experience counseling assessment for mental health. The purpose of this study was to explore the shared experiences of TGNC participants with counseling assessments.

Assessment information informs and guides counseling treatment (Hays & Hood, 2014). In the current study, I promoted the voices of TGNC persons who seek counseling services and are asked to complete a counseling assessment. Understanding TGNC persons' experiences may enhance counselor insight into the benefits and limitations of counseling assessments from a culturally diverse perspective. With improved insight, counselors may develop culturally sensitive assessment practices to inform counseling treatment.

The literature review I conducted for this study indicated a gap in knowledge about the experiences of TGNC persons with counseling assessments. Chapter 1 includes the problem statement, purpose statement, research questions, and conceptual framework. I also explain the nature of this study, conceptual definitions, assumptions, scope and delimitations, limitations, and significance of this research.

Background

In the background section of Chapter 1, I discuss the unique experiences of TGNC persons. The categories in this section were based on an extensive literature review. This background section includes gender identity, sex, and sexual orientation; discrimination and prejudice; Suicidality; barriers to counseling; gender affirmations; and assessments in counseling. I also explore implications for this study as they related to this background section. This section includes considerations for similar populations, research focus, cultural diversity, assessment requirements, research format, wellness perspectives, and the researcher role.

Gender identity, sex, and sexual orientation. Some people do not have the comfort of their physical bodies matching their identified selves. Those people labeled at birth as male or female, based on their sex organs, may not identify as the gender assigned at birth. Others may not feel comfortable in male or female gender labels and prefer a fluid gender expression. Individuals who do not identify with the gender assigned at birth may identify as TGNC (Harper et al., 2013). TGNC persons are often classified under this umbrella term to give expression to their unique experiences (American Psychological Association [APA], 2017; Harper et al., 2013).

Understanding the differences between gender identity, sex, and sexual orientation may help bring clarity to common misconceptions about gender-marginalized communities. Sex is a biological identification often made at birth and is based on anatomy, hormones, and other physical attributes (APA, 2017). Gender identity is the

understanding of the subjective sense of self as identified on a spectrum of possible gender identities (APA, 2017; Harper et al., 2013).

Sexual orientation is often confused with gender identity. Sexual orientation, however, involves attraction. Someone who is TGNC can be gay, straight, bisexual, pansexual, or asexual (APA, 2017; Harper et al., 2013). Identifying as TGNC does not imply a mental health condition, and TGNC persons are capable of living happy and fulfilling lives (ACA, 2010). Although the potential for wellness exists for TGNC persons, barriers to optimal functioning may arise. TGNC persons may have challenges related to their mental health, gender identity, discrimination, and prejudice (ACA, 2010).

Discrimination and prejudice. Discrimination and prejudice are pervasive and worrisome concerns for TGNC populations (Mizock & Lundquist, 2016; Sinnard, Raines & Budge, 2016; Su et al., 2016). Stigma, discrimination, and victimization can induce mental health disparities in minority populations, a concept known as minority stress theory (Meyer, 2014). Experiences of racism, transphobia, poverty, and violence were seen to increase negative coping behaviors like promiscuous sex, self-objectification, substance use, and body shaming (Seveluis, 2012).

Discrimination negatively impacts mental health regardless of other risk factors or trauma histories. A community-based study with TGNC adults indicated that when discrimination increased, so did post-traumatic symptoms (Reisner et al., 2016). The discrimination experienced by TGNC people is damaging to health and wellness. Geographical location may impact levels of discrimination experienced by TGNC persons. For example, Reisner et. al (2016) found that living in rural areas increased

discriminatory attitudes toward TGNC populations. Sinnard et al. (2016) found that TGNC participants from Arkansas, Louisiana, Oklahoma, and Texas had higher levels of anxiety and depression compared to other communities in the United States. Conservative values in rural communities increased minority stressors for TGNC people (Sinnard et al., 2016).

Suicidality. When conducting the literature review, I found a meta-analysis of suicidality research in which TGNC people were identified as being 14-22 times more likely than general populations to have suicidal ideation and behaviors (N. Adams, Hitomi & Moody, 2017). TGNC persons may experience higher incidence of discrimination and mental health implications than other gender-marginalized communities. According to Su et al. (2016), TGNC persons reported more discrimination, depression symptoms, and attempted suicides compared to lesbian, gay, and bisexual participants. N. Adams et al. (2017) found that 56% of transgender participants had experienced lifetime suicidal ideation, and 29% had attempted suicide. TGNC persons may have heightened risk factors for suicidality. Counselors and counselor educators should explore process improvements and client satisfaction with services that are intended to help (WPATH, 2011).

Barriers to counseling services. Mizock and Lundquist (2016) found numerous barriers for TGNC clients in counseling. The experiences demonstrated a severe lack of counselor competencies, little to no respect for TGNC diversity, and limited self-awareness of bias (Mizock & Lundquist, 2016). The barriers identified in these results

were similar to the results found by Ellis, Bailey, and McNeil (2015) that counselors were not properly trained to work with TGNC persons.

Ellis et al., (2015) collected survey data from the United Kingdom to explore the experiences of TGNC people who sought mental health and gender identity services. Ellis et al. integrated quantitative data, using descriptive statistics, and qualitative data with content analysis. The sample included 889 participants, 621 who used mental health services and 202 who attended gender identity clinics. Ellis et al. found that most health practitioners were "poorly informed about trans issues and experiences" (p. 14). Several problematic concerns arose from the data. The first area of concern was that mental health providers were the gatekeepers for hormone therapy and surgery. Gatekeepers for gender identity interventions, who have little experience or cultural knowledge about TGNC populations, are working outside of competency standards for the profession (ACA, 2014).

According to the ACA (2014), counselors must work within their professional skill and knowledge. Continued education, training, and research may help counselors to develop skills and cultural competency. When conducting the literature review, I found that counselors who had limited insight and knowledge about the experiences of TGNC persons were still positioned as gatekeepers for their wellness.

Gender affirmation. Glynn et al. (2016) used a multivariate regression model to identify aspects of gender affirmation that could help reduce adverse health outcomes and increase protective health factors in transgender women. The study included 573 transgender women with histories of sex work in the San Francisco Bay area. Gender

affirmations were identified as protective factors from the adverse psychological impact of discrimination. The research results indicated that transgender women who received social affirmations had lower levels of depression and improved self-esteem, while the affirmations made by a medical provider increased self-esteem barely over a significance level (Glynn et al.). Glynn et al. recommended avoiding standardized intervention models "because of the multiple components of gender affirmation and the individual variability in perceived importance of the different components" (p. 341). There are varying factors that could influence the categorized importance of standardized models. There was no research found in this literature review on how categories in standardized models are used within assessments with TGNC persons. Because researchers have not identified the validity, reliability, or impact of counseling assessments on TGNC persons I found it important to explore their experiences in this study.

Assessments in Counseling

Moe (2016) supported findings from previous studies that standardized methods can miss important qualitative information for TGNC persons that could be relevant to their care. Counselors integrate multiple sources like testing, interviews, medical records, and observational information for the development of diagnoses and treatment plans (APA, 2017). The instrument, the participant, prejudices of the administrator, and cultural considerations are included in result interpretations. Moe (2016) found that standardized biopsychosocial assessments need modification to meet the complexity of problems, issues, and strengths that are present for gender-marginalized clients. Counseling

assessments should occur on a multidimensional continuum of sexual identity and should address a variety of gender topics deemed relevant to the individual (Moe, 2016).

Diagnosis. Assessments are typically the first step in assigning a diagnosis in counseling treatment. Diagnoses assigned by a mental health professional guide and direct how a counselor chooses to proceed in treatment (Hays & Hood, 2014). A diagnostic label of gender dysphoria given by a mental health professional is often needed to provide medical services to TGNC persons, such as affirming surgeries or hormone therapies (WPATH, 2011). Despite the benefits of classification for insurance recognition, some professionals and advocates disagree regarding the efficacy of such labels.

A mental health professional assigning a diagnostic classification of gender dysphoria can create stigma that TGNC persons are mentally ill (Ellis et al., 2015). Additionally, pathologizing and labeling TGNC persons seeking counseling for issues not related to gender identity could cause negative counseling experiences (Ellis et al., 2015). TGNC participants shared concerns about the risk of enrolling in counseling and having their concerns minimized or falsely associating to their gender identity (Ellis et al., 2015). There were 66% of participants who entered counseling for reasons that did not pertain to gender reassignment surgery (Ellis et al., 2015). Most TGNC persons needed counseling for mental health concerns that anyone might need regardless of gender identity.

Assessment interview considerations. Donatone and Rachlin (2013) outlined strategies to change assessment procedures to provide a better-fit process. The researchers discussed potential template guidelines for an initial intake of college

students who identified as TGNC. College-aged TGNC students sought out mental health services outside of the college because "they perceive student health services as not sensitive to their needs" (Donatone & Rachlin, 2013, p. 201). Donatone and Rachlin addressed culturally appropriate definitions that fall under the umbrella term TGNC and described how initial interviews should start with respectful terminology and inclusion of preferred gender pronouns.

In the current study, I used correct terminology and respected preferred pronouns during participant selection and data collection. I asked how each participant would like to be identified during the interview and focus group. I was careful to ensure I used the correct terminology and asked for clarification as needed. The online questionnaire was gender neutral and included open-ended questions. Documentation of gender identity can create unpredictable problems and reduce privacy, and some TGNC individuals may use stealth in wanting a transition to be kept private (WPATH, 2011). In the current study, the prescreen questionnaire included a question of whether the interested individual identified as TGNC, which was a requirement to participate. The first letter of the individual's name was used in coding and data collection to distinguish participants from one another without revealing their names or suggesting a particular gender identity. Each letter was associated with an individual to affirm the importance of the person. I chose not to use pseudonyms in this study as a gendered-sounding name may have been perceived as inaccurate or offensive. I also chose not to use a coded number as it felt impersonal and contrasted from the rich stories and experiences shared by participants.

Wellness and standardized models. According to Moe (2016), although some standardized assessments can be useful, assessments should have "functioning beyond simple categorization or diagnostic labeling" (p. 50). Assessments have more potential than labeling diagnostic categories (Lopez, 2012). Although there are gender-neutral assessments, researchers had not explored the perspectives of TGNC participants.

In the current study, I considered how wellness assessments might impact the experiences of TGNC populations as an alternative to standardized assessment models. Myers and Sweeney (2008) found no study that had addressed the use of a wellness assessment with TGNC populations. Because there was limited literature on the experiences of TGNC persons, it was difficult to identify TGNC preferences. I chose to focus my research on the experiences TGNC persons had with counseling assessment to gain insight and understanding.

Wellness Models

An extensive literature review helped clarify the role of wellness models and assessments. Myers and Sweeney (2008) explored the evolution of the wellness model with an examination of 32 related doctoral dissertations between 1995 and 2008. Although the article was 9 years old, it provided a synthesis of evidence-based research on how wellness models evolved. According to Myers and Sweeney, wellness models were effective across the lifespan but showed a disproportionate preference for convenience sampling. Undergraduate students were the populations of choice in most of the reviewed studies, and few focused on nonstudent populations (Myers & Sweeney, 2008). The accumulation of data indicated that low-income communities and ethnic

groups scored lower on physical wellness factors compared to White populations (Myers & Sweeney, 2008). Increasing age also impacted wellness levels (Myers & Sweeney, 2008). Only two out of 32 studies focused on the wellness of gender-marginalized populations, none of which were TGNC. According to Myers and Sweeney, there is "urgent need" (p. 491) to research subgroups and diverse cultural wellness across the lifespan. A wellness model provides an alternative to standardized perspectives; however, limited research prevents generalization to gender-marginalized persons.

Indivisible self-wellness model. Avera, Zholu, Speedlin, Ingram, and Prado (2015) examined the need for the counseling profession to have a strengths-based perspective of the "personal, developmental, emotional, relational, and mental health issues facing transgender clients" (p. 273). Avera et al.'s case study used the indivisible self-wellness model (IS-Wel), introduced by Myers and Sweeney in 2008, to develop a comprehensive understanding of the experiences of people who are TGNC. An additional focus of the IS-Wel was the experiences of individuals who were TGNC and how those experiences related contextually to heterosexist culture and norms (Avera et al., 2015). There were considerations also included for providers. Avera et al. explored how the IS-Wel definitions of gender identity are helpful but not inclusive of the potential reasons why someone may seek counseling. The case study included a single participant and addressed how each portion of the IS-Wel could be used therapeutically by the counselor and client (Avera et al., 2015). This study provided a conceptualization and proposed application of the wellness model. This conceptualization helped fill a research gap for holistic assessments within TGNC populations.

Focus of Research

I used qualitative methods to explore the shared experiences of TGNC persons with counseling assessments. No studies, qualitative or quantitative, had addressed the experiences of TGNC persons with counseling assessments. My study filled a gap in research on counseling assessment experiences for TGNC populations. Understanding TGNC experiences can help identify barriers, strengths, and gaps in counseling assessments for TGNC clients (WPATH, 2011). I recruited adults who identified as TGNC and were 18 years or older. The underlying assumptions in this study were that experiences of TGNC people may inform culturally sensitive counseling practices. I focused on counseling assessments for mental health. I chose not to focus on assessments of hormone or medically affirming surgeries, although I did not exclude those individuals who were also participating for mental health purposes. Counselors may use the study findings to better understand the experiences of TGNC persons with counseling assessments.

Problem Statement

I identified a lack of research on TGNC experiences with psychological assessments relating to counseling and mental health concerns. Researchers had examined TGNC experiences with assessments regarding required health screenings, transitional gender-identity procedures, and hormone therapies (Alpert, CichoskiKelly & Fox, 2017; Owen-Smith et al., 2016; Thompson, 2016). However, researchers had not addressed TGNC experiences with counseling assessments. The strengths, potentialities,

and resiliencies of TGNC people and their personal experiences were underrepresented in assessments (Alpert et al., 2017; Lurie, 2005).

Assessment Influence and Experiences

Assessments can occur throughout the counseling process and have an ongoing influence on diagnosis, treatment planning, and therapeutic interventions (Hays & Hood, 2014; Hood & Johnson, 2007). Experiences with assessment can have repercussions for an individual's desire to seek out or continue counseling (Ellis et al., 2015; Mizock & Lundquist, 2016). Assessment experiences in counseling can impact the wellness of TGNC persons (WPATH, 2011). TGNC people constitute an estimated .06% of the U.S. population, or roughly 1.4 million people (Flores, Herman, Gates, & Brown, 2016). Counselors are expected to address gender-marginalized communities' needs. Counselors must be aware of personal bias and develop competencies with culturally diverse populations (ACA, 2014; APA, 2015; Singh & Burnes, 2010). According to the ACA (2014), counselors have a primary responsibility to respect the dignity and welfare of clients. Some counselors lack proper preparation and training to assess the impact of assessments on diverse populations (Singh & Burnes, 2010). Counselors lack consistent and quality training on TGNC counseling standards (Phillips & Fitts, 2017; Rivers & Swank, 2017; Singh & Burnes, 2010).

Barriers to Services

There are numerous stages of counseling that can cause harm and create barriers to services. Fear of discrimination from health providers may impact a TGNC person's desire to seek help (Ellis et al., 2015; Mizock & Lundquist, 2016). One study indicated

that gender-marginalized communities experienced counselors as lacking cultural competence and skill (Mizock & Lundquist, 2016). Counselors should examine all phases of the therapeutic process to identify barriers to TGNC persons seeking mental health services (WPATH, 2011). Mizock and Lunquist (2016) were unable to find research validating TGNC persons' experiences with assessments that pertain to mental health counseling.

Cultural Sensitivity

Ethical and cultural considerations should inform how assessments are implemented in counseling to promote wellness and reduce harm. Counselors need to be culturally sensitive to "age, color, culture, disability, ethnic group, gender, race, language preference, religion, spirituality, sexual orientation, and socioeconomic status on assessment administration and interpretation" (ACA, 2014, p. 12). Health providers must also be aware of their biases and should understand the social and cultural contexts that might "perpetuate heterosexist, genderist, and sexist norms" (Harper et al., 2013, p. 19-20).

Counselors should develop awareness of the complex and diverse histories of gender-marginalized people to understand how heterosexist norms may influence the practice of assessments (Moe, 2016). Examples of counseling assessments that do not have heterosexist and cisgender bias include the Beck Depression Inventory and Strong Interest Inventory (Moe, Finnerty, Sparkman, & Yates, 2015). These assessment tools are gender neutral and do not imply pathology or preference toward binary norms.

Diagnostic and Statistical Manual of Mental Health Disorders

The *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM) is used in the field of counseling to standardize the classification of mental disorders through a process called diagnosis (APA, 2013). Treatment in counseling depends on assessment conceptualizations that may lead to a diagnosis of a mental health disorder (Hays & Hood, 2014; Hood & Johnson, 2007). Negative perceptions of counseling can develop during the assessment process (Ellis et al., 2015; Mizock & Lundquist, 2016). The DSM has been used to apply pathological perspectives to gender-marginalized groups (Carrol, Gilroy & Ryan, 2002). The DSM, 1st and 2nd editions, labeled homosexuality as a mental disorder (Carrol et al., 2002). Recent editions of the DSM do not include the outdated terminology.

The current DSM-5 includes a diagnostic label of gender dysphoria to describe an incongruence between the gender assigned at birth and the gender someone self-identifies, causing distress to the individual (APA, 2013). A diagnosis has value in the counseling community as a guide for treatment (APA, 2013). There are professional disagreements about the current DSM-5 terminology and inclusion of gender-related diagnosis categories (Ellis et al., 2015). Counselors may refrain from providing a diagnosis if there is potential to harm (ACA, 2014). Pathologizing gender-marginalized persons by labeling them as having a mental illness further contributes to stigma and discrimination (Mizock & Lundquist, 2016).

According to the ACA (2014), counselors should promote wellness, dignity, potentiality, and strength for clients within social and cultural contexts. Lopez and Snyder

(2009) noted that mental health professionals tend to see perspectives focused on pathology instead of strengths. According to Myers and Sweeney (2008), there is an "urgent need" (p. 491) to research subgroups and diversity within cultural wellness. Professionals in the field of counseling desire strengths-based and culturally sensitive perspectives for assessment (Ellis et al., 2015; Mizock & Lundquist, 2016).

Purpose

According to Harper et al. (2013), an assessment provides structure for the standards of care when providing health services to lesbian, gay, bisexual, transgender, and queer (LGBTQ) clients. The purpose of this study was to explore TGNC adults' experiences with counseling assessments, using Gadamer's qualitative hermeneutics. I used online questionnaires, interviews, and a focus group with TGNC persons who may not have been near each other geographically but had a common experience. Additionally, how the focus group communicated collectively about counseling assessments provided valuable insight into their experiences.

Research Questions

The primary research question was the following: How do TGNC persons experience counseling assessments? Two subquestions were also addressed: What experiences do TGNC persons interpret as culturally unique in the counseling assessment process? How is the researcher's fusion of horizon impacted after data analysis?

Conceptual Framework

The conceptual framework for this study was Gadamer's hermeneutics. Hermeneutics is derived from the Greek word *hermeneutikos*, meaning to interpret

(Palmer, 1969). Hermeneutics is used to understand meaning in language and to explore the complexity of human experience (Palmer, 1969). Hermeneutic principles identified by Plato and Aristotle contrast with Descartes's perspective on truth needing certainty and empirical evidence (Mantzavinos, 2009).

According to Dobrosavljev (2002), hermeneutic philosophy is a schema built on (a) Aristotle's concept of *praxis*, a practical understanding of experience; (b) Heidegger's perception of being as time; and (c) *dasein*, which is the idea that to understand experience one must explore being. To know something, a person must experience something; the act of being is truth within itself (Dobrosavljev, 2002). The hermeneutic approach relies on developing understanding through communication. Communication is fluid and subjective, which requires hermeneutic researchers to develop comfort with ambiguity and the position of interpretation (Kinsella, 2006).

According to Gadamer (1996), the *fusion of horizon* is the continuous development of understanding. The past and the interpreter's influence come together via language to develop a comprehensive snapshot of a lived experience. This constant integration of new information into the fusion horizon is called the hermeneutic circle (Kinsella, 2006).

Hermeneutic Circle

The hermeneutic circle is a foundation for how individuals can gain truth in a world of subjective experiences. The hermeneutic circle is a continuous cycle of information that changes when new information is introduced (Kinsella, 2006). To Gadamer, mutual understanding is not permanent, and it will change the fusion horizon

(Westphal, 1997). Mutual understanding comes from acceptance of differing perceptions and influences. A new interpreter who examines the hermeneutic circle alters the fusion of horizon. According to Kinsella (2006), the search for understanding can only conclude when the interpreter is satisfied with the depth of understanding received, or when the interpreter becomes too exhausted to continue. An extensive explanation of the hermeneutic foundation is presented in Chapter 2.

Experiences of Truth

Ellis et al. (2015), Mizock and Lundquist (2016), and McCullough et al. (2017) advocated for phenomenological methods to understand TGNC experiences. According to philosophical hermeneutics, truth is not limited to empirical and observable fact (Gadamer, 1996). The lived experiences of TGNC persons are legitimate sources of understanding (Burdge, 2014). In the current study, I did not intend to give certainty as a means of truth, but rather to understand being as a means of authentic experience. Hermeneutic approaches help to improve knowledge of TGNC people because of TGNC-specific language and experiences (Burdge, 2014). The terminology and experiences that TGNC persons have are different from the general population and other gender-marginalized communities (WPATH, 2011).

Agency and Authority

It is important to respect the agency and authority of TGNC persons in research (Burdge, 2014). TGNC persons are the experts on their lived experiences. Research based on individual experience helps to reduce researcher bias on gender-related topics (Burdge, 2014). Learning about the experiences of TGNC persons in an open format may

reduce the risk of myself inserting gender bias in the results. Hermeneutics provides a strong philosophical basis for understanding ongoing changes that may occur for TGNC persons (Burdge, 2014). TGNC persons experience factors of normal development, self, social acceptance, as well as discrimination and stigma across the lifespan. According to Regan (2012), Gadamer's hermeneutics focus on being, which allows participants to examine understanding and misunderstanding through language as a medium. The participants in the current study were able to communicate about counseling assessments and their experience of being. Hermeneutic phenomenology provided a framework to validate the experiences of TGNC persons.

Focus Groups

A focus group was the preferred method of gathering information in this study. In addition to the focus group, an online questionnaire and individual interviews were also included. All data collection methods were qualitative to support participants' voices. The focus group was a communication hub for participants to contribute to a new fusion horizon of understanding. Qualitative methods like focus groups can help researchers gather information about the current experiences of TGNC persons (Singh et al., 2014). I wanted my study to be relevant to current experiences of TGNC persons because counseling methods and standards of care have changed over time.

According to Guest, Namey, Taylor, Eley, and McKenna (2017), focus groups promote sensitive disclosures that are less likely to be shared in individual interviews. TGNC persons in the current study were asked to share personal experiences with counseling assessments, which may have been sensitive. According to Guest et al.

(2017), disclosures in individual interviews might not address sensitive topics if the researcher is a different race, ethnicity, or culture than the participants. Sharing with other TGNC persons promoted disclosure of more sensitive themes compared to those that may have been shared individually.

Aguayo-Romero, Reisen, Zea, Bianchi, and Poppen (2015) used a focus group, historical interviews, and quantitative data to gather information about the social and sexual climate for TGNC persons in Bogota, Columbia. Aguayo-Romero et al. used multiple methods to gather information, but the focus group was necessary to gather experiences with personal motivation, including satisfaction with gender affirmation and body modifications. Focus groups allowed participants to build on researcher questions with their own culturally unique reflections and group interactions (Aguayo-Romero et al., 2015).

Gadamer's Hermeneutics and TGNC Experiences

I used qualitative methodology to delve into the experiences of TGNC persons who had completed a counseling assessment. Gadamer's hermeneutics provides a rich understanding of truths experienced between participants (Kinsella, 2006). Interpretation from the researcher, such as prejudices from historical consciousness, become part of a newly developed fusion horizon (Kinsella, 2006). Gadamer's hermeneutic circle was used to answer the research questions with newly integrated information. The hermeneutic circle was used to explore unique experiences from TGNC persons, dialogue within the group, and guidance and interpretation from me.

Nature of the Study

The methods in this study included Gadamer's philosophical hermeneutics. Philosophical hermeneutics is a type of qualitative phenomenology. According to C. Adams and van Manen (2017), phenomenology gathers a "constellation of experiences" (p. 782) that can help encompass the lived experiences of individuals. I am a pragmatic pluralist, and this may have impacted the research design, process, and interpretation. Pragmatist pluralists tend to believe in a few universal truths; those truths are subjective experiences and are the basis of problem-solving (Decuir-Gunby & Schutz, 2017). In the current study, I assumed that TGNC persons would be the best source to inform culturally relevant assessment procedures for TGNC populations.

I also assumed that to promote meaningful communication with TGNC persons, I must be part of the focus group as the guide and gatherer of information. The research questions focused on the experiences of TGNC persons with counseling assessment. I explored the language, contexts, and communications that occurred in the focus group. Interactions between group members and I occurred to develop an understanding of experiences. To move forward in developing culturally sensitive and effective assessments, counselors must understand what it is like to experience assessments as a TGNC person (WPATH, 2011). Those who have experienced assessments can appreciate the richness of information in this qualitative study. This research provides a snapshot of understanding.

This study was qualitative, and I used the same interview questions in the online questionnaire, interview, and focus group. Participants included 12 TGNC persons ages

18 years and older who experienced a counseling assessment. Data were gathered with SurveyMonkey, in-person interviews, and the focus group. Analysis of the data involved open coding techniques to identify larger themes. I asked questions, made comparisons, and found similarities and differences among participant responses.

Definitions

Ally: A person who advocates and affirms the rights of gender-marginalized individuals (Fenway Health, 2016).

Cisgender: Matching of the identified self with sex identified at birth (Fenway Health, 2016).

Gender affirmation: An alternative word choice to *transition*, which is viewed by some as offensive. Gender affirmation speaks to the process of matching the external appearance and gender expression with hormone and/or medical interventions to what was internally identified (Fenway Health, 2016). Transition speaks to changing while gender affirmation speaks to matching what the individual already experiences (Fenway Health, 2016).

Gender binary: A cultural construct that male and female are the only ways to classify gender and that individuals must fit one role and expression (Fenway Health, 2016).

Gender dysphoria: Significant distress caused when the identified self is not congruent with the sex labeled at birth. This diagnostic label is included in the DSM-5 and is clinically significant if it impacts social, occupational, academic, family, or other areas of daily living (Fenway Health, 2016).

Gender expression: The external appearance a person chooses to express internally identified gender. Gender nonconforming encompasses expressions that do not include binary labels (Fenway Health, 2016).

Gender identity: The understanding of a person's subjective sense of self on a fluid spectrum of possible gender identities (APA, 2017; Harper et al., 2013). Sexual orientation should not be used as a synonym for, or as inclusive of, gender identity (Fenway Health, 2016).

Intersex: The term describing an individual who is born with both male and female biological parts. Typically, doctors have difficulties assigning a binary male or female label to these infants, so instead they get labeled intersex (Fenway Health, 2016).

Sex: The biological identification, often made at birth, based on anatomy, hormones, and other physical attributes (APA, 2017; Fenway Health, 2016).

Sex affirming surgery: Surgery or other medical procedures used to align the physical self with the identified gender identity (Fenway Health, 2016).

Sexual orientation: Physical attraction (APA, 2017; Fenway Health, 2016; Harper et al., 2013).

Transgender or gender nonconforming (TGNC): Individuals who do not feel comfortable or congruent with the gender labeled at birth (ACA, 2010; Fenway Health, 2016). This study included individuals who are intersex in the definition of TGNC. TGNC persons may feel more congruent with the opposite gender prescribed at birth or may choose to not identify within gender-binary labels, such as male or female (APA,

2017; Harper et al., 2013). Gender nonconforming may not fit into either male or female gender expressions.

Two-spirit: A modern connection between lesbian, gay, bisexual, and transgender persons and their native heritage (Fenway Health, 2016).

Assumptions

Research begins with underlying assumptions that influence the direction and nature of a study. An assumption I made was that qualitative methods would enable me to explore the impact of assessments for TGNC persons (see Burdge, 2014). Another assumption was that the hermeneutic circle would be an appropriate means of interpreting new information. This research included identification of the fusion of the horizon's subjectivity as truth for the individuals involved (see Kinsella, 2006). The hermeneutic circle also involves an assumption that truth exists without empirical certainty (see Kinsella, 2006). These assumptions were necessary because individuals are not quantifiable (see Mantzavinos, 2009). Experiences are subjective, and the researcher may also influence the interpretation of results (Kinsella, 2006). The cultural uniqueness of individuals within the TGNC community was valued within this study.

Additional assumptions for this study included the benefits of focus groups. Focus groups may allow for more accessibility to individuals from diverse geographical locations. Focus groups provide anonymity for personal disclosure about sensitive issues (Guest et al., 2017). A private venue with anonymity was beneficial for TGNC persons to discuss counseling assessments with other TGNC persons.

Although the focus group was the ideal data collection method for this study, I learned during recruitment that some prospective participants wanted to participate without being in a group format. The asynchronous approach would enable participants to have access at any time to participate (Guest et al., 2017). Differing time zones may make aligning schedules difficult. For those who wanted to share privately, an online questionnaire with the same research questions from the focus group was made available. Additionally, I offered to conduct individual interviews if someone wanted to give more information in person or over the phone. All changes were approved by the Walden University institutional review board (IRB).

Scope and Delimitations

The scope and delimitations of research define focus of a study. Experiences gathered from TGNC participants contributed to an understanding of the impact of assessments. I determined that there was no research on TGNC experiences with counseling assessments and that research on TGNC persons lacked focus on strengths and resiliencies (see Alpert et al., 2017; Lurie, 2005). I explored counseling assessment benefits, limitations, and suggestions for culturally appropriate assessment practices shared by TGNC participants. Assessments in this study excluded those used only to verify hormone therapy and gender-identity services to align with the field of counseling and a gap in research (see Alpert et al., 2017; Owen-Smith et al., 2016; Thompson, 2016). Instead, the focus was on assessments for mental health and counseling.

Participants in this study identified as TGNC persons18 years old or older who had experienced a counseling assessment with a mental health professional. This study

focused on the implications of results to the counseling profession. The experiences of TGNC persons may bring insight into the impact of assessments in counseling. The results cannot be generalized to larger populations due to the sample size. The results may be transferable to readers who want to compare the results from this study to different contexts, but the results from this study are not predictive or generalizable to wider populations.

Factors that influence wellness are shown to change across the lifespan (Myers & Sweeney, 2008). The participatory age range for this study included persons over the age of 18 years. Individuals who participated were adults with the legal right to complete their own consent to treatment. A larger age range was beneficial for this study so experiences across the lifespan could be examined in responses. Recruitment was done from online safe and affirming community gathering places for TGNC adults. A small selection of online chats, support groups, and forums served as the primary recruitment source due to time and financial constraints of this research project. The website hosts requested an IRB approval letter and reviewed the content of informed consent. The hosts also requested sample questions to approve the study for recuitment on their sites.

Theories in Research

Theories in the literature review that were used with TGNC populations included minority stress theory, feminist theory, and queer theory. Minority stress theory is used to explore how prejudice and harassment impacts gender-marginalized individuals (Reisner et al., 2016). TGNC persons are negatively impacted by minority stressors that can develop outcomes; such as suicidal ideation, anxiety, depression, and internalized

transphobia (Budge, Adelson, & Howard, 2013; Reisner et al., 2016). Minority stress theory is also useful when examining resiliency and strengths of TGNC persons to overcome adversity and discrimination (Breslow et al., 2015). Feminist theory is used to explore gender identities and the social constructs that can impact oppressive practices (Gedro & Mizzi, 2014). Queer theory is more specialized to sexual minorities as reclamation of the term *queer* to resist oppressive movements toward identity categories (Gedro & Mizzi, 2014). Minority stress theory was the lens used in the current study to capture the implications of TGNC experiences as they relate to the counseling field and assessments.

Conceptual Framework

Gadamer's philosophical hermeneutics was the conceptual framework I used to explore the experiences of TGNC persons. Minority stress theory provided the lens for how themes were developed in this study. The theoretical lens helped me identify TGNC challenges, strengths, and opportunities for growth (Budge et al., 2013; Reisner et al., 2016). The purpose of this study was to explore the experiences shared by TGNC persons, not to develop a hypothesis or impact outcomes. Minority stress theory and Gadamer's hermeneutics offered a framework to develop understanding of TGNC persons' experiences with assessments.

The hermeneutic circle occurs within dialogue between members and the researcher. The information gathered is verbatim language from the client to capture the client's voice. The hermeneutic circle constantly changes based on the varying perspectives held by the participants, and it will not predict outcomes (Kinsella, 2006).

Saturation was considered complete when no new data emerged, and themes were developed based on the minority stress theory lens.

Limitations

Limitations of this study occurred on the participant level and within the study. Participants included anyone who self-identified within the TGNC umbrella. Umbrella terms can be a limitation because there are many possibilities of how someone may identify with a fluid spectrum of gender identities. Future research may help to separate these groups further to define more cultural variances between subgroups (Worthen, 2013). I chose to focus on anyone who identified as TGNC to gain more participants. Narrowing to smaller populations would have been a challenge to recruitment given the time limitations in this study. Additional limitations included the online format for the prescreen and questionnaire. To be considered as a participant in this study, the person needed access to a computer and a reliable Internet connection. If someone expressed interest in participating but lacked a computer or Internet access, I provided an individual interview option in person or over the phone.

I interpreted data and results for quality in this study differently than I would in quantitative research. According to Lincoln and Guba (1985) credibility, transferability, dependability, and confirmability are more appropriate for qualitative studies. Credibility means that the results are believable from the perspectives of the participants. I addressed this limitation by recruiting TGNC persons to speak about their experiences with counseling assessments. The results were statements shared directly from the participants. The data from interview and focus group formats were saved as audio recordings and

transcribed verbatim. The text from the online questionnaire was copied into qualitative data collection software. The ability to determine exactly what was said helped me avoid misinterpretation while analyzing the data.

Transferability is the appropriateness of the results to transfer to other settings (Lincoln & Guba, 1985). Transferability in this research was limited, as the study involved 12 participants and did not include empirically valid and reliable measurements. Phenomenological research is subjective, which is not a limitation within the hermeneutic circle but is important to note (Kinsella, 2006). Other researchers or counselors may be able to transfer results to other settings when considering TGNC perspectives.

Dependability is the constant integration of different factors that may influence the context of a study (Lincoln & Guba, 1985). Dependability is like reliability, but reliability is getting the same results twice, which is not the purpose of qualitative research. I updated the fusion horizon as contexts changed within the results to address this quality consideration. As understanding developed, themes emerged.

Confirmability is the consideration of how the researcher's perspective might influence the study (Lincoln & Guba, 1985). My knowledge of the experiences of TGNC persons with counseling assessments prior to this study was lacking. I used the hermeneutic circle to account for potential researcher bias as part of the fusion horizon.

The limitations in this study were addressed using credibility, transferability, dependability, and confirmability as a form of quality control. Some researchers feel that qualitative research should not have separate criteria from quantitative research (Trochim, 2006). However, Trochim (2006) stated that qualitative research is not an

extension of quantitative research and can benefit from methods checking that relates to qualitative research. I used credibility, dependability, transferability, and confirmability to strengthen the results of this qualitative study.

Significance

The findings from this study may foster positive social change by enhancing counselors' understanding of the experiences of TGNC persons with counseling assessments, which may inform counseling practices. According to Ellis et al. (2015), treatment and health care decisions need to involve people from gender-marginalized communities to appreciate the complexity of gender identities. Donatone and Rachlin (2013) acknowledged that the number of people who identify as TGNC is growing; providers need to find culturally sensitive approaches for this population. TGNC persons who experience discrimination and stigma, may fear sharing and expressing themselves; ultimately impacting their health and wellness (Mizock & Lundquist, 2016). This research provided a venue for TGNC persons to share their experiences with psychological assessments.

Richness of Experience

According to the WPATH (2011), mental health professionals should use psychosocial context to assess gender identity and gender dysphoria. The developmental history, impact of stigma, discrimination, and the natural support network for TGNC persons should be considered (WPATH, 2011). Individuals conducting assessments need the richness of information from TGNC experiences to uphold WPATH's standards of care.

Appropriate Diagnosis

Assessment information may lead to a diagnosis of gender dysphoria, another diagnosis that better explains the presenting concerns, or no diagnosis at all (WPATH, 2011). The assessment process leads into the counseling practice as it identifies presenting concerns for treatment. Presenting concerns often stem from the identified diagnosis from assessment (Hays & Hood, 2014). Standards of care in counseling include affirming and culturally sensitive practices that honor individual diversity and consider the impact of discrimination and heterosexist norms on TGNC persons (ACA, 2010; APA, 2009; WPATH, 2011). This study provided information that may inform diagnosis practices. The research may highlight areas for future growth and development in terms of diagnosis.

Strengths Based

This study may advance counselors' knowledge of TGNC persons' strengths, resiliencies, and experiences with assessments. Communication from TGNC persons may provide insight into needed cultural competencies for counselors who use assessments to guide treatment (WPATH, 2011). Counselor educators may advance the knowledge of their students by promoting discussion about the unique experiences of gender-marginalized communities. Supervisors may guide clinicians regarding treatment planning around a diagnosis given after an assessment. The findings may also be used to improve future practice around the content, implementation, and analysis of counseling assessments.

U.S. Policy

There are conflicting stances in the United States regarding politics, medical coverage, and social stigma that complicate and develop barriers to TGNC persons seeking mental health services. Some assumptions are driven by U.S. policy, for example the attempts to block TGNC persons from serving in the military (Zelman, Van Der Veer Holt, & Aguilar, 2017). Most politically and socially driven stigmas about TGNC persons are based on fear and assumptions that are not grounded in truth (Westbrook & Schilt, 2014). This study has implications for positive social change because it validates and affirms the experiences of TGNC people. This research advocated for counselors and counselor educators to support affirming experiences for all clients based on their experiences. If TGNC persons feel safe and affirmed before, during, and after assessments, they may decide to continue counseling services. This research was intended to promote wellness by examining TGNC persons experiences with assessments to understand potential benefits and implications of their use.

Summary

There was little research on TGNC experiences in counseling, and there was no research on their experiences with counseling assessments. The purpose of this study was to explore and understand how assessments in counseling impact TGNC persons. The research questions for this study focused on understanding how TGNC persons experience counseling assessments and how they communicate those experiences. Another goal was to have the dialogue from participants impact a fusion of horizon of

understanding to develop into themes. Chapter 2 provides a comprehensive literature review on topics of health, counseling, and assessments for TGNC persons.

Chapter 2: Literature Review

Counseling Assessments

The American Counseling Association (ACA, 2010) and the World Professional Association for Transgender Health (WPATH, 2011) seek culturally appropriate counseling assessment practices for transgender and gender nonconforming (TGNC) persons. According to the ACA Transgender Competencies (Standard C.5), counselors should be knowledgeable about the limited research on TGNC issues and the urgent need for research on process monitoring and service delivery. Assessments are ongoing measurements that inform and influence counseling treatment (Hays & Hood, 2014; Hood & Johnson, 2007).

There are benefits to valid and reliable quantitative assessments (Ellis, Bailey, & McNeil, 2015; Moe, 2016). However, there is also a need for qualitative research to learn the experiences and perceptions of TGNC participants (Mizock & Lundquist, 2016). Recent studies on TGNC persons and assessment experiences were limited, and the primary focus had been sex change procedures or other gender-identity specific services (Alpert, CichoskiKelly, & Fox, 2017; Owen-Smith et al., 2016; Thompson 2016). The current study focused not on the assessment required for sex change procedures but on counseling assessments related to mental health. There were no studies found in the literature review that demonstrated that counselors were knowledgeable about TGNC experiences with counseling assessments.

There was limited peer-reviewed research on counseling assessments for TGNC persons. Most of the assessment-specific literature contained TGNC assessment

guidelines, quantitative research on specific measures used with TGNC persons, and sex change or hormone therapy assessment considerations (Alpert et al., 2017; Owen-Smith et al., 2016; Thompson 2016). My literature review included topics from a variety of backgrounds, including other types of assessments, that helped inform this study. I began the search strategy by finding search terms and articles within the past 5 years. The search results provide an overview of TGNC persons and the current cultural climate in the United States. A philosophical exploration of personal identity emerged as well when I searched gender identity. The core of this literature review was relevant to TGNC persons' mental health and counseling assessments. A final topic I explored was the impact of connection and resiliency among TGNC persons. The hermeneutic perspective and minority stress theory lens were supported in the literature review and are further examined in Chapter 3.

Literature Search Strategy

The search strategy for this study was initially broad and then narrowed. No research in this review addressed the lived experiences of TGNC persons with assessments for counseling. The initial search included the following key words: *transgender* AND *gender non-conforming experiences* AND *counseling assessments*, and *transgender* AND *gender non-conforming* AND *assessments*. I began the search by accessing journal databases and using relevant search terms. I found many results in this first attempt, with numerous topics being suitable for the population but not specific to counseling assessment. For example, most articles about TGNC persons focused on the required evaluation for sex change procedures or gender identity services (Alpert et al.,

2017; Owen-Smith et al., 2016; Thompson 2016). Some articles addressed mental health and the medical field. For example, one study addressed the relationships between gender-confirming medical interventions (genital surgery, chest surgery, hormone therapy, hysterectomy, and hair removal) and eating disorder symptoms influenced by nonaffirmation of gender identity and body satisfaction (Testa, Rider, Haug, & Balsam, 2017). Other researchers addressed the experiences of TGNC persons and the counseling process; an example is a qualitative article by McCullough et al. (2017) that provided insight into the selection process of TGNC persons when picking mental health counselors.

I used the database PsychINFO in EBSCOhost to search specific terms related to *transgender* OR *gender nonconforming*. The search resulted in 3,849 articles. The variety of articles across different professions made the results too general for this study. Several tactics were implemented to find articles that were more relevant to this study. The first tactic was to use only peer-reviewed articles to ensure the articles had been reviewed by professionals in the field, narrowing results to 3,680. The dates included were from 2012-2017 to identify more current research, reducing the search field to 2,437. Older articles are included in this study that are foundational to the theoretical foundation or influential to TGNC topics in counseling.

The results that pertained to TGNC persons included research on youth, military, sexual violence, victimization, homelessness, suicidality, counselor competencies, sexual orientation, HIV health risks, and assessment guidelines. Although these topics were relevant to TGNC populations, they were too expansive for the constraints of this study. I

had to narrow the results without limiting essential articles for this literature review. I wanted this study to focus on adults ages 18 and over, which brought the results down to 1,389. I tried to find *transgender* as the population (175 articles). There was no specifier to add within EBSCOhost for *gender non-conforming* other than in the initial search. I also explored changing the term *assessment* (14 articles) while still including the term *transgender* OR *gender non-conforming*- to *diagnosis* (five articles), *discrimination* (45 articles), *counseling* (34 articles), and *experiences* (84 articles) to explore related search results.

I continued with this search method through other electronic databases for consistency in results. Criteria included articles published within the past 5 years, peer-reviewed articles, and search terms *transgender* OR *gender non-conforming* AND *assessment*. I found 22 articles in PsycARTICLES that focused on gender-affirming surgery and TGNC risk factors. For example, one article addressed the role of counselors as gatekeepers for gender-affirming surgery, and best practices per WPATH for writing the letters required to demonstrate gender transition readiness (Budge, 2015). The most relevant article in the psycARTICLES results was a review of published assessment measurements for transgender-related concerns that identified strengths and gaps in research. The assessment review questionnaire came primarily from the TGNC community and focused on the issue related to the quality of life for TGNC persons (Shulman et al., 2017).

The third database I used for this study was the LGBT LIFE with Full Text. I obtained 66 peer-reviewed articles published in the last 5 years. This database includes

only LGBT-related results. This database had the most comprehensive search results for standards of care, best practices, assessment results, risk factors, and gender identity for TGNC persons. It is important to note that 37 of the articles combined LGBT populations in the research or included only gay men. TGNC experiences are unique from other gender-marginalized groups and require separate research considerations (Su, 2016; Worthen, 2013).

There were four articles on the standards of care for TGNC persons in health care and mental health settings. However, only two articles were specific to TGNC persons; one article broadly defined the health of TGNC persons, and the second article was about nursing standards. Much of the practice standards included all LGBT populations or were specific to medical interventions. I used the standards of care set by the ACA (2010) and WPATH (2011) because they are the most comprehensive and focus on TGNC health, psychological wellness, and self-fulfillment. No articles were found that addressed the experiences of TGNC persons with counseling assessments.

Conceptual Framework

The conceptual framework for this study was Gadamer's philosophical hermeneutics. Philosophical hermeneutics is used to explore experiences as truth and through text and language. There is legitimacy within human sciences, art, philosophy, and history that is outside of empirical truth and knowledge (Gadamer, 1996). Knowledge can be attained through human experiences (Gadamer, 1996). The interpreter and the subject matter are inseparable, creating a new product of understanding (Matthews, Gadamer. & Linge, 1979; Palmer, 1969). As experiences occur, they develop

into perceived truths that the individual senses and interacts with in the moment (Kinsella, 2006).

Philosophical Underpinnings

Gadamer followed phenomenological traditions of Husserl, Dilthey, and Heidegger (Gadamer, 1996). Husserl was a pivotal phenomenological philosopher who classified experiences as a true sense of being (Smith, 2016). Phenomenology is used to explore social and linguistic interactions, perceptions of the world, sensations of the body, thoughts and desires of the mind, and experiences with emotions (Smith, 2016). Husserl felt that *intentionality* directed the self toward the interpretation of the world through a lens of experience that would come to develop meaning (Smith, 2016).

Fusion Horizon

Previous experiences combine with the current self and environment to develop meaning. The historical consciousness, current sense of being, and interactions with the external world combine into a fusion horizon (Kinsella, 2006). Like a horizon in the sky, a fusion horizon is the bigger picture as all the experiences come together as one at a given point in time (C. Adams & van Manen, 2017). Dilthey (as cited in Makkreel, 2016) identified that consciousness is only obtained through comparison with others, developing an understanding from the external to the internal. Heidegger (as cited in Horrigan-Kelly, Millar & Dowling, 2016) similarly viewed the self and others as being connected. Heidegger, as cited in Horrigan-Kelly et al. (2016), believed that inner being, and the external world were inseparable. How experiences are communicated, based on interactions with others, can influence meaning (Horrigan-Kelly et al., 2016).

Historical consciousness is a collection of experiences that impact and transform current understanding (Gadamer, 1996). The past guides patterns of behavior and thought. In this study I explore the experiences of TGNC persons with counseling assessments. This approach will explore the combined experiences from the past provided by TGNC persons with counseling assessments. The newly developed *fusion horizon* in this study may influence understanding for counselors. Hermeneutic researchers do not problem solve or hypothesize; but instead the researcher develops understanding (Smith, 2016).

Gadamer's Hermeneutics in this Study

Previous researchers found a need to understand the experiences of TGNC persons with phenomenological perspectives (Ellis et al., 2015; and McCullough et al., 2017; Mizock & Lundquist, 2016). In this study, I asked TGNC participants to recall their historical consciousness about experiences with counseling assessments. Phenomenological perspectives are respectful of cultural diversity (McCullough et al., 2017). I appreciated the dialogue between TGNC community members in the focus group and the context it helped provide. In this study, Gadamer's hermeneutics addressed both historical consciousness and the current sense of *being*. Participants shared about a counseling assessment experience, combining both past and present perceptions, to develop new understanding for counselors.

Literature Review

Research on the experiences of TGNC persons with assessments is underrepresented in the field of counseling (ACA, 2010; Alpert et al., 2017; Lurie, 2005).

The ACA Code of Ethics (2014) affirms that counselors should work to provide ethical and culturally sensitive care to all clients. Understanding the experiences of TGNC persons may inform counselors of culturally sensitive assessments practices. I value learning about TGNC experiences, and I integrated the best practices of ACA and WPATH (ACA, 2010; WPATH, 2011) into this study. According to ACA, standard E.3, (2010) counselors must be competent to address mental health concerns of TGNC clients; as they relate to relationships; health-harming behaviors, and health risks. In this study I used qualitative approaches to consider possible impacts to wellness. I used open-ended questions because it gave more richness and insight into the experiences of TGNC persons.

In this literature review, I explore the roles assessments can play in counseling, for TGNC persons. I found that several research articles examined assessment and diagnosis specifically. Other topics in this section include how people form a sense of identity and specifically gender identity. I then explore research on discrimination, risk factors, and health-harming behaviors for TGNC persons. Additionally, I found research about experiences TGNC persons had with counseling that helped provide insight into perceptions of care. I also included research pertaining to connection, strength, and resiliency because assessments should consider both strengths and barriers (Avera et al, 2015).

Assessments in Counseling

An assessment is a systematic method of information gathering about a person, population, community, or subject to problem solve and draw inferences (Hays, 2014).

Assessment of individuals cognitions, emotions, and behaviors are an integral part of counseling (Hays, 2014). Per ACA standard G.6 (2010), competent counselors will provide a comprehensive assessment that appreciates all aspects of a TGNC person's life; regardless if there is desire for medical interventions. A comprehensive assessment for TGNC persons would consider multiple facets of their life. Assessments in counseling explore mood, personality, suicidality, eating disorders, career aptitude, sexual identity, gender identity, relationships, substance use, abuse, trauma, anxiety, culture, and more (Hays, 2014).

Categories. The categories in a counseling assessment include *ability*, *intelligence*, *career*, and *personality* (Hays, 2014). *Ability* is the evaluation of achievement and aptitude (Hays, 2014). *Intelligence* is the measurement of cognition, communication, learning, reasoning, problem-solving, and abstract thought (Hays, 2014). *Career* assessments explore content knowledge and professional development (Hays, 2014). *Personality* tests assesses character types, traits, and states (Hays, 2014).

Comprehensive measurement. Assessments should include qualitative and quantitative methods because the sum of information provides a comprehensive analysis (Hays, 2014). Standardized tests are only one component of an assessment. Formal testing, interviews, observation, rating scales, and records reviews are all methods of assessment (Hays, 2014). For example, a test score provides perspective on a student's achievement, but only on a specific test. A comprehensive assessment may use test scores over time, Intelligence Quotient (IQ), family history, self-report, and school behavior. A comprehensive assessment is more helpful if you want to understand the influencers of

test scores to create future change. Assessments that intend to problem-solve should be comprehensive (Hays, 2014). The information discovered may impact future practices and solution-finding.

DSM and Assessment

The DSM-5 is the official assessment tool to diagnose mental health disorders (Hays, 2014). Some insurance entities require a DSM-5 diagnosis, by a mental health professional, because it may be required for billing purposes. A DSM-5 labels and categorizes mental health symptoms, but it does not include treatment suggestions (Hays, 2014). The DSM-5 contains categorical assessments, counting symptoms, and dimensional assessment that explore prevalence and severity (Hayes, 2014). Most assessment protocols have not been normed with TGNC populations (ACA, standard G.11, 2010). The lack of TGNC norming makes the validity and reliability of a DSM-5 diagnosis questionable (WPATH, 2011).

History. Counselors have a responsibility to understand the history of the DSM-5 and how has impacted TGNC individuals and their families (ACA, standard E.1, 2010; WPATH, 2011). In the past, the DSM labeled gender-marginalized people as mentally ill and sexually dysfunctional; negatively impacting counseling and community perspectives (Ellis et al., 2015). Individual experience of TGNC persons should be carefully assessed before assigning a diagnosis (Coleman et al., 2012; Ellis et al., 2015).

Gender dysphoria. Standardized assessments need development to consider the complexities of TGNC experiences, strengths, and concerns (Moe, 2016). The diagnosis of gender dysphoria in the DSM-5 has both benefits and limitations for TGNC persons.

According to ACA (2010), counselors should define their role to TGNC clients; and be open about the ongoing debate around the inclusion of gender identity as a medical diagnosis in the DSM-5. According to Rodgers and O'Connor (2017), a diagnosis of gender dysphoria may be needed for some insurance companies to cover mental health and medical costs for a TGNC member. A letter to confirm gender dysphoria by a mental health professional may be required by some medical professionals as well (Rodgers & O'Connor, 2017). Potential limitations of a DSM-5 diagnosis include over-generalizing TGNC concerns to gender-identity, pathologizing TGNC communities, and increasing mental health stigma (Rodgers & O'Connor, 2017).

Developmental considerations. According to ACA, standard A.2, (2010) developmental considerations should be incorporated into assessments because it can help develop appropriate interventions. Distress caused by gender dysphoria may develop from generational, societal, and childhood developmental influences (WPATH, 2011). It is important to view people holistically to provide a reliable and accurate diagnosis (ACA, 2010; Coleman et al., 2012). The DSM-5 may not be comprehensive enough to appreciate the complexity of cognitive, developmental, and environmental factors for TGNC persons (Rodgers & O'Connor, 2017; WPATH, 2011).

According to Rodgers and O'Connor (2017), the requirement for a diagnosis to be insistent, persistent, and consistent is problematic. In Rodgers and O'Connor's qualitative study (2017), TGNC youth reported that their experiences of gender identity were consistent, and they appeared self-assured. Older generations were more ambivalent; they valued therapeutic support, had concerns about past choices, and questioned if medical

interventions would make them feel the desired gender enough (Rodgers & O'Connor, 2017). The generational differences may demonstrate a developmental shift; and possibly societal influence while the person transitioned (Rodgers & O'Connor, 2017).

Diversity. Individual diversity should be considered when an assessment or diagnosis is used with TGNC persons (WPATH, 2011). In this study, following ACA's Transgender Competencies (2010), I affirm a full spectrum of gender identities, expressions, and presentations; without gender binary constraints. A diagnosis was not required in this study because of mental health stigma associated with the classification of gender-marginalized persons. I integrated ethical standards, set by ACA and WPATH (ACA, 2010; WPATH, 2011), to appreciate diversity among TGNC persons without the need for diagnosis.

True-Self Reality

Personal identity relates to philosophical questions about what it means to be people; the essence of being (Olson, 2015). Issues that inform a sense of being are complex and contextual (Pilarska, 2017). Questions might include: "who am I"; "what makes me who I am"; "What aspects of me are distinctly mine"; "What is the connection between my experienced self and my physical self"; "Can I lose or change what makes me uniquely me"; and "do I persist through time." These questions are important because they paint the canvas of who we are. According to Olson (2015), a person has ownership over their identity and their identity can change. Ownership is a deep collaboration between the self and an essence of being (Olson, 2015). Ownership development occurs throughout life and is contextually subjective (Pilarska, 2017).

Certain aspects of personal identity may be controllable like choices in life, time spent on activities, and belief systems (Locke & Hume, 1956). Fixed aspects that do not change include aspects such as skin color, where someone grew up, and genetic make-up (Locke & Hume, 1956). There are many facets to personal identity and expression. According to Locke and Hume (1956), the mind is a compilation of perceptions that needs reflection to gain insight. Personal exploration is an individual process that has no defined timeline (Beemyn, 2015). A true-self existence develops when a person's creative expression develops into their potential for being (Rodgers & O'Conner, 2017). Some TGNC people do not have the means or acceptance from society to explore personal identity freely (Testa et al., 2012).

Gender Identity

Gender identity is an important aspect of personal identity. According to ACA (standard A.1., 2010) counselors should affirm the diversity of the gender spectrum; including diversity of presentation and non-binary identities. Gender identity is a spectrum that is unique for each person (APA, 2017; Reiner & Reiner, 2012; WPATH, 2011). TGNC persons experience their gender identity as not being congruent with Male or Female labels socially prescribed at birth (Teich, 2012).

Two spirit. Gender fluidity and incongruence is present throughout American history. Some indigenous populations, during the European colonization of the Americas, took on roles and relationships of the opposite gender identity (Lang, 2016). Indigenous people who feel incongruent with the sex labelled at birth identify as *Two Spirits*; a term that promotes collective inclusion for LGBTQ and Native identities (Lang, 2016).

European colonizers introduced concepts of homophobia (Lang, 2016). European colonization villainized *Two Spirits* and forced indigenous tribes to convert to Christianity (Lang, 2016). European American history identifies sex and gender in binary terms of being male or female (Lang, 2016). Often, the sex of a baby is then associated with a gender identity such as male or female. For example, babies labelled male at birth may receive blue clothes while baby girls receive pink.

Littleton vs Prange. A malpractice suit between Littleton and Prange demonstrates how gender norms influence societal perspectives and legal treatment (Littleton & Prange, 1999). Christie's husband, Jonathon, died in 1996 after surgery complications; in response Christie, as the surviving spouse, filed a malpractice suit under the Texas Wrongful Death and Survival statute (Littleton & Prange, 1999). Christie was a woman, documented by her psychologist and gender-affirming surgeries (Littleton & Prange, 1999). Christie was a woman, legally married to Jonathon, and yet Chief Justice Hardberger ruled against her lawsuit. Chief Justice Hardberger outlined that Christie was transgender and that despite surgical treatments she lacked female internal organs (Littleton & Prange, 1999). His argument was that Christie had male chromosomes and that all the parts making Christie female were made by a physician. Christie was labelled as a man in court and since gay marriage was not legal in Texas, Christie had no legal means to sue as a spouse (Littleton & Prange, 1999). The case was dismissed based on the ideology that if someone is chromosomally male, they cannot file a malpractice suit as a female spouse. The Littleton case demonstrates the biology-based gender argument that sex and gender are unchangeable (Westbrook & Schilt, 2014).

Christie was unable to begin a reasonable examination into the unexpected death of her husband, due to the court disagreeing with her gender identity.

The ideology that I follow in this study is that sex and gender are both cultural constructs. Sex labels are socially normative binary labels for biological aspects of a person; while gender is a social construct based on gendered personalities (Mikkola, 2016). I aim to affirm the gender identities and expressions of TGNC persons in this study (ACA, standard A.1., 2010).

Presence. Regardless of the debate around the social constructs of sex and gender, TGNC persons exist, and reported numbers are growing (Flores, Herman, Gates & Brown, 2016; Meerwijk & Sevelius, 2017). Despite growing numbers, TGNC persons most likely underreport. Stigma and fear of discrimination may decrease how many TGNC persons feel safe disclosing their gender identity (Meerwijk & Sevelius, 2017). A U.S. data survey found that TGNC persons were an estimated .06% of the population (Flores et al., 2016). Per a metanalysis by Meerwijk and Sevelius (2017) .39% of U.S. residents identified as TGNC, averaging 1 million adults or 390 per 100,000. The rise is attributable to TGNC persons feeling freer to express themselves openly (Meerwijk & Sevelius, 2017). Similarly, MacCarthy, Reisner, Nunn, Perez-Brumer, and Operario (2015) shared that rising reports of TGNC persons may be due to acceptance in US policy, laws, and improved community knowledge.

Discrimination and Prejudice

Although perceptions in the U.S. have improved towards TGNC persons there are still conflicting policies and social norms that negatively impact TGNC persons

(Meerwijk & Sevelius, 2017). TGNC persons experience high levels of discrimination, mental health risks, and social disparities when compared to other gender-marginalized populations (Miller & Grollman, 2015; Mizock & Lundquist, 2016; Sinnard, Raines, & Budge, 2016; Su et al., 2016). A study conducted by Su et al. (2016) included 770 participants who shared experiences of discrimination; Those who identified as TGNC had their responses compared to cisgender persons. According to that study, TGNC persons reported lower socioeconomic statuses and higher levels of discrimination (Mean (M)= 44.0 compared to M=34.7) (Su et al., 2016). They had more reports of recent depression (M= 53.8 compared to M= 33.4), and higher lifetime suicide attempts (M= 37.6 compared to M= 15.9) (Su et al., 2016). According to Miller and Grollman (2015), 70% of TGNC people reported experiences of transphobic discrimination on a National Transgender Discrimination Survey.

Macroaggression. Discrimination towards TGNC persons may occur overtly and covertly. Macroaggressions are openly discriminating, and for TGNC persons, often includes physical and sexual violence (Testa et al., 2012). TGNC persons, ages 18-65 who took the Virginia Transgender Health Initiative Survey, found that physical and sexual violence reported by TGNC men and women was relatively similar; with no differences observed across race or ethnicity (Testa et al., 2012). June 12th, 2016 a mass shooting at a nightclub called Pulse, in Orlando Florida, became a tragic example of how dangerous macroaggressions are for LGBTQ people. The shooting claimed 49 victims and wounded 53 others (Alvarez & Perez-Pena, 2016). According to Stultz et al. (2017),

even months after the tragedy, survivors were scared for their safety; across race and ethnicity.

Military ban. The proposed military ban, by President Donald Trump, is another overt act of discrimination towards TGNC persons. The ban was presented by President Trump with on Twitter, a social media platform, on July 26th, of 2017 that said "After consultation with my Generals and military experts, please be advised that the United States Government will not accept or allow.… Transgender individuals to serve in any capacity in the U.S. Military. Our military must be focused on decisive and overwhelming…. victory and cannot be burdened with the tremendous medical costs and disruption that transgender in the military would entail. Thank you[.]" (Zelman, Van Der Veer Holt, & Aguilar, 2017). According to Judge Colleen Kollar-Kotelly of the Federal District Court for the District of Columbia, the ban was unconstitutional and would cause harm to the US military and conflicted with the 5th amendment; therefore, the ban was blocked (LGBT Law Notes, 2017). Judge Colleen Kollar-Kotelly also noted that the 6th and 11th Courts appealed the ban stating gender identity discrimination is sex discrimination and requires "heightened scrutiny" (LGBT Law Notes, 2017, p. 432).

Microaggressions. Microaggressions may be more subtle aggressions than macroaggressions but they can be harmful as well (Mizock & Lundquist, 2016). A microaggression might be assuming a gender pronoun and calling someone "he" or "she. Per Mizock and Lundquist (2016) assuming someone's pronouns is disrespectful because assumptions are often based on binary male or female classifications. A TGNC client in eating disorder treatment felt that you should… "always ask for pronouns. Use the name

they ask you to use—I can't stress this enough." (Duffy, Henkel, & Earnshaw, 2016, p. 143).

Privilege. There are inherent privileges if you are cisgender and appear congruent to a perceived gender (Miller & Grollman, 2015). According to Stultz et al. (2017) after the Pulse nightclub shooting, cisgender males had lower levels of perceived safety concerns in the following months compared to LGBTQ people and cisgender women. TGNC persons who appear gender non-conforming experience higher levels of discrimination (Miller & Grollman, 2015).

According to Westbrook and Schilt (2014), poor treatment of transgender women may occur when they use restrooms because of cultural norms for femininity. Those who appear differently than their identified genders may have assumptions made about them that could invoke violence (Miller & Grollman, 2015). Discrimination that is not based on physical differences is usually based on imaginary differences; such as questionable assumptions about self-identity and values (Westbrook & Schilt, 2014).

Geographical location may also influence discrimination and mental health outcomes for TGNC persons. TGNC persons who live in rural areas may experience hostility due to societal values that align with binary gender norms (Sinnard et al., 2016). Per Sinnard et al., (2016) TGNC persons living in the West Central division of the US experience higher levels of depression and anxiety compared to those in more diverse locations.

Health-Harming Behaviors

TGNC persons who experience high levels of discrimination engage in higher levels of health-harming behaviors (Miller & Grollman, 2015; Seelman 2016). Health harming behaviors might include attempted suicide, drug or alcohol abuse, promiscuous sex, body shaming, self-objectification, and smoking. Gender dysphoria can influence the development of eating disorders for TGNC persons who want to influence their body shape or size (Deshane, 2015; Duffy et al., 2016). Feelings of incongruence with the physical-self negatively impacts the eating habits and thought patterns of TGNC persons.

Suicide risk. A study of 220 low-income, Latina transgender women, explored the relationship between discrimination and suicidality. According to Bazargan and Galvan (2012), TGNC Latina women who reported experiencing discrimination daily, or at least twice a week, also had severe depression. The study also found that 6/10 participants identified they had been victims of sexual partner violence (Bazargan & Galvan, 2012).

The rates of suicide attempts and ideation for TGNC populations are drastically higher than the general population (N. Adams et. al, 2017). Suicidality for TGNC persons is 14 to 22 times higher than for the general population (N. Adams et al., 2017). According to N. Adams et al. (2017), a meta-analysis of 42 studies on TGNC suicidality presented that, on average, 56% of participants had lifetime suicidal ideations, and 29% of individuals had ever attempted suicide.

Counseling Experiences

TGNC persons face barriers and challenges to quality counseling services (Ellis et al., 2015, Mizock & Lundquist, 2016). According to McCullough et al. (2017), 13 TGNC participants identified counseling as essential but were cautious about how they proceeded with counselor selection. TGNC people have difficulties acquiring affirming and culturally-sensitive counseling (Ellis et al., 2015; Duffy et al., 2016; Mizock & Lundquist, 2016).

Generalizations. A qualitative study conducted by Mizock and Lundquist (2016) had 45 TGNC participants share their experiences in therapy; they identified subtle and overt barriers that negatively influenced their perceptions of care. One study participant shared "…all they want to talk about is how it must be because I'm trans, and how that must the cause of all my problems, and that's very frustrating" (Mizock & Lundquist, 2016, p. 151). People who identify as TGNC may enter counseling services for mental health reasons other than for gender identity concerns (Miller & Grollman, 2015; Mizock & Lundquist, 2016; Sinnard et al., 2016; Su et al., 2016). According to Su et al., (2016) one participant stated "many of my doctors told me I was trying to cover for my eating disorder by claiming that I was transgender, which couldn't have been farther from the truth. I have an eating disorder in addition to being a trans person, they are not necessarily related, though there are parts of them that interact." (p. 143).

Counselor vetting and trust. Some TGNC persons use filtering to check on a counselor's perceptions using methods like interviewing or testing reactions to certain statements (Duffy et al., 2016; McCullough et al., 2017). An informal vetting procedure

is an additional barrier. A qualitative study of 84 TGNC participants, in eating disorder treatment, found that 40% did not reveal their gender identity to the counselor; while the remaining 60% disclosed their status, and 10% of those disclosures were ignored altogether (Duffy et al., 2016).

Counselor competency. Counselors are often untrained on TGNC issues and do not understand non-binary genders (Duffy et al., 2016; Ellis et al., 2015; Mizock & Lundquist, 2016). A TGNC participant reflected "I think that trying to find a competent, friendly therapist is a struggle and a lot of trans people don't have a therapist that is completely aware and comfortable." (Mizock & Lundquist, 2016, p. 151). Many TGNC persons feel exhausted having to educate their counselors about their gender identity (Duffy et al., 2016; Mizock & Lundquist, 2016, p. 151). An additional concern identified by a participant was the counselor's interjection of personal beliefs and values. "She…had a very narrow view of gender and wanted to talk about it her way and not my way." (Mizock & Lundquist, 2016, p.151). It is disrespectful, and potentially harmful, to ignore the someone's self-identified gender identity (Mizock & Lundquist, 2016). Some felt that their counselor was avoidant of their gender identity; or that they were not skilled enough to approach both TGNC issues and mental health concerns (Duffy et al., 2016; Mizock & Lundquist, 2016).

Pathologizing. Other counseling issues experienced by TGNC people included gender-repairing, attempts to "fix" gender identity concerns to fit cisgender norms, and gender pathologizing (Mizock & Lundquist, 2016). The act of gender-repairing and pathologizing is unethical and not supported by professional standards (ACA, 2014; APA

2017; WPATH, 2011). According to Mizock and Lundquist (2016), gender repairing was perceived by one participant as unethical, unprofessional, and incompetent; leading the individual to refuse future counseling. “A lot of [doctors and psychiatrists] seem to think that me being transgender is a mental illness, and that’s why I have all these problems.” (Mizock & Lundquist, 2016, p. 152). Gender pathologizing can create negative perspectives of both the self and counseling (Mizock & Lundquist, 2016).

Gatekeeping. Another consideration made by TGNC persons was the role of counselors as gatekeepers for medical procedures and hormone therapy. “I was reluctant to give her all of my feelings about being transgender because of this whole gate-keeping thing that goes on with the medical community…. I really told her a lot of what she wanted to hear. Honestly, I held back a lot of things.” (Mizock & Lundquist, 2016, p. 152).

The experiences of TGNC persons in counseling demonstrate a severe lack of counselor competencies involving self-awareness and appropriate training (Duffy et al., 2016; Ellis et al., 2015, Mizock & Lundquist, 2016). Counseling is intended to help and actively work to reduce any risk of harm (ACA, 2014). The list of barriers TGNC individuals have in counseling is a concern and deserves attention. In this study I fill a gap in research about TGNC persons’ experiences with counseling assessments. My study narrowed the topic from existing research of counseling to a more defined understanding of TGNC experiences with counseling assessments. In this study I used a focus group, online questionnaires, and in-depth interview to gather experiences.

Connection and Resiliency

The strengths and resiliencies of TGNC persons are critical to consider because they allow researchers to interpret results from a balanced perspective (Avera et al., 2015). According to Avera et al. (2015), a holistic view of wellness for TGNC persons can provide a strengths-based model of care. Avera et al. explored themes around intimate connection and appreciating one's gender-identity (Burdge, 2014). All participants shared three broad themes: 1) intimate connection with self, 2) intimate connection with others, and 3) intimate connection with a larger purpose (Burdge, 2014).

The first theme broke down into *being true*, *being a unique whole*, and *being strong*. An integrated authentic and distinctive sense of self contributed to feelings of connection and appreciation to one's gender identity (Burdge, 2014). The second theme focused on *being free*, *being open to others*, *being socially competent*, *being helpful to others*, and *being in stronger relationships* (Burdge, 2014). Positive social connection with others may also reduce mental health risk factors. According to a study by Glynn et al. (2016), TGNC persons who received social affirmations had lower levels of depression and improved self-esteem. The final theme a larger purpose, was broken down into *spiritual involvement* and *being part of social change* (Burdge, 2014).

According to Burdge et al. (2014), the strengths and resiliencies of TGNC persons does not contradict the struggles and hardships many have faced. It is equally important to consider what improves wellness; as it builds awareness and insight (Avera et al., 2015). Burdge's study differs from my research as it explored what could improve strengths-based care in counseling. My research focuses specifically on TGNC persons

previous experiences with counseling assessments. My study does not hypothesize what kinds of processes or interactions will improve care. Instead, my study provides a venue for genuine dialogue with TGNC participants; who themselves provide recommendations for counselors based on their personal experiences with counseling assessments.

Minority Stress Theory

I found no research in this literature review that supported a specific theoretical orientation to examine experiences of counseling assessments for TGNC persons. Despite the lack of research available, most of the research on TGNC experiences aligned with minority stress theory. Minority stress theory is used in this study for data analysis. Minority stress theory correlates mental health disparities and chronic stress for minority groups who experience social stigma, discrimination, and victimization (Meyer, 2007; Meyer, 2014). According to Reisner et al. (2016), there is a correlation between TGNC adults who experience discrimination and the development of PTSD symptoms.

Belonging to multiple disadvantaged groups; multi-racial, low income, or gender marginalized increases the impact of discrimination (Meyer, 2007; Miller & Grollman, 2015). Discrimination is also influenced by how many marginalized groups an individual belongs. Survivors of the Pulse nightclub shooting, who were part of multiple disadvantaged groups, had increased concerns about future safety and discrimination compared to those who were only part of the LGBT community (Stultz et al., 2017). Discrimination, stigma, and victimization can create mental health disparities in TGNC persons (Reisner et al., 2016).

The lack of available research on culturally sensitive assessment practices, normed for TGNC persons, demonstrates a need to remove barriers that may exist within counseling assessments. Minority stress theory would assume that TGNC populations, especially those who belong to multiple disadvantaged groups, have a higher likelihood of experiencing discrimination, prejudice, and victimization (Meyer, 2007; Miller & Grollman, 2015). Counselors should ensure quality care and that assessment processes are ethical, effective, and culturally sensitive; to reduce the risk of unnecessary harm and to promote wellness (WPATH, 2011). In this study, I connected the importance of identifying barriers to reduce risk of causing further harm to individuals who may have heightened risk factors for health disparities.

Summary and Conclusions

Gender identity is imperative to understand as a cisgender researcher to appreciate the unique influences, strengths, and barriers experienced by TGNC persons (WPATH, 2011). I found many studies that assessed discrimination and stigma experienced by TGNC persons. Discrimination and violence highlights concern for physical and psychological safety with this population (Meyer, 2007; Miller & Grollman, 2015). There were numerous barriers for TGNC persons to receive effective and ethical counseling services. Assessments inform counseling, and without research on counseling assessments specifically for TGNC persons, it was relevant to explore experiences within counseling (Ellis et al., 2015; Mizock & Lundquist, 2016). Although there was more research on negative aspects of care, I also found research that focused on strengths.

Studies on empowerment for TGNC persons and affirming care highlight the strengths and resiliencies of the TGNC community (Burdge, 2014).

I did not find research in this literature review that explored the experiences of TGNC persons with counseling assessments. I was able to find research that emphasized the importance and role of assessments in counseling (Hays, 2014). The role of identity and gender-identity plays a unique role for TGNC persons (Teich, 2012). I chose to address the gap in research for TGNC persons and assessments that may evaluate someone's gender identity and mental health.

The purpose of this study was to understand TGNC person's experiences with counseling assessments. The experiences helped fill a gap in the current literature. The results help to explore and understand the role and impact counseling assessments have with TGNC persons. To inform best practices for the use of assessments in counseling I used in this study WPATH Standards of Care and ACA Code of Ethics transgender competencies. I used culturally-appropriate language as identified in the current literature and preferred pronouns by participants. I used minority stress theory to provide understanding about how discrimination and stigma might impact participants in this study. Chapter 3 establishes Gadamer's Philosophical Hermeneutics as the conceptual framework and minority stress theory as the theoretical lens.

Chapter 3: Research Method

Methodology

I used qualitative hermeneutic in this study to explore the experiences of transgender and gender nonconforming (TGNC) persons who had partaken in a counseling assessment. The purpose of this study was to better understand the experiences of TGNC persons regarding counseling assessments. Chapter 3 includes a rationale for the use of Gadamer's philosophical hermeneutics and minority stress theory. I also address my role as the researcher in this study. Additionally, I explain how participants were selected, the data collection process, and the data analysis process. I also address issues of trustworthiness and ways to improve the quality of the data. To conclude, I describe ethical considerations as they pertained to the research methodology and participants.

Research Design and Rationale

The research questions were designed to explore the shared experiences of TGNC persons who had taken an assessment for counseling. The study was designed to develop understanding of TGNC persons' experiences as truth. The primary research question addressed TGNC persons' experiences with counseling assessments: How do TGNC persons experience counseling assessment? The subquestions addressed possible implications of counseling assessments with TGNC persons: What experiences do TGNC persons interpret as culturally unique in the counseling assessment process? How is the researcher's *fusion of horizon* impacted after data analysis?

Concepts of Gadamer's Philosophical Hermeneutics

This phenomenological study was rooted in philosophical hermeneutics. Hermeneutics began in the 19th-20th centuries to explore theological texts; the approach graduated to explorations of the ontological understanding of how the world is interpreted (Mantzavinos, 2009). Hermeneutics is considered more of a philosophy than a theory as it pertains to the art of thinking and is separate from the phenomenon itself (Moules, 2015). A qualitative approach fits easily with the hermeneutic tradition as thought is flexible and dependent on the individual and dialogue.

Hermeneutic Circle

The ongoing process of interpretation based on context and dialogue is known as the hermeneutic circle (Kinsella, 2006). The hermeneutic circle is the combination of historical consciousness, language, and prejudices (Gadamer, 1996). No one piece of understanding is complete; perceptions and experiences integrate continually in the hermeneutic circle (Mantzavinos, 2009). Hermeneutics starts at a place of misunderstanding and gradually develops understanding through words and context (Gadamer, 1996). Understanding is, therefore, an ongoing process. Misunderstanding in this research tradition does not dictate poor communication but rather is a signal that a more intensive and thorough search for understanding is needed (Mantzavinos, 2009).

The hermeneutic circle is a complex interweaving of shared experiences that develop into meaning (Kinsella, 2006). According to Gadamer (1996), the fusion horizon is the snapshot of experiences at a selected point within the hermeneutic circle. Analyzing a different segment within the hermeneutic circle would provide different meaning due to

interpretation, experiences, and context (Gadamer, 1996). This study aligns with the research tradition of philosophical hermeneutics developed by Gadamer. Gadamer's approach focused on how people come to understand the world around them (Gadamer, 1996).

Universality

According to Gadamer (1996), universality is the structure that develops from language and communication. In the current study, structure existed with the selection of participants who had experienced a similar phenomenon: counseling assessments. Gadamer does not dismiss science; science is one component within a larger perspective of human understanding. The research questions in this study focused on the experiences of the individuals, not on solving problems or measuring outcomes. Human expression of meaning, being, and language is used to develop understanding without limiting it to objectification (Moules, 2015).

Historical Consciousness

Historical consciousness is a central concept to this approach as it relies on a conscious awareness of things that have already been interpreted (Moules, 2015). To communicate, a person uses a thorough historical awareness of each perspective and the interpretive influence of the past (Gadamer, 1996). The historical perspective is always changing as new events keep occurring. The focus is on fluid states of being compared to static traits, events, or interpretations. The historical consciousness within this study was the perspective that all participants had previous interpretations through experience,

cognition, and being. The experiences TGNC persons had with counseling assessments impacted their interactions and thoughts about counseling.

Outcomes of this study emerged as new experiences and interpretations overlapped. Change over time does not invalidate previous experiences. Instead, those communicated experiences become a snapshot of being. *Bildung* is a self-renewing process as new experiences fold into historical consciousness (Moules, 2015). Bildung is an individual process that occurs with the formation of new interpretations. Bildung are like the currents in the ocean. Although currents may not always have visible waves on the surface, the current still pushes and pulls, leaving the formation of the ocean hitting the shore as endlessly new.

Language

Language is another critical factor in Gadamer's hermeneutics. Language brings people together to develop understanding (Gadamer, 1996). The meaning assigned to experience is the language chose to explain it (Moules, 2015). The language used in this study was also considered to enhance understanding for readers and participants. All participants in this study were 18 years old or older, but education level and experience with research was unknown. To make the language of this study more accessible to the average reader, the reading level in the consent forms and research questions was eighth grade.

Some experiences cannot be shared linguistically, such as sight. Art, however, is significant because of the meaning the interpreter gives it, which evokes emotion and connectedness (Moules, 2015). I used a focus group, online questionnaire, and individual

interviews to collect data. I had originally intended for the study to include an online focus group format; however, I received feedback from potential participates who wanted the anonymity of an online questionnaire and others who wanted an in-depth private interview. Change requests were sent to my committee chair and the IRB and were ultimately approved and inserted into the study.

Typed text and audio transcription was the format used to collect the data in this study. Text analysis helped me identify dialogue within a conversation that might be culturally relevant for TGNC persons. Text transcription also helped ensure accuracy of audio interpretation. Language naturally leads into conversation, which is the exploration of ideas with others. Genuine conversation is led by the subject matter, not by goal-directed questioning (Moules, 2015). The questions in this study were open-ended with no assumptions made about the participant's responses. Shared understanding can develop within research with clear questions that are open for genuine conversation (Moules, 2015). The genuine conversations between people have historical consciousness of traditions, culture, and meaning (Gadamer, 1996). The focus group format allowed for participants to share genuinely about their experiences. The individual interviews allowed participants to express their experiences to me directly. Although the online questionnaire lacked connection between participants, it provided anonymity that was requested by many of the TGNC persons interested in the study.

Experiences

Experiences are the avenue for qualitative research to capture meaning in dialogue and language (Moules, 2015). Without experiences to explore for

understanding, there would be no topics for researchers to examine. In this study I investigated the experiences from TGNC participants to develop richer understanding. Experiences demonstrate finitude in research as a person cannot know what has not happened yet. This research was conducted to explore understanding from a perspective that was lacking in the current research. These research outcomes cannot be used to assume future outcomes of TGNC populations. I hope the outcomes of this study inspire counselors to ask quality questions and have genuine conversation with TGNC persons about their experiences to inform the use of assessments in counseling.

Role of the Researcher

In this study I highlight both the experiences of TGNC participants as well as my role as the researcher. I provided a structured and safe environment for participants to engage in genuine conversation about their experiences with counseling assessments. I took the primary role of an observer; but I also provide open-ended questions if something appeared to need expansion or follow-up. All participants were volunteers; they are not current or prior clients, students, or supervisees of myself as a researcher. The informed consent allowed individuals to remove themselves from the study at any time, for any reason.

Prejudices

Prejudices are neutral in Gadamer's hermeneutics (Moules, 2015). Prejudices pertain to the preconceived understandings that exist in each persons' individual histories (Gadamer, 1996). Those prejudices are then communicated within dialogue and should be expected and reflected upon within research (Moules, 2015). I inferred that each

participant entered the study with prejudices; and that those prejudices were communicated through themes. Prejudices in Gadamer's hermeneutics are not negative (Gadamer, 1996). Instead prejudices are the foundation of understanding (Cammell, 2015). Gadamer also noted that the interpreter brings their *horizon* into the mix (Gadamer, 1996). The results from this study were finite; pertaining only to this study. I also built awareness of how my understanding influenced the discussion results in this study. Interpretations from this study may develop into meaning that counselors can integrate into their practice of assessments.

Researcher Awareness

Researchers need to be aware of culture, socioeconomic status, gender identity, and potential biases that might impact studies involving TGNC persons (Reicherzer, Shavel, & Patton 2013; World Professional Association of Transgender Health [WPATH], 2011). I am Caucasian, middle-class, cis-gender, and female. I identify as an ally for gender-marginalized communities and have worked as an affirming counselor for youth. I have volunteer and training experience with Odyssey Youth Movement, a community drop-in center for adolescents.

I have a sister who is transgender, and that relation is likely to influence my perspectives on this study. My sister has experienced discrimination and stigma in the community. I have been an advocate for her and will continue to do so. I recognize inherent privileges, as a cisgender woman; I have not experienced discrimination, stigma, or abuse about my gender identity. I am not an *insider* because of my cisgender status. *Insiders* have unique knowledge of experiences for a population (WPATH, 2011).

Although I have had experience professionally and personally with people who identify as TGNC, I cannot generalize my experiences to others.

Researchers need to have caution and respect for cultural variation (ACA, 2010; WPATH, 2011). In this study I respected cultural variation by using personal experiences from TGNC community members to identify themes, variations, and points for advocacy. The hermeneutic circle accounts for prejudices that impact interpretations of the results (Kinsella, 2006). Gadamer's hermeneutics would expect interpreters to have prejudices; I developed awareness of my own biases to help understand their influence on this study.

The articles in this literature review are subject to interpretations from the reader. According to Matthews, Gadamer, and Linge (1979), a piece of work is open to limitless integrations that go beyond the limits of historical perspectives. This literature review is comprehensive and based on peer-reviewed research. I was able to develop understanding about the role assessments in counseling. As a counselor, I have seen when assessments had positive impacts on counseling. I have seen clients become motivated and empowered when assessments track progress and barriers in treatment. As a clinical supervisor, I have supervised clinicians who lacked training in providing assessments to TGNC populations. My experiences as a clinician and supervisor have widened my perspective on assessments. Assessments are beneficial to guide and inform treatment; however, if misused and without cultural-awareness, counselors can cause harm (Hays, 2014).

My role as a doctoral student at Walden University also influences this study. Walden University has a mission statement focused on positive social change. I have

participated in this mission statement since 2010. I have a strong desire to improve the quality of care for clients and underserved populations. Advocacy is an essential aspect of both my personal and professional life. As a researcher, I must have an awareness of how my experiences influence my perceptions. The interpreter becomes part of a new comprehension in the hermeneutic circle (Guzys, Dickson-Swift, Kenny, & Threlkeld, 2015; Matthews, Gadamer, & Linge, 1979; Palmer, 1969).

According to Cammell (2015), Gadamer's philosophy of understanding is an ongoing process of negotiation between the self, dialogue, and others. According to ACA (standard G.15, 2010) counselors should explore personal narratives of TGNC persons to understand and integrate appropriate assessment procedures. The narratives in this study developed into themes that created a new *fusion horizon* of understanding.

Methodology

This study included persons who identified as transgender or gender non-conforming (TGNC) who were 18 years or older. A smaller age range was originally considered for this study, between 18-25 years old, however, feedback from potential participants requested participation for adults 18 and over. Specifically, they felt it was discriminatory to exclude older age groups. After careful review with the committee chair and the Institutional Review Board (IRB) the requested change was made and integrated into the study. According to Meyers and Sweeney (2008), many factors can influence wellness, and those can change over time. In this study there were not enough participants to generalize about age and development. Per ACA (2010) counselors need to understand that there is a developmental influence for TGNC individuals. Future

studies may be able to gather larger participant pools to explore developmental considerations.

Those interested in the study were directed to a confidential online pre-screen with Survey Monkey. The person had to give consent to participate in the study. Once consent was complete, they got directed to complete pre-screen questions. If pre-screen criteria were met, the individual got to choose to participate in either a focus group, online questionnaire, or an individual interview. Focus groups are effective in gathering information about social understanding and can present varied perspectives that can be expanded with follow-up (Graham, Trehame, Ruzibiza, & Nicolson, 2017). The online questionnaire could be completed at any time; however, it did need internet access. The individual interview option was either via phone or in-person in a private setting.

Initially I was going to use an asynchronous focus group setting; Edmodo- an online virtual classroom. The changes made however, transitioned the focus group to an in-person experience, without the need for internet access. Only three people wanted to participate in the focus group. It was conducted in person to meet the needs of the participants. The online questionnaire was available for those who wanted to complete the research questions independent from other TGNC persons and the researcher. The individual interviews provided dialogue between the researcher and participant, but it did not include other TGNC persons. An alphabetical letter was assigned to each participant to code their identities without using numeric or pseudonym coding. I wanted the results to be connected to a person; without choosing a pseudonym that might be offensive or inaccurate to someone's preferred gender identity. Individuals were able to void consent

at any time, prompting myself to destroy their records. The study was open for six weeks to participate.

Participant Selection

To participate in this study, individuals had to have had a counseling assessment with a mental health professional; excluding assessments solely for sex affirming surgeries or hormone therapy. The desired sample size was at least 5 persons, so recruitment included 15-20 TGNC persons, 18 years or older. I recruited using snowball sampling. Snowball sampling benefited this study because it allowed current participants to recruit people, they knew met the criteria. A participant in this study encouraged two others to complete the focus group. Snowball sampling can help recruit individuals that are not easy to access in the general population (Heckathorn, 2011). I used online communities to initially reach potential participants. Online TGNC communities, chats, and support groups that identified as TGNC affirming and safe helped to publicize the study. Sites included www.transgender.support.com, www.dailystrength.org/group/transgender, http://trans-academics.org, www.tgboards.com, and www.transadvice.org/aup. These websites requested documentation of Institutional Review Board (IRB) approval, a copy of the research questions, and the purpose of the study to ensure safety to their group members. I provided documentation and posted the link to pre-screen questions. I am a licensed mental health counselor, so I intentionally did not recruit any previous or current clients into my study. Sampling from online forums allowed recruitment from diverse locations.

Participants met essential pre-screen criteria before proceeding with the study. Participants identified as either Transgender or Gender Non-Conforming (TGNC). Individuals who met criteria then completed the research questions tin the format of their choice. Initially there were not enough participants in the three-week period allotted. I staffed with my committee chair; I then incorporate feedback from TGNC persons and web hosts as they acted as a safeguard for the online community. I received requests from some people who were above the age of 25 (the original age set in this study). I also had requests to participate outside of a focus group; as they did not feel comfortable talking openly about their mental health. I offered an individual interview on the phone or in person. An additional option was added to include an online questionnaire with SurveyMonkey. The research questions were the same across all modes of data collection.

Sources of Information and Data

The outcomes of qualitative research are open-ended without a need for certain outcome or ending (McCarthy & LaChenaye, 2017). This research study had criteria for participants; criteria included TGNC persons 18 or older who had participated in a counseling assessment with a mental health professional; excluding assessments given solely for affirming surgeries or hormone therapies. I wanted the assessment to be mental health focused, so results could guide and inform counseling treatment. The results of the study were determined based on participation and emerging themes that arose from minority stress theory.

Prescreen requirements. The sources of information for this study were 12 persons who identified as transgender or gender non-conforming (TGNC). Public discussion boards on safe and affirming online community settings publicized this study. Interested individuals gained access to a website link to SurveyMonkey.com to participate in the study. The initial prescreens included the participation requirements of age (18 or over), gender identity (transgender or gender non-conforming), and experience with a counseling assessment provided by a mental health professional.

Data analysis plan. The data analysis plan for this research was to be explorative and to understand the experiences that TGNC people have had with counseling assessments. The research questions were open-ended, and the format was flexible to promote discord between participants, as well as the researcher, in the focus group and interviews. The online questionnaire was static, and the results showed less interaction and depth in responses. I collected the data as the sole researcher in this study. Information was member checked to clarify questions and to ensure that the information presented was accurate. Presentation of the unaltered data helped to develop understanding and meaning of TGNC experiences. Participants who provided their email contact will receive a debrief email after the study is complete with a summary of results and additional online TGNC resources. There was no follow-up meetings or interviews required for this study.

Participation. The original three-week participation allotment was extended to a six-week recruitment period until the desired number of participants was reached. The data was collected verbatim from either Survey Monkey or transcribed from an audio

recording of the interview or focus group. All audio recordings were permanently deleted post transcription. All data collected was stored on a password protected computer on an encryption-protected Google drive. If individuals did not meet the pre-screen survey questions, it thanked them for their interest in the survey but did not proceed them further in the study. If individuals met the pre-requisites, but did not complete any of the research questions, they were not included in the total number of recruited individuals. Incomplete pre-screens were removed from the research and any pertaining data was not considered in the study.

Issues of Trustworthiness

Reasonable precautions were taken in this research to include alphabetic coding procedures for anonymity, thorough qualitative procedures, and snowball sampling. Participants have an alphabetical letter, instead of identifying details, that associate with results to keep personal information private. Information about the nature of the study and research protocols was provided online, prior to participation. Information was made available at an 8th grade reading level for accessibility to the average reader. Informed consent and pre-screening questions were the first steps to enroll participants in the study.

To establish credibility, transferability, dependability, and confirmability in this study I used researcher reflectivity and thick descriptive data. I addressed my background and biases within the role of the researcher section. I am transparent about any potential influences on this study. The methods section also addresses how the hermeneutic circle accounted for the role of the researcher. The qualitative data is direct from TGNC participants. The personal reflections and interactions between group members provides

rich descriptions that provides credibility to their responses. According to McCarthy and LaChenaye (2017), qualitative research skills relate to counseling micro-skills and can help give more concrete direction for how to proceed. This study used the ability of reflexivity to give perspective and voice to TGNC persons; as a foundation of the working relationship. Questions were qualitative and open-ended. The questions explored personal experiences and perspectives which also helped to develop rapport and engagement.

Reflective responses can develop clarity and promote mutual understanding; as it is more of a risk to misunderstand subjective reporting than it is to influence responses (McCarthy & LaChenaye, 2017). I used member checking of responses to ensure the data was an accurate representation of the original transcription or text. Additionally, I had an external auditor review the transcriptions and texts for accuracy and consistency. Check-in's and summaries can help synthesis understanding of the experiences (McCarthy & LaChenaye, 2017). As the interviewer in the focus group and individual interviews I reflected with the participant and was able to draw more depth to responses. I used empathetic and holistic responses; mindful of culture, context, and personal perception.

Ethical Procedures

Participants in this study were volunteers, free to disengage from the study at any time. If someone chose to leave the study their information was permanently deleted. To maintain ethical standards, I received informed consent for all participants and provided information to the IRB including all changes made to the study. I submitted an IRB application before proceeding with this study. The research participation link was

labelled as a research project for a dissertation with Walden University. Respectful and ethical treatment of participants was a priority and approval from the TGNC community hosts was received. The online option for participation provided anonymity and physical distance, so participants could participate from the comfort of their homes. The various formats allowed the participants to engage in a way that made them feel safe and comfortable. There was no permission needed to access online TGNC websites, chats, and forums and they were are free. I did need permission however from the web hosts to post the research study after they reviewed the IRB approval, research questions, and purpose of the research statement. All the web hosts accepted the recruitment information and shared freely on the websites.

Harm prevention. Ethical factors in this study included considerations for the classification of TGNC persons, participant confidentiality, procedures, researcher awareness, and interpretation of the results. People who identify as TGNC may have had previous negative experiences with research, counseling, or health providers. An ethical challenge for researchers is how to navigate forward from a history of objectification and dehumanization of participants (Reicherzer et al., 2013). The purpose of this research was to understand the experiences of TGNC persons with counseling assessments. Ethical and moral gatekeeping in research can help to prevent future harm to participants (Reicherzer et al., 2013). According to the American Counseling Association (ACA) standards G.1.d. and G.1.e (2014), counselors who conduct research need to have reasonable precautionary measures to protect the rights and dignity of participants. It is also important to consider power, authority, and privilege when working with a gender-

marginalized community (Ratts et al., 2015; Reicherzer et al., 2013). I was diligent to protect against harm and stigma to the TGNC community and focused on preventative measures. I worked collaboratively with TGNC participants and followed WPATH (2011) recommendations for standards of care in research.

Privacy and informed consent. Some people who identify as TGNC may not want to participate in research due to fear of discrimination (Wagner, Kunkel, & Compton, 2016). This study adhered to state, federal, and institutional policies regarding confidentiality (ACA, 2014). An alphabetical coding procedure protected participant privacy. Password-protected and encrypted data helped to promote anonymity. Any email addresses saved for post research debrief will be permanently deleted at the end of the study. According to ACA (2014), researchers will provide an informed consent process, so individuals can decide if they want to participate. An informed consent process was linked into the pre-screen. Individuals were able to make an informed decision about participation before providing sensitive information.

Terminology. I used the term transgender and gender non-conforming (TGNC) as an *umbrella* term for those whose gender identity "transcends, breaks, transgresses, cuts through, or otherwise deviates from traditionally established gender categories" (Wagner et al., 2016, p. 269). The term gender-marginalized was used to identify communities of people whose gender identity and sexual orientation was either fluid or falls upon a continuum of possible expressions. Gender-marginalized also expresses the idea that these populations are viewed differently based on societal prejudices and social norms- to shift responsibility to the public perspective.

Population grouping. Inadvertent or intentional grouping of gender-marginalized communities in research could potentially cause harm (Wagner, Kunkel, Asbury, & Soto, 2016). The experiences of TGNC persons are different than other sexual minority groups. For example, TGNC persons may experience depression, low self-esteem, and suicidal ideation connected explicitly with gender identity (Institute of Medicine, 2011). According to Worthen (2013), a categorical grouping of gender-marginalized populations is a stigmatizing and inappropriate standardization of care. Most people who are TGNC experience research from a disease model (Reicherzer et al., 2013). It is essential for people to have access to unbiased health care that may "...not fit within the cis-normative gender binary." (Wagner, Kunkel, Asbury, et al., 2016, p. 50). In my research, I addressed ethical concerns by including TGNC community members to participate; separate from other gender marginalized communities. I aimed to validate the unique experiences of TGNC people.

Summary

The methodology within this study focused on gathering assessment experiences of TGNC persons; The aim of the study was to develop understanding of how assessments were experienced by some TGNC persons. Participant selection occurred in an online format. The focus group and interviews were conducted in person or over the phone. The questionnaire was available online and was accessible 24/7 on Survey Monkey. Ethical and procedural considerations were assessed throughout the process to ensure a safe and supportive environment. The qualitative nature of this study allowed genuine and open dialogue. Themes developed that relate to minority stress theory in the

dialogues and TGNC narratives and are further discussed in Chapter 4 and 5. Chapter 4 includes the setting, demographics, data collection and analysis, issues of trustworthiness, and the participant results.

Chapter 4: Results

Results

In this chapter the study results are presented. The purpose of this qualitative study was to explore the experiences of transgender or gender nonconforming (TGNC) persons with counseling assessments. I used Gadamer's hermeneutics to gather participant feedback about the benefits, challenges, cultural sensitivity, and future suggestions for counseling assessments. Minority stress theory was used to classify and group responses into themes as they arose from the data. The data were gathered from a focus group with three participants, two in-depth interviews, and seven online surveys. The data gathered reflected the lived experiences of TGNC persons. These 12 participants provide valuable insight into the lived experience of counseling assessments.

In this chapter I address the changes made during recruitment and data collection based on feedback from TGNC persons. I also present the prescreen results of those who participated in the study and the methods used for collecting the data. I explore in more detail how minority stress theory was used to identify themes that arose in responses. Issues of trustworthiness are also explained to ensure that the information gathered would meet the qualitative standards set within this study. I conclude by summarizing the results and provide tables for the data.

Adjustments to Recruitment and Data Collection

The results of this study were impacted by changes made to recruitment and data collection after the initial recruitment phase in Week 3. TGNC persons and the web hosts for the TGNC communities I had hoped to recruit from provided feedback that people

older than 25 wanted to participate and that recruitment for the study was difficult. Those who wanted to participate were from varying age groups, and some felt that focusing on a narrow age range was exclusionary. Based on the feedback and low recruitment numbers in the first 3 weeks, I requested a change to adjust the age range of this study to 18 years or older.

Additionally, I requested to add other means of participation for those who wanted more privacy in their responses. An online questionnaire was provided with Survey Monkey. In-person and phone interviews were provided to two individuals who, due to technology and comfort reasons, wanted to provide rich detail but did not want to be in a group format. Across all formats, the interview questions were qualitative and remained the same. The final requested change was to offer a $10 gift card for participation in the survey. My committee chair and the IRB approved revisions to this study based on participant feedback. These changes impacted the setting, format, and compensatory nature of the study.

Setting

The settings for this study were the online questionnaire, in-person and phone interviews, and an in-person focus group. Online data collection required Internet connection and a computer, tablet, or smart phone. The online surveys included the informed consent form at the start of the process that recommended completion in a private setting. The responsibility of ensuring the confidentiality of the survey was with the individual participant. All online questionnaire responders chose to be anonymous, no e-mail addresses were provided, and their chosen settings were unknown to me. The in-

person interviews and focus group were conducted in a private meeting space. The interviews occurred at a comfortable and private location for each participant. One interview was conducted over the phone. The other interview was conducted at a private setting in the participant's community for comfort. The focus group was held in a private office typically used for counseling; privacy was ensured with closed doors and a sound machine.

Prescreen Data

The participants came from diverse backgrounds and experiences. The online participants did not have to disclose geographical location. The phone interview respondent was from East Wenatchee, Washington. The other interview respondent was from Spokane, Washington. The three focus group participants were from Spokane, Washington. The prescreen required individuals to identify as transgender or gender nonconforming, be age 18 years or older, and have had a counseling assessment by a mental health professional. The age of participants ranged from 18 to 65 years. All participants identified as transgender or gender nonconforming. All participants had a counseling assessment related to mental health. Table 1 presents the participants' prescreen frequencies.

Table 1

Participant Prescreen Frequencies

Participation method	Frequency total	Age group	Reported assessment time frame
Focus Group	3	*18-24* (3)	Within 3 months (2) > 12 months (1)
Individual Interview	2	*25-34* (2)	> 3 but < 12 months (1) > than 12 months (1)
Online Questionnaire	7	*18-24* (1) *25-34* (1) *35-44* (2) *45-54* (1) *55-64* (1) *Unreported* (1)	Within 3 months (3) > 3 but < 12 months (1) > 12 months (3)

Note. Only those who engaged in the research questions and met prescreen requirements were included in the results of this study.
Note. (#) is equal to the number of participants in that category or grouping.

Age Brackets. The study participants were between the ages of 18-64 years old. The 3 participants in the focus group identified as being between 18 and 25 years old. The two interviewees identified as being between the ages of 25 and 34 years. The age ranges for those who completed the online questionnaire were more diverse. One person identified from each age bracket other than the 35-44 age bracket, which had two participants.

Time Frame

In the focus group, there were two individuals who reported having their assessment within the last 3 months. The third individual in the focus group had an assessment more than 12 months prior. The participant from the face-to-face individual identified having had an assessment more than 3 months but less than 12 months ago. The person who chose to have a phone interview shared that the assessment was more

than 12 months prior. The online questionnaire results included three participants identifying as having had their assessment in the last 3 months, one person the assessment more than 3 months but less than 12 months ago, and three people had an assessment more than 12 months before.

Data Collection

Twelve TGNC persons completed the prescreen requirements and completed the interview questions. Participation was counted regardless of participation method (focus group, individual interview, or online questionnaire). A completed response included prescreen requirements, informed consent, and responses for any of the eight interview questions.

Participants. The focus group had three participants who identified as transgender he/him pronouns. Two of the focus group participants lived together as natural support systems, and all three focus group participants knew each other. The participants who completed the interviews and online questionnaires did not interact with other participants during the study. Two in-depth interviews were conducted, one over the phone and the second in person. Seven individuals chose to complete the online questionnaire. Eleven individuals completed the prescreen but did not proceed to the interview questions and were removed from the study results.

Structure and length. Data collection was posted across several TGNC support groups and forums for a 6-week period. The data collected from the surveys, interviews, and focus group were qualitative. Responses were given to eight open-ended interview questions. The eight questions were the same across all formats. The interviews and focus

group had additional depth as interaction among group members and the researcher fostered further engagement. The interviews and focus group were between 25 and 40 minutes in length. The data for interviews and the focus group were recorded with an audio recorder and were transcribed by me. The survey responses were collected at a password-protected online collection site. The responses were in text format and were copied and pasted into NVivo qualitative analysis software. The average completion time was between 5 and 10 minutes for the survey responses.

Gift cards. Initially, participation in this study did not include compensation. Due to low numbers of individuals initially responding, incentives were considered to increase participation. I requested a change to the IRB, which indicated offering a $10 gift card from Starbucks or Subway to those who provided an e-mail online or met face to face to participate. The gift card was to thank individuals for their participation and was not contingent on completion of the survey. Individuals who completed the e-mail field, prescreen questions, and informed consent received a $10 gift card.

Data Analysis

The inductive process from coded units to a larger representation began with identifying themes. I used NVivo to input and analyze the data from participants. The research questions that were consistent across the survey, interview, and focus group responses. The responses were an in-depth consideration to many potential facets of counseling assessment impact on TGNC persons. As responses were gathered, themes began to develop for coding. The conceptual framework and theoretical lens helped guide decision making for coding and theme development.

Conceptual Framework

Gadamer's hermeneutics is the conceptual framework that promotes the voice of individual experience (Burdge, 2014). The themes arose from the shared narratives of TGNC persons. According to C. Adams and Manen (2017) different individual experiences come together to develop new understanding and meaning. In this study, responses were unique and provided a picture to explore deeper understanding. Each theme pulled into the *fusion horizon* concluding with recommendations for positive social change. The *fusion horizon* changes and is composed of dialogue that represents human experience (Gadamer, 1996). The recommendations for positive social change in counseling assessments are a synthesis of TGNC lived-experiences.

Theoretical Lens and Themes

Minority stress theory is the understanding that minority stressors such as discrimination and stigma influence on the mental health of minority populations (Meyer 2007; Meyer, 2014). TGNC persons are a gender-marginalized population that make up around one million adults in the U.S. (Meerwijk & Sevelius, 2017). TGNC persons experience higher levels of discrimination and stigma than the general population (Mizock & Lundquist, 2016; Sinnard, Raines, & Budge, 2016; Su et al., 2016). Mental health concerns are a pervasive issue for TGNC individuals who experience discrimination, stigma, and victimization. Suicide rates are 14-22 times higher than the general population (N. Adams et al., 2017). Some TGNC persons may fear healthcare providers and refrain from seeking services (Mizock & Lundquist, 2016).

Assessments are one of the first steps to engage an individual in counseling (Hays & Hood, 2014; Hood & Johnson, 2007). Yet, I could not find literature on TGNC experiences with counseling assessments to assess for barriers to care. In this study I address the gap in literature. With research being underrepresented for TGNC populations in counseling, it is important for counselors to actively find ways to affirm clients and provide ethical and culturally sensitive care (ACA, 2010; ACA, 2014; Alpert, CichoskiKelly, & Fox, 2017; Lurie, 2005). According to WPATH (2011) understanding positive experiences, backgrounds, challenges, and strengths of TGNC persons can help improve gaps in care. The themes in this study are based on TGNC experiences with people and processes that influenced perceived benefits, costs, and barriers to having a counseling assessment for mental health. Six themes arose: 1. Motivation, 2. Positive outcomes, 3. Barriers during participation, 4. Mental health professional, 5. Cultural sensitivity, and 6. Impact. The final category of impact was the summation of whether the assessment experience influenced mental health, access to services, as well as the desire to continue in counseling.

Evidence of Trustworthiness

Evidence of trustworthiness in this study relies on both scientific steps to increase reliability and credibility within human experience. Qualitative research is both a scientific exploration of knowledge and an artistic connection between information and experience (Gadamer, 1996). This study uses Gadamer's hermeneutics to consider the truth that is within human experience (Gadamer, 1996). The first steps that were taken

towards trustworthiness included technical aspects of confidentiality and confidentiality in the study.

Informed consent and confidentiality. All participants agreed to the informed consent process and understood their responses would be used in this study. Participant responses were immediately coded with a letter initial for confidentiality (for example, A. or S. abbreviates a name without providing identifying details). Even if the person felt comfortable with their actual name being included it was changed to single letter for consistency. Confidentiality aided to the trustworthiness of this study as it promoted honesty in responses. Participants could leave the study at any time, and in the case of the survey responses, there were individuals who left. This study was done freely by participants to contribute to the knowledge in the field.

Researcher role. My background as a researcher and mental health counselor are addressed in the researcher's role section. Sharing about myself explains biases that may exist or may influence this study. The hermeneutic circle allows for researcher bias to be accounted for within this study. I found that sharing about myself was viewed as helpful to participants to increase comfort in sharing. Since I do not identify as transgender or gender non-conforming, participants wanted to know that I was trustworthy with their information. Transparency about myself as a researcher and about study protocols improves the ability for modifications to made to future research questions.

Credibility, transferability, dependability, and confirmability in this study also help strengthen trustworthiness. According to C. Adams and Manen (2017) qualitative narratives help illustrate credibility; they show the unique representation from each

population group. To strengthen credibility in this study, I incorporated feedback from potential participants. I was able to increase avenues for participation that permitted greater confidentiality. Additionally, I had research questions vetted with the Institutional Review Board (IRB), my committee members, and the web hosts of the TGNC community forums.

In this study I used reflective questions to develop richer responses from the interview and focus group participants. I also used summaries and check-in's during the interviews and focus group to clarify answers and to ensure accuracy in my interpretation of responses. According to McCarthy & LaChenaye (2017). Checking-in with participants and reflective questions helps increase credibility, dependability, and confirmability of these results. To help increase dependability further, responses were in quotations, so transcriptions would be direct from the participant. Participants were recruited from online TGNC forums and support groups. The online forums required approval from the website host to assess appropriateness of the study for their population. The web host evaluation helped credibility as they screened to ensure questions were not harmful or discriminatory. One host even shared how much a study like this was needed because they had a TGNC group member have a terrible experience with a counseling assessment and did not know how to assist them further. With the hosts approval, I was permitted to proceed in gathering participant volunteers. Additionally, I used an external auditor to review responses and ensure transcriptions and text was accurate and consistent between my transcription and the raw audio or text. The external auditor did not have access to any participant names or confidential material. Transferability was harder to

achieve in this study with 12 participants, due to sample size, however the narratives of this study helped increase understanding of TGNC experiences. This study can encourage counselors and counselor educators to consider how the assessment process, purpose, procedures, and interactions may impact TGNC persons.

Results

The results section is listed by themes that were present across the participant responses. The themes are Motivation, Positive Outcomes, Barriers to Participation, Mental Health Professional, Cultural Sensitivity, and Impact. The data is presented with quotations; verbatim to what the respondent gave while answering the questions. The responses also identify if the response was completed within the online questionnaire, an interview, or focus group. Coding helped identify which responses belonged to who within the appendix and demographic sections. Each theme has a coding structure used to sort the participant data.

Motivation

Coding. The first theme was *motivation*, see Table 2. Motivation was the persons reasons for seeking a counseling assessment for mental health. Coding occurred in this category if the terminology reflected direction towards a mental health assessment. One example is the response "I needed to move and determine a path forward as I was depressed about my situation" (M.). Terminology might include words like *help, required, desired, start, transition, move, path, forward, and finding.* Some phrases were coded backwards, like the statement that motivation came from the “inability to continue

in my assigned gender" (B.). This statement implies that inaction was no longer helpful.

Table 2 presents the participant responses in the theme of motivation.

Table 2

Motivation for a counseling assessment

Participant Initial	**Response**
T.	"To get help for my depression and anxiety. I wanted to find someone I could talk to about the things going on for me. Like maybe I needed medications or something".
C.	“I had finally admitted to myself that I was pretty sure I was trans and felt like I needed help in processing those feelings and understanding possible next steps".
M.	"I needed to move and determine a path forward as I was depressed about my situation".
J.	"It was a required part of accessing therapy".
I.	"The desire to begin medical transition".
D.	"Myself".
B.	"Inability to continue in my assigned gender".
H.	"umm...Just like struggling with drugs and alcohol and my own self with life forever. Just with trying to find more ways to get better".
S.	“To medically transition”.
P.	“For me personally I was in a really bad spot in my life where I was really depressed. I was really depressed, and I was getting frustrated with, you know, not being seen as how I felt and so I was also in that stage of my life where my mom and I were having issues because she just couldn’t wrap her brain around what I was going through. So, I decided, I was 21, I need to go get this done. I went and did it anyways and said I’m an adult I’m just going to do it. I talked to my counselor and he wrote up a letter for me and I was able to start the testosterone. For me that was like the biggest boost for my confidence and I was okay for a while after that and I started my testosterone, I was almost done with my college. I was on

	that track forward and I felt like I was moving up…. That’s what motivated me, I hit a bad spot. I knew I needed mental health counseling alongside the transgender transitioning process. I wanted to start, and I knew I needed to get a mental health therapist for that.”
R.	“I have a bunch of life story things I could just tell you, to tell you why I wanted to transition but ever since a very young age I didn’t like dressing up as a girl. My step-dad was extremely against the whole thing and when I first figured out it was like an eye opener and I was like *Oh My Gosh*...”
L.	“Yeah, basically the same thing for me is that I wanted to start testosterone and continue on that path. I had been seeing a mental health counselor already for that, so it was not so much for the mental health part of it but to get the transition process started and finally, you know get there and not delay it anymore.”

Future oriented. All participants shared that their motivators were linked to exploration of the future self or a path to move forward. The primary motivators to seek a counseling assessment were wanting to receive services for mental health symptoms and the desire to medically transition. Some linked their motivation specifically to mental health or substance use concerns, such as "to get help for my depression and anxiety. I wanted to find someone I could talk to about the things going on for me. Like maybe I needed medications or something" (T.) or “struggling with drugs and alcohol and my own self with life, forever. Just with trying to find more ways to get better" (H.). One survey respondent viewed the assessment as a step towards treatment, "It was a required part of accessing therapy" (J).

Identity. Some motivation linked with a sense of self, identity, or medical transition. One participant stated that "I needed to move and determine a path forward as I was depressed about my situation" (M.). Another identified “myself” (D.) as a motivation for starting the process. Most of the responses specifically called attention to

the desire to transition or to understand what to do next, such as “I had finally admitted to myself that I was pretty sure I was trans and felt like I needed help in processing those feelings and understanding possible next steps" (C.) or "inability to continue in my assigned gender (B.)". Two others were more direct with their motivation to complete the assessment for the purpose to transition, with statements like “the desire to begin medical transition” (I.) and “to medically transition” (S.).

Positive Outcomes

Coding. The second theme was *positive outcomes* see Table 3. Positive outcomes were experiences that the individual found helpful or beneficial from participating in a counseling assessment. An example of this category would be "I learned more about my reactions and beliefs about things I wouldn't have thought about on my own" (J.). Coding occurred in this category if the experience was helpful or seen as positive. Terms that were presented in this category included *helped, accepted, able to, caring, understanding, learned, and* important. Items in this coding could have occurred during the assessment process or after as an outcome of the assessment. Individuals who felt there was nothing positive were included only to see which participants did not find anything beneficial about the counseling assessment. Table 3 presents participant responses in the theme of positive outcomes.

Table 3

Positive Outcomes

Participant Initial	Response
T.	"I eventually got in to talk to someone. The talking helped to not bottle things inside anymore. Being able to talk without my family around helped me too, prior experience with counseling it was basically my family saying that my depression and whatever was from me identifying as transgender. I just needed to work out my thoughts on my own."
C.	"I felt accepted and treated as any other person would be in a counseling session. I was also provided with some materials and things to think about".
M.	"I was able to talk to someone who was caring and understanding".
J.	"I learned more about my reactions and beliefs about things I wouldn't have thought about on my own".
I.	"The counselor seemed to want to learn more about Transgender people".
D.	"None".
B.	"1step towards HRT complete. Now the three months wait before the 12-month wait before they schedule surgery and wait".
H.	"I feel like she listened to me".
S.	"Not really, I felt like she did want to help but she wasn't really able to".
P.	"It's kind of hard because when people first come in they might not want to be completely open about everything that is going on. They might address the major issues or concerns going on but like I know for me personally, when I did my intakes, I was kind of closed off and I didn't share everything that was going on in my head. So that can kind of set your counselor up for failure. It's good though for them to get a feel for you too, so they can be like who can we put you with who knows what you are going through and yeah, it's like a good and bad thing. Not really a bad thing but there are some downsides to it too. At least from the patients end".

R.	“One of the benefits I would say is to kind of prove to people. My family thinks it’s like what you guys do, your generation. Like they think it is what millennials do, and I’m trying to convince them and tell them otherwise… but I feel like getting an assessment helps me, not only to get on testosterone, but to prove to people that it’s not just a phase or something rather than what it is”.
L.	“For me it was, what was the most important thing to address. I was going through an extremely rough time so what was the most important thing to address before we get to the other stuff, so you know you start to feel a little better. So, I didn’t do a transgender assessment until, maybe 6 months ago.

Helpful and compassionate. Positive outcomes for counseling assessments included having access to someone caring and who wanted to help. One person from the survey related to this stating “I was able to talk to someone who was caring and understanding" (M.) and "I feel like she listened to me” (H.). Other responses found that being treated respectfully and learning new skills related to mental health was helpful, such as "I felt accepted and treated as any other person would be in a counseling session. I was also provided with some materials and things to think about" (C.) and "I learned more about my reactions and beliefs about things I wouldn't have thought about on my own" (J.). A focus group respondent shared that “for me it was, what was the most important thing to address. I was going through an extremely rough time so what was the most important thing to address before we get to the other stuff, so you know you start to feel a little better. So, I didn’t do a transgender assessment until, maybe 6 months ago” (P.).

Privacy and family. There were responses about how privacy let people explore mental health and identity without fear of judgement. It was also stated that having an assessment helped validate experiences to their families. One person identified how they

needed the space to explore mental health, "I eventually got in to talk to someone. The talking helped to not bottle things inside anymore. Being able to talk without my family around helped me too, prior experience with counseling it was basically my family saying that my depression and whatever was from me identifying as transgender. I just needed to work out my thoughts on my own" (T.). The focus group also identified that "one of the benefits I would say is to kind of prove to people. My family thinks it's like what you guys do, your generation. Like that it is what millennials do, and I'm trying to convince them and tell them otherwise, but I feel like getting an assessment helps me, not only to get on testosterone, but to prove to people that it's not just a phase or something rather than what it is (R.).

Obstacles for positive outcomes. Not everyone agreed that there were significant benefits of the counseling assessment. Some felt that the counselors did the best they could, but when asked if it there were positive outcomes responses were "not really, I felt like she did want to help but she wasn't really able to" (S.) and "the counselor seemed to want to learn more about Transgender people" (I.). One participant did identify that it moved them further towards transitioning, however it is framed as a time exhaustive process, "1step towards HRT complete. Now the three months wait before the 12 months wait before they schedule surgery and wait" (B.).

One focus group participant shared their opinion about why barriers for positive outcomes might exist, "It's kind of hard because when people first come in, they might not want to be completely open about everything that is going on. They might address the major issues or concerns going on but like I know for me personally, when I did my

intakes, I was kind of closed off and I didn't share everything that was going on in my head. So that can kind of set your counselor up for failure. It's good though for them to get a feel for you too, so they can be like who can we put you with who knows what you are going through and yeah, it's like a good and bad thing. Not really a bad thing but there are some downsides to it too. At least from the patients end" (P.). Those who had positive outcomes related to a positive therapeutic relationship and skills development. Those who felt it was not beneficial identified skill and knowledge deficits in the counselor. It was also shared that they did not feeling comfortable sharing openly during an initial assessment.

Barriers to Participation

Coding. The third theme was *barriers to participation* see Table 4. This section contains responses related to challenges encountered before or during the assessment. Coding occurred in this category for any terms linked with negative connotations, implications, or influences. Keywords in this section included *wait, exhausted, cautious, guarded, challenged, uncertainty,* and *issues.* The phrases included either internal barriers or external obstacles. Counselor competency and the assessment process were repeated across several participants in this study. An example of this would be "the counselor did not know much at all about Transgender people or how to serve us, she was flipping through a tiny and apparently dated DSM and mislabeling me in ways that really could hurt some people. At the end of the session the burden of educating her was placed on me. That I would be teaching her how to serve trans people" (I.). Table 4 presents participant responses to the theme barriers to participation.

Table 4

Barriers to Participation

Participant Initial	Response
T.	"My counselor didn't really know what being transgender meant. I mean she may have known but we never specifically focused on it. It was like she avoided the topic. We talked about the depression and my anxiety which helped, but I felt like we could have covered more to help me about my identity. She told me she would refer me out if I wanted but it was such a painful process to get in I didn't want to wait more for someone else. I had to have an assessment done downtown with no support people, they were all busy and like I said I didn't want my family there. I had to wait for over 3 hours to get in for the assessment, once I did it was with someone who wouldn't even be my therapist. She just took a lot of info, barely made eye contact, and read off question after question from the computer. After all the paperwork and that assessment, I was exhausted!"
C.	"I was nervous and wanted to make a good first impression as I recognized that the therapist was also a gatekeeper of sorts. It made me more cautious and guarded about opening up".
M.	"I was challenged by my own fears of uncertainty".
J.	"I was worried that my reactions to things would be seen as part of my being transgender, rather than just part of my whole self".
I.	"The counselor did not know much at all about Transgender people or how to serve us, she was flipping through a tiny and apparently dated DSM and mislabeling me in ways that really could hurt some people. At the end of the session the burden of educating her was placed on me. That I would be teaching her how to serve trans people".
D.	"My family".
B.	"None".
H.	"The only reason I don't go to therapy anymore is I talk out my problems and then I have no use for the other person. I feel like I am not getting anything from it…. At the time I felt like it was a waste of time and that she didn't care" .... "I have had a mental health assessment happen almost every single year of my life. So, I have done them like a billion

	times. It is always the same questions and obviously changed a little over ten years of recovery and stuff but every session as like maybe I just seem okay on the outside and then we wouldn't really talk about the things that were happening in my head. I felt like she didn't take me seriously about things that I really feel crazy about. Like why I am having these crazy thoughts, I feel like she didn't take me seriously. Our conversations always led into makeup or hair or things that were not about why I was there, or like guys, and I wanted to say out-loud like what are you doing? But I'm not doing her job. I felt too guilty to switch so I just stopped going".
S.	"Yeah, the counselor didn't know barely anything about transgender individuals at all. She had her old looking DSM and uh… used terms that were outdated. That I was a transvestite, which would be the wrong thing to say. So, I think she was not educated at all about that".
P.	"When you first come in your like closed off and you don't know who to trust… especially for people with trust issues. It's hard to know who to trust at first and hard to open up immediately". (3) "You also have to find the right person to talk to, because with my old therapist it was really hard because she wasn't a good fit for me. But then I switched to who I have now, and I was able to talk and talk and talk. Get help and feedback".
R.	"I haven't had any issues before. I had a really good counselor who referred me to a really good doctor. I changed to that doctor. She said if I had any issues to come to her and she would fix it. So, it was really good, so I didn't have any problems. Except I have to pay money".
L.	"Well it's more like familial issues like if you try to tell your parents like *hey this is me*...and especially with me they say, *I don't believe in your lifestyle and I can't have this in my house*".

Counseling process. The majority of respondents shared that barriers arose prior or during the counseling assessment process. One person felt the "family" became a barrier to the assessment process (D.). Responses from the focus group also aligned that family can become a barrier "Well it's more like familial issues like if you try to tell your

parents like "*hey this is me*"... and especially with me they say, *"I don't believe in your lifestyle and I can't have this in my house*" (P.).

Internal barriers. Internal barriers also arose such as, "I was challenged by my own fears of uncertainty" (M.), "I was worried that my reactions to things would be seen as part of my being transgender, rather than just part of my whole self" (J.), and "I was nervous and wanted to make a good first impression as I recognized that the therapist was also a gatekeeper of sorts. It made me more cautious and guarded about opening up" (M.).

Counseling competency. Several participants shared frustrations with the counselor lacking specific knowledge or skill for working with TGNC persons. For example, "The counselor did not know much at all about transgender people or how to serve us, she was flipping through a tiny and apparently dated DSM and mislabeling me in ways that really could hurt some people. At the end of the session the burden of educating her was placed on me. That I would be teaching her how to serve trans people" (I.) and "Yeah, the counselor didn't know barely anything about transgender individuals at all. She had her old looking DSM and uh… used terms that were outdated. That I was a transvestite, which would be the wrong thing to say. So, I think she was not educated at all about that" (H.).

Counselor avoidance. Another person shared their experience with counselor avoidance and the assessment process itself, "my counselor didn't really know what being transgender meant. I mean she may have known but we never specifically focused on it. It was like she avoided the topic. We talked about the depression and my anxiety

which helped, but I felt like we could have covered more to help me about my identity. She told me she would refer me out if I wanted but it was such a painful process to get in I didn't want to wait more for someone else. I had to have an assessment done downtown with no support people, they were all busy and like I said I didn't want my family there. I had to wait for over 3 hours to get in for the assessment, once I did it was with someone who wouldn't even be my therapist. She just took a lot of info, barely made eye contact, and read off question after question from the computer. After all the paperwork and that assessment, I was exhausted" (T.). Another perspective shared that "I have had a mental health assessment happen almost every single year of my life. So, I have done them like a billion times. It is always the same questions and obviously changed a little over ten years of recovery and stuff but every session as like maybe I just seem okay on the outside and then we wouldn't really talk about the things that were happening in my head. I felt like she didn't take me seriously about things that I really feel crazy about. Like why I am having these crazy thoughts, I feel like she didn't take me seriously. Our conversations always led into makeup or hair or things that were not about why I was there, or like guys, and I wanted to say out-loud like what are you doing? But I'm not doing her job. I felt too guilty to switch so I just stopped going" (S.).

No barriers reported. Two survey participants had differing experiences from those who had barriers during the assessment. One survey identified "none" (B.) when asked if there were barriers present. A focus group participant shared "I haven't had any issues before. I had a really good counselor who referred me to a really good doctor. I changed to that doctor. She said if I had any issues to come to her and she would fix it.

So, it was really good, so I didn’t have any problems. Except I have to pay money" (I.). Although money was identified in this person’s statement, with member-checking it was clarified that the cost for an assessment was felt to be reasonable.

Mental Health Professional

Coding. The fourth theme was about the *mental health professional* who provided the assessment see Table 5. This theme included responses that provided detail about the personal interactions during the assessment. Coding involved mental health professionals and how they used interpersonal communication, therapeutic relationships, boundaries, and perceptions of TGNC competencies. Phrases involved emotions, perceptions of education and training on TGNC issues, and the experience itself with the assessment provider. Words that were in this category included character statements *nice, personable, comfortable, unassuming, relaxed,* and *terrible.* Other words that flagged for assessment provider included how the person felt about attending the assessment with the provider, such as *scared and anxious*. An example of this category is "… She was very personable and made me feel as comfortable as she could. She went through her background and experience as a practitioner generally and with trans issues specifically" (C.). Table 5 presents responses from participants that contributed to the theme of the mental health professional.

Table 5

Mental Health Professional

Participant Initial	Response
T.	"The person doing the assessment was nice enough, I don’t know she smiled and introduced herself. But she really focused on reading questions off a template. That was it, for an hour. Then I was done and assigned to someone I never met before to start counseling, but she was booked almost 2 weeks out already. She gave me a diagnosis; I wasn’t told what it was until after I met with my counselor much later".
C.	"Good. She was very personable and made me feel as comfortable as she could. She went through her background and experience as a practitioner generally and with trans issues specifically".
M.	"It was very positive".
J.	"Assessments in general are highly anxiety inducing. This was no different".
I.	"As stated previously she didn’t have the specific and current knowledge she needed to serve trans patients and she place her education in my hands".
D.	"Terrible".
B.	"Unassuming and relaxed approach to possibly awkward questions".
H.	“My assessment wasn’t done by my counselor. I can’t even remember who did it. They are always the same, a bunch of paperwork that you just fill out to get to the actual person. Sign sign sign...Okay when do I meet her? It took a long time too...like two weeks before I saw someone. I was feeling super mentally unstable and wanted to see someone immediately and then it just didn’t end up working out, so I ended up going to rehab again. Which wasn’t her fault I just couldn't get the help that I was looking for and I don't trust myself out in the world and that is why I go to treatment every year except this year".
S.	“The transgender pieces were really tripping her up".
P.	"For me personally, I remember walking out a lot of it. I was scared about opening up. I almost didn’t want to admit to myself that I had mental illness and that something was up with me. At the same time, I

	was really lethargic, and I was having a hard time getting up out of bed in the morning. I was having a hard time keeping up with my studies. I hated my job and I was dealing with a lot of intrusive and bad thoughts. I was like I knew something was up though. At the intake it was hard for me to say all those really negative things because I have always been scared of freaking out about it. I had to tell myself that this person is here for this, this is their job, they want to know the deep-dark".
R.	---no comment---
L.	"Yeah before I went to have my assessment, I had a really bad anxiety attack to the point of extreme intrusive thoughts. I basically, after I had the anxiety attack, I told my mom that I need help. So, she said, tomorrow morning we will go down and you will get an assessment".

Comfort and experience. The participants in the survey had varying perspectives about the interactions with the mental health professional providing the assessment. Some individuals felt the experience was positive with statements like, "good. She was very personable and made me feel as comfortable as she could. She went through her background and experience as a practitioner generally and with trans issues specifically" (C.), "It was very positive" (M.), and "unassuming and relaxed approach to possibly awkward questions" (B.). The counselors comfort level and experience working with TGNC persons appeared to influence a more positive experience.

Process and connection. Some of the experiences were about the process of the assessment, such as "the person doing the assessment was nice enough, I don’t know she smiled and introduced herself. But she really focused on reading questions off a template. That was it, for an hour. Then I was done and assigned to someone I never met before to start counseling, but she was booked almost two weeks out already. She gave me a diagnosis; I wasn’t told what it was until after I met with my counselor much later" (T.)

and “My assessment wasn’t done by my counselor. I can’t even remember who did it. They are always the same, a bunch of paperwork that you just fill out to get to the actual person. Sign sign sign...Okay when do I meet her? It took a long time too...like two weeks before I saw someone. I was feeling super mentally unstable and wanted to see someone immediately and then it just didn’t end up working out, so I ended up going to rehab again. Which wasn’t her fault I just couldn't get the help that I was looking for and I don't trust myself out in the world and that is why I go to treatment every year except this year" (H.). A survey participant concurred that "assessments in general are highly anxiety inducing. This was no different" (J).

Competency and Skill. Other negative experiences with the assessment clinician involved clinician competency and skill. One survey response shared "as stated previously she didn’t have the specific and current knowledge she needed to serve trans patients and she place her education in my hands" (I.). A second individual also noted that there were gaps in knowledge, “The transgender pieces were really tripping her up" (S.). Another survey shared less detail but stated their experience with the assessment provider was "terrible" (D.). For these participants, the lack of clinician competency around transgender issues was a detriment to the assessment process.

Fear and anxiety. A third type of experience involved fear about opening-up, anxiety about the process, and uncertainty about the unknown. One focus group participant shared an experience about how their mental health impacted their perspective of the assessment, "for me personally, I remember walking out a lot of it. I was scared about opening-up. I almost didn’t want to admit to myself that I had mental illness and

that something was up with me. At the same time, I was really lethargic, and I was having a hard time getting up out of bed in the morning. I was having a hard time keeping up with my studies. I hated my job and I was dealing with a lot of intrusive and bad thoughts. I was like I knew something was up though. At the intake it was hard for me to say all those really negative things because I have always been scared of freaking out about it. I had to tell myself that this person is here for this, this is their job, they want to know the deep-dark" (P.). In response, another focus group member agreed and shared "yeah before I went to have my assessment, I had a really really bad anxiety attack to the point of extreme intrusive thoughts. I basically, after I had the anxiety attack, I told my mom that I need help. So, she said, tomorrow morning we will go down and you will get an assessment" (L.). The focus group responses stemmed from mental health symptoms that influenced their perspectives of the assessment.

Cultural Sensitivity

The fifth theme was *cultural sensitivity,* see Table 6. This section explored the ways that cultural sensitivity was experienced during the assessment. Codes for this category related to diagnosis, identity, procedures, and relationship between provider and client. Terminology in this theme included words like *diagnosis, gender dysphoria*, *pronouns, identity, understanding, language, challenges, and health.* This category also included recommendations for improving cultural sensitivity. For example, one participant (I.) shared that "all counselors need to be brought up to speed on transgender health, and more than that they need to be better versed in the correct nomenclature and social cues. A trans person shouldn’t have to sit and guide you through a flow chart of

sometimes derogatory and dated terms to help you understand check a box for a gender they are working on figuring out themselves". Table 6 presents responses from participants that were in the theme of cultural sensitivity.

Table 6

Cultural Sensitivity

Participant Initial	Response
T.	“I didn’t agree with the diagnosis, gender dysphoria or something. I was there for my depression mainly...I get that may impact it, but to have my gender identity be the focus was off-putting. And then yeah, my counselor only really worked with the depression anyways, but it was confusing about what the real focus should have been.” "Get to know the person you are counseling. I felt like the assessment was just about checking boxes and not enough about getting to know me as a person. I felt like I spent so much time and got very little actually done. Working with me to get to a diagnosis, at least so I knew what it was so if I had questions someone could help me in the moment."
C.	"Asking about pronouns, preferred names and just trying to make me feel at ease". "Reinforcing that there is no one way to handle the situation. Any path can be the right one if it helps an individual to feel better and doesn't hurt anyone unnecessarily. I think couching the assessment in terms of finding out how best to help rather than as some sort of grading scale is very useful as well. Just give people space to be themselves and explore their identities".
M.	"She was understanding of my age". "As an older white woman, I don't have much experience with cultural insensitivity. My counselor was about my age".
J.	"None seemed culturally sensitive. All questions were generalized. Language used around family was shifted from gendered language to "spouse" but that was it". "It's complicated. People are complicated. Assessments are formulaic because they have to be. Improve cultural sensitivity by understanding the needs and challenges faces by trans people".

I.	"None!" "All counselors need to be brought up to speed on transgender health, and more than that they need to be better versed in the correct nomenclature and social cues. A trans person shouldn't have to sit and guide you through a flow chart of sometimes derogatory and dated terms to help you understand check a box for a gender they are working on figuring out themselves".
D.	"None".
B.	"None". "I think a great deal of relabeling and patronizing has already gone in... almost too much".
H.	"Not at all. Actually, because I don't think she believed I had any issues. Or like I was not as important as her other clients in there. The process is not easy or quick, so it's not like I signed up and got here on a whim. I had to walk here, be outside in this disgusting neighborhood, come here and do this. There is only one way to do this and you just have to suck it up and go. And I did, the month that it took, I don't see it as a waste now because like I learned stuff from it but she didn't do what I wanted and I didn't feel comfortable saying I need to switch therapists; and then coming into the same building and seeing her and feeling bad, like I see you and you know I think you're a terrible therapist and I got another therapist and now it's awkward."... "With the prescriber. It was required to attend counseling to be given access to a prescriber. I needed that to keep my head on track. I can't keep my thoughts together completely without my prescriptions. There is no other way for me to get them without going to rehab again. I didn't realize I had to keep going (to counseling) to keep getting them (medications). So, then that happened...I got discharged and I stopped getting my meds. It's not their fault but I started using again, I started drinking again, and then I was in rehab again". "This might already happen for some, it didn't happen for me though. If someone had checked in with me to see how I liked her, or how it was going I would have. If I called every time and got to someone who didn't sound like they didn't give a fuck about what I was trying to deal with maybe that would have helped to. The girls when you go in are like. I get there are people doing internships and stuff, but they have their own

things and they don't care. But somebody else could have checked-in. Rather than just my counselor who never checked in. It was just me her and (my prescriber), but really just myself. Every week going out of my way for no reason. Then it turned into just going in for the prescriptions and then I was like I can't do this; it is out of my way and I don't like the neighborhood. So that would be cool. And why does it have to end in 6 months? What is that about? Just knowing it is going to end is hard for some people." …

"I feel like eventually it would have come up about my gender identity, but she never asked me questions, there were never thought-provoking questions. I just learned about this myself a few weeks ago but I never had words to tell. I grew up my whole life thinking I was going to get a sex change, but then I fell in love with who I was, so I didn't but I never knew that there were ways to describe someone who didn't identify with either sex. It took me 10 years to figure this out on my own. I just didn't know. There are people who already know that who they are is what they look like you know? So, this is coming from someone who didn't know at the time and I could have found out and it could have saved me lots of time and effort but, the questions just weren't there".

"Maybe like, what are you dealing with? Why are you here?... and then let me respond and then ask me more. Don't just type up a question and not have eye contact and then like move onto the next question. Just like 'well it's noon goodbye'...okay I guess I'll go talk to my friends. Who aren't qualified to answer some of my questions? But that was just one person too that's just my experience. I know there was like... I remember hearing about a care team. I never saw that or experienced that. There are things offered that you can go do, but ya reaching out would be way better. I felt just felt like a number and so that was just a really big deal to me".

"I don't know maybe make it (the office) more colorful or something the walls are all just white and bland."

S.	"not really, no. Whatever assessment she was using had dated terms that were offensive". "For the counselors to have more knowledge of terms to use and more exposure to transgender education so that when someone comes in they can know how to help without having to ask. Also referring to people as how the self-identify rather than of going to down a grid".

	“I'd say to the people coming in, new counselors, don’t place the burden of education on the people your serving".
P.	"They are already pretty decent. It’s just a matter of maybe reassuring patients that no matter what you say like that’s my job, you can open up to me. Try to level with them. For me personally, at my intake she was just typing on the computer the entire time it felt really closed off. I was talking, and she was just copying what I was saying, so that felt a little impersonal to me. But um, I don’t know maybe allowing them to have recording devices, so they could take the time to just have 1-1 conversation". "...then allowing the intake person to see like, your crossing your arms right now you seem pretty closed off. So, they can address it and get as much as they can from the patient. This is ideal utopia world it’s not going to happen like that all the time".
R.	---no comment---
L.	"Yes, face to face conversation would help because then it’s not…if someone is turning towards the computer more than actually facing you". "If the intake people could know a little bit more about body language like, closed off or not".

Comfort and understanding. The topic of cultural sensitivity had some of the most in-depth responses from participants across all formats. Two people identified that the assessment was culturally sensitive and shared "she was understanding of my age". "As an older white woman, I don't have much experience with cultural insensitivity. My counselor was about my age" (M.) and "asking about pronouns, preferred names and just trying to make me feel at ease". "Reinforcing that there is no one way to handle the situation. Any path can be the right one if it helps an individual to feel better and doesn't hurt anyone unnecessarily. I think couching the assessment in terms of finding out how best to help rather than as some sort of grading scale is very useful as well. Just give

people space to be themselves and explore their identities" (C.). Having a counselor with similarities in age and gender, and asking about pronoun use and preferred names, was culturally sensitive. Recommendations for cultural sensitivity involved flexibility with treatment paths and getting to know the person before moving into more structured and process-oriented aspects of the counseling assessment.

Diagnosis. Other participants shared frustration with the diagnosis portion of the assessment responding about whether or not the assessment was culturally sensitive with “not really, no. Whatever assessment she was using had dated terms that were offensive", they shared recommendations “for the counselors to have more knowledge of terms to use and more exposure to transgender education so that when someone comes in they can know how to help without having to ask. Also referring to people as how the self-identify rather than of going to down a grid…. I’d say to the people coming in, new counselors, don’t place the burden of education on the people your serving" (S.). Another participant also shared that “I didn’t agree with the diagnosis, gender dysphoria or something. I was there for my depression mainly... I get that may impact it, but to have my gender identity be the focus was off-putting. And then yeah, my counselor only really worked with the depression anyways, but it was confusing about what the real focus should have been.” This person recommended assessment clinicians to "get to know the person you are counseling. I felt like the assessment was just about checking boxes and not enough about getting to know me as a person. I felt like I spent so much time and got very little actually done. Working with me to get to a diagnosis, at least so I knew what it was so if I had questions someone could help me in the moment” (T.).

Language. Language and how the assessment counselor communicated was also identified as a cultural consideration. One person felt that "none seemed culturally sensitive. All questions were generalized. Language used around family was shifted from gendered language to "spouse" but that was it". They shared that "It's complicated. People are complicated. Assessments are formulaic because they have to be. Improve cultural sensitivity by understanding the needs and challenges faces by trans people" (J.). Another survey response shared similar responses, but also feels that some of the attempts to change language becomes counterproductive. They shared "None" was culturally sensitive and "I think a great deal of relabeling and patronizing has already gone in... almost too much" (B.).

Invalidation. One of the interviews shared about how the lack of communication and understanding of concerns between themselves and assessment counselor. When asked if the assessment was culturally sensitive, they shared "Not at all. Actually, because I don't think she believed I had any issues. Or like I was not as important as her other clients in there. The process is not easy or quick, so it's not like I signed up and got here on a whim. I had to walk here, be outside in this disgusting neighborhood, come here and do this. There is only one way to do this and you just have to suck it up and go. And I did, the month that it took, I don't see it as a waste now because like I learned stuff from it but she didn't do what I wanted and I didn't feel comfortable saying I need to switch therapists; and then coming into the same building and seeing her and feeling bad, like I see you and you know I think you're a terrible therapist and I got another therapist and now it's awkward. With the prescriber. It was required to attend counseling to be

given access to a prescriber. I needed that to keep my head on track. I can't keep my thoughts together completely without my prescriptions. There is no other way for me to get them without going to rehab again. I didn't realize I had to keep going (to counseling) to keep getting them (medications). So, then that happened... I got discharged and I stopped getting my meds. It's not their fault but I started using again, I started drinking again, and then I was in rehab again". This person shared their recommendations for improving cultural sensitivity in counseling assessments stating, "this might already happen for some, it didn't happen for me though. If someone had checked in with me to see how I liked her, or how it was going I would have. If I called every time and got to someone who didn't sound like they didn't give a fuck about what I was trying to deal with maybe that would have helped to. The girls when you go in are like. I get there are people doing internships and stuff, but they have their own things and they don't care. But somebody else could have checked-in. Rather than just my counselor who never checked in. It was just me her and (my prescriber), but really just myself. Every week going out of my way for no reason. Then it turned into just going in for the prescriptions and then I was like I can't do this; it is out of my way and I don't like the neighborhood. So that would be cool. And why does it have to end in 6 months? What is that about? Just knowing it is going to end is hard for some people." ... "I feel like eventually it would have come up about my gender identity, but she never asked me questions, there were never thought-provoking questions. I just learned about this myself a few weeks ago but I never had words to tell. I grew up my whole life thinking I was going to get a sex change, but then I fell in love with who I was, so I didn't but I never knew that there were ways to

describe someone who didn’t identify with either sex. It took me 10 years to figure this out on my own. I just didn't know. There are people who already know that who they are is what they look like you know? So, this is coming from someone who didn’t know at the time and I could have found out and it could have saved me lots of time and effort but, the questions just weren’t there. Maybe like, what are you dealing with? Why are you here?... and then let me respond and then ask me more. Don’t just type up a question and not have eye contact and then like move onto the next question. Just like ‘well it’s noon goodbye’...okay I guess I’ll go talk to my friends. Who aren’t qualified to answer some of my questions? But that was just one person too that’s just my experience. I know there was like... I remember hearing about a care team. I never saw that or experienced that. There are things offered that you can go do but reaching out would be way better. I felt just felt like a number and so that was just a really big deal to me” (H.). This person felt that the process was cumbersome, exhausting, and lacked communication about the things important to them. The recommendation is focused on developing a positive professional relationship that isn’t afraid to dive deeper in a respectful manner.

Attending and body language. The focus groups responses focused more on recommendations to improve cultural sensitivity in assessments "I can’t think of any...no. Not really not that I can think of" (D.). "Yeah I don’t really remember the details" (Participant #3). In response to what ways could cultural sensitivity be improved the response from the group included, "They are already pretty decent. It’s just a matter of maybe reassuring patients that no matter what you say like that’s my job, you can open up to me. Try to level with them. For me personally, at my intake she was just typing on

the computer the entire time it felt really closed off. I was talking, and she was just copying what I was saying, so that felt a little impersonal to me. But um, I don't know maybe allowing them to have recording devices, so they could take the time to just have 1-1 conversation" (P.). The other focus group members agreed and shared "Yes, face to face conversation would help because then it's not… if someone is turning towards the computer more than actually facing you" (L.). "It doesn't feel like they are listening, and it doesn't feel like they care"(P.). "Yeah" (Participant #3). "Like just that eye contact lets them know, your important to me"(P.). (3) "Yeah not just a…" (L.). The group also identified how body language may impact how the counseling assessment is experienced, "Even if it's their job, even if they don't really care but they want to get the most out of them as they can. It's that body language" (P.). "Body language is super important apparently" (L.). "It's the subtle things in the back of your brain you register unconsciously, and it just happens you know what I mean? You feel an emotional connection with them it happens subconsciously" (P.). "If the intake people could know a little bit more about body language like, closed off or not" (L.). "Then allowing the intake person to see like, your crossing your arms right now you seem pretty closed off. So, they can address it and get as much as they can from the patient (P.). This is ideal utopia world it's not going to happen like that all the time…. (laughter)…to help get the best results so they can help other people, faster" (L.).

Negative experiences with cultural sensitivity. Contrary to the two experiences above, the remainder of research participants shared that they felt there was no cultural sensitivity included in the assessment process. A common answer was that "none" (D.) of

the assessment was culturally sensitive to TGNC persons. The recommendations for cultural sensitivity appeared to come with each person's experience and what they felt might improve their experience. Some felt that knowledge and skill was lacking. One respondent said "none!" and continued to share recommendations that "all counselors need to be brought up to speed on transgender health, and more than that they need to be better versed in the correct nomenclature and social cues. A trans person shouldn't have to sit and guide you through a flow chart of sometimes derogatory and dated terms to help you understand check a box for a gender they are working on figuring out themselves" (I.).

Impact

Coding. The sixth theme was *impact*, see Table 7. Impact included the assessment impact emotionally or on any desire to continue in counseling services. Impact also could have included codes related to impact after the assessment occurred, such as the influence of being placed with a counselor, treatment outcomes, and overall evaluation of the counseling assessment experience. Some of the words and phrases in this section included *continue, assist, impact, positively, initial, stuck with it, only visit, wanted to be done, I've yet to return, remain,* and *opening the door.* for example, one participant noted from the experience that "because it wasn't negative, I felt certain that I wanted to continue having sessions and that she would be a good counselor to assist in my journey" (C.). Table 7 presents responses from participants in the theme of impact.

Table 7

Impact

Participant Initial	Response
T.	"It just made it a struggle to stay. I knew I needed help, but it was so much effort for very little reward." "I stayed for about three months in counseling and ended up just not going back. She tried but I felt like it wasn't really helping me. She was never prepared for me and was always busy."
C.	"Because it wasn't negative, I felt certain that I wanted to continue having sessions and that she would be a good counselor to assist in my journey". "I don't know that it had a big impact other than not stopping me from continuing. I had done a lot of reading and was already involved with some support groups, so I was perhaps slightly further along than some people in my position might be in their first assessment. I was also 49 years old at the time and very much in charge of my life, so perhaps that made it less impactful as well".
M.	"Positively". "The assessment was just that, an initial conversation to understand my motivations and goals".
J.	"Not great, but the person completing the assessment wasn't going to be my actual counselor, so I stuck with it". "The assessment ended with a diagnosis, and not one I agreed with. However, it shaped and informed all the therapeutic options I had available to me. So, I didn't stay in therapy for long, as I didn't agree with the diagnosis".
I.	"Negatively, I've yet to return to counseling my doctor is able to sign off on most if not all changes in this state for which I am fortunate".
D.	Skipped

B.	"I would have liked to remain in counselling however I was told simply to wait the 3 months and expect a call". "Besides opening the door to hrt not much sadly".
H.	"It’s the exact same experience I have had every time I’ve had counseling every year of my life. I can’t talk about it out loud if they don’t ask me questions. I need them to ask me questions that make me think this is an issue. I don’t want to come in and someone has a list of all my problems, and these are all the things I want to work through, and I’m so upset...I’m not upset I am super happy but there is shit I need to deal with you know? Knowing it would end in 6 months I already felt like I was a number. I don’t even know what that reasoning is. Why form this relationship with this person then I have to form another relationship in 6 months because I have to leave, it’s just the way the program works. Finding a therapist around here is hard. All the ones I found outside of this place it is always the same experience and I don’t know why. Maybe I shouldn’t put any effort into myself and come in looking like trash and crying"... “I can’t help but feel like I know the answer to all my problems you know? So, I need someone who can talk over me to take control of the room and not have me be the freak’n therapist. I want someone to tell me things. I need someone to challenge me"... “She may have her own stuff going on in her own life you know, she always seemed stressed out and it might not have been her work. I don’t know maybe her dad was dying or something, but she should have taken a leave of absence or something if she couldn’t be there for herself and her clients".
S.	“Negatively, as that was my only visit with her". “Um, not severely. If I felt like I needed that in the future I feel like I would need a counselor with more education".
P.	"Well once I already started counseling it was like finally relief because I had really bad counseling before because we had a family counseling. It was basically my step dad telling the counselor that me and my brother were just not listening to him and that we were rebelling. He was like this all-powerful saint that couldn’t do any wrong". "The intake, I knew in the back of my brain I was only going to see that person once, and then whatever counselor I was going to see I could continue to talk to them about the stuff that was bothering me. It didn’t

	really impact me because I was trying to get through the intake pretty fast to get to my actual counselor. I wasn’t trying to tell this person what is going on in my life to have them help me cope or deal with it. That is what my counselor is for, I will try to get to my counselor. So, I didn’t really, I just kind of wanted to get it over and done with".
R.	---no comment---
L.	"Well first I was scared to do counseling because I had that such bad vivid memory of it. I didn’t know if counseling was going to be good for me and so I was just like wary of it, but the more I started to go, it was like okay, yes, I need the therapy counseling and I also need the medication. Both of them have been working for me. Most of the time". "Me too kinda, I was really depressed so I just wanted this to be done so I could be able to talk to someone about my problems".

Benefits. Only two survey shared that the assessment impacted their desire to remain in counseling "positively". They shared that "the assessment was just that, an initial conversation to understand my motivations and goals" (M.). The second survey response that shared a positive experience stated that "because it wasn't negative, I felt certain that I wanted to continue having sessions and that she would be a good counselor to assist in my journey". "I don't know that it had a big impact other than not stopping me from continuing. I had done a lot of reading and was already involved with some support groups, so I was perhaps slightly further along than some people in my position might be in their first assessment. I was also 49 years old at the time and very much in charge of my life, so perhaps that made it less impactful as well" (C.).

The focus group participants also shared that it was a relief to begin seeking support counseling, “well once I already started counseling it was like finally relief because I had really bad counseling before because we had a family counseling. It was

basically my step dad telling the counselor that me and my brother were just not listening to him and that we were rebelling. He was like this all-powerful saint that couldn't do any wrong" (P.). Another participant agreed "… that was my experience with counseling before too is my dad had tried with his numerous girlfriends to do family counseling and it was always like..." (P.). "...for me it was a blaming session" (L.). "...like, we *need to work together, the kids aren't responding*. My dad would say is it something I'm doing, is it something way we can parent them. It was never a- *is it me?* - kind of thing. It was always, *these kids are onry"* (P.). "Basically, a blame session". "Yeah" (P.). "Where the commanding parent basically says this family is so dysfunctional that I can't handle it and it's their problem" (L.). "Right, fix them" (P.). "Well first I was scared to do counseling because I had that such bad vivid memory of it. I didn't know if counseling was going to be good for me and so I was just like wary of it, but the more I started to go, it was like okay, yes, I need the therapy counseling and I also need the medication. Both of them have been working for me. Most of the time"(L.). The focus group participants shared that they knew they needed to complete the assessment in order to begin the counseling process "the intake, I knew in the back of my brain I was only going to see that person once, and then whatever counselor I was going to see I could continue to talk to them about the stuff that was bothering me. It didn't really impact me because I was trying to get through the intake pretty fast to get to my actual counselor. I wasn't trying to tell this person what is going on in my life to have them help me cope or deal with it. That is what my counselor is for, I will try to get to my counselor. So, I didn't really, I just kind of wanted to get it over and done with" (P.). "Me too kinda, I was really

depressed so I just wanted this to be done so I could be able to talk to someone about my problems" (L).

Negative outcomes. In contrast, all other participants reported that the impact involved them not returning or continuing in counseling, such as "It just made it a struggle to stay. I knew I needed help, but it was so much effort for very little reward. I stayed for about three months in counseling and ended up just not going back. She tried but I felt like it wasn't really helping me. She was never prepared for me and was always busy" (T.) and "Not great, but the person completing the assessment wasn't going to be my actual counselor, so I stuck with it. The assessment ended with a diagnosis, and not one I agreed with. However, it shaped and informed all the therapeutic options I had available to me. So, I didn't stay in therapy for long, as I didn't agree with the diagnosis" (J.). Another participant when asked about impact on counseling stated it impacted them "negatively, I've yet to return to counseling my doctor is able to sign off on most if not all changes in this state for which I am fortunate" (I.). A participant agreed stating it impacted them "negatively, as that was my only visit with her. Um, not severely. If I felt like I needed that in the future I feel like I would need a counselor with more education" (S.). One participant wanted more from the experience, "I would have liked to remain in counselling however I was told simply to wait the three months and expect a call. Besides opening the door to hrt not much sadly" (B.).

An interview response shared details about the impact, "It's the exact same experience I have had every time I've had counseling every year of my life. I can't talk about it out loud if they don't ask me questions. I need them to ask me questions that

make me think this is an issue. I don’t want to come in and someone has a list of all my problems, and these are all the things I want to work through, and I’m so upset...I’m not upset I am super happy but there is shit I need to deal with you know? Knowing it would end in six months I already felt like I was a number. I don’t even know what that reasoning is. Why form this relationship with this person then I have to form another relationship in 6 months because I have to leave, it’s just the way the program works. Finding a therapist around here is hard. All the ones I found outside of this place it is always the same experience and I don’t know why. Maybe I shouldn’t put any effort into myself and come in looking like trash and crying... I can’t help but feel like I know the answer to all my problems you know? So, I need someone who can talk over me to take control of the room and not have me be the freak’n therapist. I want someone to tell me things. I need someone to challenge me". The person in this interview did not feel like a priority, “she may have her own stuff going on in her own life you know, she always seemed stressed out and it might not have been her work. I don’t know maybe her dad was dying or something, but she should have taken a leave of absence or something if she couldn’t be there for herself and her clients". This person identified that they are "not currently in counseling" (H.). Those participants in this student who felt there was a negative impact identified either leaving the counseling process before they wanted or not returning after the assessment. Those with positive impacts identified that they felt comfortable moving forward with counseling and that is was the first step in their counseling journey.

Saturation

According to Kinsella (2006), data saturation occurs once the researcher feels that depth of understanding has been reached; knowing it ultimately can never be completed. Data saturation for this study was met when themes kept re-occurring and information was no longer being sorted into new categories. The six overarching themes were reached with 12 participants. As this study is qualitative, the number of participants was less than a quantitative study, but the richness of narratives and depth of responses was valuable within itself.

Summary

The results of this study explored the intimate experiences of TGNC persons with counseling assessments. According to Gadamer (1996) the lived truths of people provides a type of knowledge that can help develop communication and connection. The responses improve the current understanding of the motivation, benefits, barriers, cultural sensitivity, and impact of counseling assessments for TGNC persons. The improved understanding about TGNC experiences can help to develop more effective and culturally-sensitive counseling assessments (WPATH, 2011). Chapter 5 discussion section will further develop insights from these results.

Chapter 5: Discussion, Conclusions, and Recommendations

Discussion

The purpose of this research is to provide insight into the experiences of transgender and gender non-conforming (TGNC) adults with counseling assessments. According to World Professional Association of Transgender Health (WPATH) there is a crucial need in the field for culturally appropriate assessments for TGNC persons (2011). This study was conducted based on the lack of research literature that speaks to the lived experiences of TGNC persons with assessments. The problem is that counselors provide assessments to TGNC persons without understanding what those experiences are like. The experiences people have with assessments may influence their desire to remain in counseling (Ellis, Bailey & McNeil, 2015; Mizock & Lundquist, 2016). Counseling assessments help to inform counseling, diagnosis, and referral standards of care of lesbian, gay, bisexual, transgender, and queer clients (LGBTQ) (Harper et al., 2013; Hays, 2014). The insights from this research may help counselors and counselor educators to understand the lived experiences of some TGNC persons; hopefully to increase positive experiences and cultural sensitivity with assessments.

Key Findings

Key findings from this research include participant responses that demonstrated both positive and negative experiences with counseling assessments. Overall, there were more negative experiences than positive; however, those that had negative experiences shared recommendations that were mirrored positive experiences shared by other

participants. According to Meyer (2014) minority populations experience higher levels of discrimination and stigma. The participants in this study not only shared the negative experiences but were also invested in recommending positive social change. A negative experience was shared that the counselor conducting the assessment treated them like a number and another participant identified they were worried they would have their gender identity treated instead of their whole-self. A positive experience spoke to being treated with respect, using preferred pronouns, and being treated as any other person. There was consistency between the recommendation for what was missing and what had been experienced as positive, being respected and treated as a whole-person.

The experiences of TGNC persons are beneficial because they can impact counselor understanding of assessments. According to Donatone and Rachlin (2013) feedback from those completing counseling assessments can help to inform culturally appropriate practices. The aspects of counseling assessments that are identified in this research include: motivation to have an assessment completed, benefits from the assessment, challenges or barriers, the impact that the assessment had on their desire to remain in counseling and on the rest of treatment, culturally sensitivity, and recommendations. This chapter will include interpretation of results, limitations of the study, recommendations moving forward, and implications for social change.

Interpreting the Findings

This study's conceptual framework is rooted in Gadamer's philosophical hermeneutics. Philosophical hermeneutics explores lived experience as a unique source of truth. The legitimacy of experience that exists outside of empirical knowledge is valid and

important in the search for truth (Gadamer, 1996). The findings in this study are based on the lived experiences of 12 adults, ages 18 and over, who identify under the umbrella of transgender or gender non-conforming identities. Some chose to share their experiences via an anonymous online questionnaire, while others wanted to provided rich detail in face to face interviews (also wanting to know who the researcher was). Then, there were three people who wanted to share and discuss together in a focus group format, so they could be a support for each other as they shared their experiences. The format, whether it be survey, interview, or focus group was the medium of expressed truth. According to Dobrosavljev (2002) someone who shares their truth does so by explaining practical experiences of being. Opportunity to express truths with different avenues increased participation in this study. The research questions were identical; however, the focus group and interviews had deeper discussions since there was a back and forth between participants and the researcher. The responses from this study extend knowledge in the field; there were no qualitative articles found in this comprehensive literature review on the experiences that TGNC persons had with counseling assessments.

Assessment Standards of Care

The responses from participants in this research study had limited insight into the many types of information that could be gathered as part of the assessment. According to Hays (2014), assessments should include both qualitative and quantitative data and may include additional testing measurements. Most viewed the assessment as just including an initial intake assessment. It is unclear if they did not speak about a broader assessment process because it did not occur or if they were not educated about the process. Some

participants shared that during the assessment they felt like only part of themselves was being examined. One even identified that they just felt like a number. According to the American Counseling Association (ACA) standard G.6 (2010) counselors should use comprehensive assessment processes that encompasses a holistic perspective to health. How the counselor receives information can vary, but it should be comprehensive and ongoing process throughout treatment (Hays, 2014).

Diagnosis within Assessment

In the literature review, the impact of the DSM on TGNC persons was evident with ethical standards supporting careful consideration. According to ACA (standard E.1, 2010) counselors should understand the background of stigma and discrimination towards sexual minorities within the Diagnostic Statistical Manual (DSM). Multiple participants shared negative experiences with being diagnosed from the DSM during their assessment. The experiences of these participants showed that counselor adherence to ACA standard E.1 was not followed consistently. One person identified that they were labeled as a transvestite and that the clinician used an outdated DSM. Outdated and insensitive terminology can be harmful to individuals and to community perspectives of TGNC persons (Ellis, Bailey & McNeil, 2015).

Minority stress theory and diagnosis. Diagnosis during the assessment was shared in the TGNC narratives as causing anxiety, fear, and worry. Additionally, dissatisfaction was reported with cultural competency and education of mental health professionals providing the assessments. Diagnosis with minority populations has been an avenue for discrimination and victimization, as well as making individuals feel like

gender non-conformity is an illness or sexual deviancy (Meyers, 2014; Ellis et al., 2015). Minority stress theory provided a lens that TGNC persons are more likely to experience discrimination or stigma due to a mental health diagnosis, such as gender dysphoria, ultimately influencing fear and anxiety (Meyers, 2014).

Benefits of a diagnosis. One participant experienced that during the assessment the mental health professional shared about the diagnosis and provided education which was helpful. Some participants also stated they understood why assessments are beneficial and focus group members found it helpful to provide evidence to family members who felt that being TGNC was just a phase. A diagnosis of gender dysphoria is necessary for some insurances to cover crucial medical procedures for TGNC persons (Rodgers & O'Connor, 2017). The literature review was consistent with experiences that some TGNC participants had with counseling being a requirement before beginning medical transition. The benefits of assessments found in this study were that some people were educated on their diagnosis, began the counseling process, and that it provided an avenue towards medically transitioning.

Although there were identified benefits of having an assessment completed (gaining an appropriate diagnosis, opening the doors to medical transition, and beginning the counseling process) there were also considerations that were problematic for some participants in this study. Assessment can be connected with a diagnosis for TGNC persons. Assessments should be assessed on an individual basis with a holistic view of client challenges, strengths, and experiences (Coleman et al., 2012; Ellis et al., 2015; Moe, 2016). Some experiences that were shared in this study were not person-centered or

culturally-sensitive to the needs of TGNC persons. According to WPATH (2011) counselors need to be aware of the historical trauma that surrounds diagnosis and assessments for TGNC persons. Self-evaluation may be a challenge for counselors; however, this may be a beneficial way to know the experiences TGNC persons with the assessment process.

Identity

For participants in this study, gender identity arose as a journey towards self-actualization. Gender identity is a critical component of someone's identity (ACA, standard A.1, 2010; WPATH, 2011). Some participants felt counseling was an important first step to explore gender identity and mental health. The assessment was perceived by some as a required initial step to enter counseling. Others felt that a poor assessment experience influenced them to discontinue services either immediately or after a short period of time. Some participants were able to continue their journey outside of counseling, some went to primary care doctors, and others sought out a different counseling experience. Some individuals had experiences that their treatment was short-term, and they felt they were not able to explore topics related to gender identity. One participant stated the counselor did not ask questions that would help him go deeper to explore his identity. In contrast, a participant did share a positive experience stating that the counselor was respectful and helpful despite having to ask potentially awkward questions.

Discrimination and Prejudice

Concerns that brought individuals into counseling included things like exploring gender identity, depression, anxiety, and the desire to medically transition. Some shared

that the counselor lacked TGNC-specific knowledge, but that the counselor was caring and wanted to learn more about TGNC persons. Past discrimination was shared by a couple participants, but it was not focused on their counseling assessment experiences. There were microaggressions during the counseling assessment that negatively impacted the experiences of some participants. Multiple participants shared that having their preferred pronouns used made a positive experience but found that cultural sensitivity did not expand past the use of preferred pronouns. According to Mizock & Lundquist (2016) using someone's preferred pronoun and name is respectful. So, although the use of preferred pronouns was used, most experiences shared that cultural sensitivity did not expand past verbiage changes.

The use of improper diagnosis, with an outdated DSM, reported by a participant in this study could be interpreted as lack of competency, a counselor not following ethical guidelines, or an act of overt discrimination. According to Meyer (2014) minority populations may encounter stressors directly related to discrimination, prejudice, or stigma influencing additional negative mental health implications. TGNC persons should be able to enter counseling without fear of discrimination, prejudice, or stigma. An important aspect of this is ensuring an accurate diagnosis to appropriately inform and guide treatment practices. According to the ACA (2014) counselors should work within their scope of competency and gain education or trainings if they are lacking skill or knowledge. Ultimately it is the counselor's responsibility to meet the needs of TGNC clients during assessments. Meeting individual needs includes being respectful and using diagnosis in a

purposeful and respectful manner that helps TGNC persons reach their goals (WPATH, 2011).

Counseling Experiences

The experiences that TGNC participants shared with previous counseling experiences did align with the literature review. TGNC persons have additional barriers and challenges to receiving affirming and culturally sensitive counseling (Ellis et al., 2015; Duffy, Henkel & Earnshaw, 2016; Mizock & Lundquist, 2016). Multiple participants shared that previous negative experiences in counseling influenced them to have anxiety about the assessment process. Depression was shared as a reason some individuals sought counseling. Anxiety was associated by several as being tied to anticipation and the assessment process itself.

During the interviews and focus group the topic shifted from the assessment to sharing about past bad experiences in counseling. The past negative experiences were powerful enough to integrate into current interpretations of counseling assessments. Negative experiences during the assessment mirror previous research that showed counselors overly focused on gender identity or avoided the topic altogether (Mizock & Lundquist, 2016). Another similarity to the literature review is counselor competency on TGNC topics and concerns. Counselors often lack specific training and knowledge about how to work with TGNC persons (Duffy et al., 2016; Ellis et al., 2015; Mizock & Lundquist, 2016).

The negative experiences shared by participants included that the assessment clinician placed the burden of education on the client. According WPATH (2011)

counselors who work with TGNC persons should have 1. skill in use of the current DSM, 2. recognize and differentiate between coexisting mental health diagnosis and gender dysphoria, 3. supervised training to ensure competency, 4. knowledge about TGNC identities, expressions, and how assessment informs treatment of gender dysphoria, and 5. use continuing education to evolve assessment practices and skills.

Positive experiences shared in this study included that the clinician was knowledgeable, caring, and helpful. Beyond knowledge and care for clients, counselors would also ideally continue to grow and maintain cultural competency. Advocacy and knowledge about public policy issues that impact TGNC persons and their families is also important for clinicians (WPATH, 2011). Additionally, knowledge about sexuality, gender identity, sexual health concerns, and treatment of sexual disorders may also prove helpful (WPATH, 2011). These practices should be under supervision for new counselors to the field if working with TGNC persons to ensure ethical and cultural competencies are being met (WPATH, 2011). There is more to working with TGNC persons then a willingness to learn. Counselors who provide assessments need to develop awareness, knowledge, and skill about issues and topics relevant for TGNC persons and their families.

Connection and Resiliency

Connection and resiliency were present in the results of this study. According to Avera et al. (2015), wellness includes more than just physical health, it includes the whole self. Those participants who experienced challenges and barriers also shared about resiliency to fight for their identity and wellness. Conversation and terminology in this study focused on a journey towards self-actualization and connection with others.

Connection was most evident during the focus group as the three members interacted with one another. All three focus group members supported each other, and this was evident in how they talked about supporting each other in the past and during the focus group. Social affirmations can help lower levels of depression and improve self-esteem (Glynn et al., 2016). At one point, a participant shared about the time it has taken to feel comfortable with their gender identity. The other group member encouraged them and normalized the time it takes to transition successfully. Willingness of individuals to share their experiences openly in this study demonstrated a desire to help, be heard, and to be understood.

Limitations of the Study

Limitations at the participant level within this study included the use of a TGNC umbrella term, using multiple formats, and internet access. Those who wanted to participate in this study were pre-screened as identifying under a transgender or gender non-conforming umbrella. It was apparent however that there are subgroups under TGNC categories that will be important to examine in more detail in future studies. According to Worthen (2013) future studies need to study subgroups instead of grouping individuals who may have different ranges of experience.

Format for Recruitment

Using a focus group became a limitation in this study because some participants wanted to share more detail in person or be allowed to be anonymous. Focus groups can help provide depth about interactions between participants (Graham, Trehame, Ruzibiza, & Nicolson, 2017). The focus group provided in-depth interactions between group members but lacked anonymity and focused interaction with the researcher. Additional

options for the online questionnaire and interviews were added to allow more TGNC to participate for those who did not feel comfortable in a focus group.

Internet access did not present itself as a limitation as previously expected in this study. The form of recruitment online and word-of-mouth allowed individuals to either participate online or attend an in-person or phone format. According to Heckathorn (2011) snowball sampling helps gain access to individuals who may be more difficult to reach with a more targeted approach to recruitment. Recruitment began in this study online in TGNC support groups and forums. Some individuals followed the recruitment link to complete or forwarded it to others they felt might want to participate in the study. Individuals also heard about the study by word of mouth within the local community and referred themselves or others if they felt it was appropriate.

Gender Identity Classification

Some participants appeared to prefer more fluid terms but still recognized as being under the TGNC umbrella. According to ACA (standard A.1., 2010) counselors should recognize that gender fluidity is on a spectrum and that presentation is unique and individual. Some participants stated that they just identify by their name, as queer, or gender fluid. During interviews and the focus group I, as the researcher, was respectful of the terminology the participants preferred. According to WPATH (2011) counselors and assessments should use respectful terminology and the preferred names and pronouns of the individuals they serve. Those who identified as an alternative label, other than TGNC, shared that they understand that a formal classification might identify them as gender non-conforming or transgender.

I used preferred pronouns during the interviews and focus group as well. I asked if they felt they fell under the TGNC umbrella and wanted to share their experiences with counseling assessments. All of those who identified as TGNC, but preferred a different classification such as gender fluid, were still included in this study. I wanted to be respectful of individual identity and the uniqueness that may occur in presentation. According to Pilarska (2017) ownership of the self is individual, ongoing, and is highly subjective. To counter limitations of studying too many subgroups at a time, future research could recruit from under a specific TGNC subgroup, such as gender-fluid, or gather a larger quantity of participants and analyze subgroups. This study does not have enough participants to generalize results across multiple gender identity categories.

Study Changes

Initially this study intended to only use a focus group format online. However, feedback from the TGNC community, via the online forums and support groups, included that people wanted to participate from multiple age groups and with options for confidentiality. A focus group meant members needed to disclose some identifying information related to email and contact information, coordinate schedules, and participate with other individuals. According to Graham et al. (2017) focus groups develop social understanding of experiences. The individuals who wanted to participate in the focus group knew each other and felt comfortable sharing with one another. It also developed understanding of how they supported and connected with one another during their experiences with counseling assessments.

Some participants online shared feedback that they wanted to participate anonymously and without time restrictions. To counter this limitation, I created more avenues for participation within the study, with IRB approval. An online questionnaire was developed for anonymity of those who wanted to participate online. The focus group met in-person. There were also two individuals who wanted to share more in-depth with the researcher. Individual interviews for two individuals was also made available. A limitation with having three types of data collection included the time commitment to complete the additional interviews and in-person interviews. An additional three weeks was added to the study, six weeks total. The narratives were rich with detail, so it made the time commitment worthwhile.

Internet Access

The potential limitation for those who may not have internet access was countered by the option for in-person interviews and focus group. The interviewees decided to participate in person or on the phone to provide more detail. All those who participated in the online surveys had internet access due to the recruitment being online forums and support groups. There were enough participants online to conduct a qualitative research study, however, over half of the people who initiated online did not complete the questions. Incomplete survey responses online created an additional, unexpected limitation. Online responses had more skipped questions. According to Guest et al. (2017) increased time for questions in the study can help increase the richness of the response. In-person interviews and the focus group provided additional time and follow-up questions to participants. Those who completed interviews and the focus group spent

more time (between 25-45 minutes), completed all the questions, had more depth, and clarification in responses.

Quality of Data

Credibility

This research study relied on qualitative methods for data quality checks. Qualitative research helps gather information from credible sources who are deeply involved in the topic (C. Adams & Manen, 2017). Credibility was achieved in this study by using internet forums and support groups specific to TGNC populations. All the questions were screened by the website hosts to ensure that questions were respectful and appropriate. I also had to verify that my research was approved by the Institutional Review Board (IRB). I was not previously aware that the TGNC community had safe-guards in place online for those who are seeking to research participants. I was happy to see these safeguards to ensure quality and ethical use of research with TGNC persons.

Confidentiality and feedback. The website hosts were honest and helpful with feedback. One person shared that they had someone talk to them about a negative counseling assessment experience and how needed this study is to help TGNC persons access services. Another webhost shared, per observations, that most TGNC persons online do not like to participate in research due to risks of discrimination, stigma as well as the time commitment. According to Guest et al. (2017) some TGNC persons may want anonymity and privacy to participate in research. An online questionnaire was also available for those who wanted to share online. Confidentiality increases credibility because not all TGNC persons may want their identities to be known, but still want to

share. Confidentiality allows individuals to participate without dear of discrimination or other adverse impacts. There were no pressures to participate and individuals could leave the study at any time.

Transferability

There is a limitation with transferability with this study as there were only twelve participants. This study is subjective to each participant, but it is not a limitation within the hermeneutic circle. The experiences of participants do not need to be generalized but instead to be understood. According to According to Regan (2002) shared experiences are authentic examples of truth. The individual experience is truth and how it is interpreted becomes another form of truth (Kinsella, 2006). The results of this study will not be generalized to larger population, but instead will be insightful to inform the practice of counseling assessments.

Dependability

Dependability in this study is the consistency of the results to be interpreted into fusion horizons as new information is added. A hermeneutic approach to research is beneficial with TGNC persons to integrate TGNC voice and impact (Burdge, 2014). The responses from participants is qualitative integrating their voice directly into the study. I used member checking of responses post data collection to ensure the data collected was an accurate representation the original transcription or text. Check-in's and summaries can help synthesis understanding of the experiences (McCarthy & LaChenaye, 2017). Checking-in during and after the participant engaged in the study was helpful to gain more understanding and clarity to the results.

All the responses were qualitative and recorded as accurately as possible with typed transcription. An external auditor, someone outside of the study, reviewed transcriptions and texts to help improve accuracy of information. The external auditor was a mental health counselor who volunteered to assist. No identifying information was provided to the external auditor. At the end of the audit verification, members were offered to review the information to ensure what was collected was an accurate representation of their responses. Any feedback was incorporated and changed in the original transcription.

The hermeneutic circle is an evolving fusion horizon that changes as new information is added (Westphal, 1997). I provided the participant's responses in themes and categories that were reliant on the responses in the study. The discussion of this data is relevant only to the experiences provided by participants within this study. The interpretation of the findings also includes me as the researcher influencing the fusion horizon. The responses are the foundation, while the interpretation includes my own worldview and on what I have learned from this study.

Implications

Individual Benefits

This study has several implications for positive social change for the field of counseling and assessments. One implication from this study was on an individual level. Participants were eager to be able to share their experiences with assessments. Counselors should understand TGNC topics and concerns and how they could impact wellness on a larger psychosocial model (ACA, 2010, standard E.3; WPATH, 2011).

Those who completed the interview and focus group shared that they had never been asked what it was like for them, and they appreciated the opportunity. According to Alpert, CichoskiKelly, and Fox (2017) counseling assessments do not consistently highlight TGNC strengths and experiences. Asking for recommendations from participants helps place them in the expert role of their own care. Participants also wanted to help improve the process for other TGNC persons who may have a counseling assessment. Participants identified the benefits of counseling and want to reduce barriers to accessing services.

Practice Standards

Assessments are often provided at the onset of treatment or to help inform the treatment options made available to clients (Hays & Hood, 2014; Hood & Johnson, 2007). Counselors can see what the experiences were like for participants in this study and decide if they are providing assessments in a respectful and culturally sensitive manner to TGNC persons. According to ACA (2014) counselors should develop competency to provide beneficial and culturally sensitive services and to reduce risk for harm. Counselors can examine their practice with the standard of care tools recommended for TGNC persons. Counselor educators can reinforce the importance of the therapeutic alliance in all assessment processes, and not just in the counseling session. According to ACA (standard C.2.d., 2014) counselors have responsibility to monitor effectiveness and work to improve if decencies are found. Supervisors can also ensure that supervisees are being provided the adequate supervision to develop competencies for work with TGNC persons. The WPATH practice standards for assessments are highly

recommended by this researcher for ensuring ethical practices. Integrating feedback forms and quality measurements can help to monitor effectiveness.

Assessment Education and Feedback

Counselors providing assessments need to better educate clients about the assessment process and purpose. According to ACA (standard E.3.a., 2014) the nature and purpose of measurement tools and assessments should be thoroughly explained to clients prior to the assessment. All participants in this study shared about a one-time meeting with a standardized document, mostly aimed at diagnosis. Assessment can include multiple types of information-gathering including standardized assessment, observation, tools and measurements; and the process should be ongoing in treatment (Hays, 2014).

Counselor educators, supervisors, and counselors can help improve the assessment process for TGNC persons who complete assessments by listening to their experiences and integrating their feedback. Assessments for TGNC persons should consider cultural sensitivity and individuality of needs (Coleman et al., 2012; Ellis et al., 2015). The results from this research study highlighted that experiences are important for how counseling assessments and counselors were perceived. According to Moe (2016) assessments should encompass the whole self-considering the complexity of individual experience.

Recommendations

TGNC participants in this study gave recommendations for counselors providing assessments. This qualitative study revolved around their experiences; it is important to

note their recommendations first. The responses from participants involved aspects of counselor competency and the therapeutic relationship. Recommendations included a request for counselors to be knowledgeable in issues and topics relevant to the TGNC community. According to WPATH (2011) counselors should have knowledge in TGNC topics and concerns, as well as how assessments can inform and guide diagnosis and treatment for TGNC persons. Another way to develop awareness of issues related TGNC persons with assessments is to explore the history of how diagnosis was used in the past to associate gender identity with a mental illness. Assessment providers should be aware of the stigma and historical significance of diagnosis for TGNC persons (Rodgers & O'Connor, 2017).

Assessment Provider Competencies

Recommendations also include receiving the appropriate trainings, so the burden of education does not land on the client who is seeking help. Counselors can demonstrate assessment skill and knowledge with appropriate diagnosis. According to WPATH (2011) counselors should accurately diagnosis gender dysphoria, as well as any co-occurring concerns to not miss critical elements of care. It is important to ask respectful questions, that allow individuals to explore identity and mental health, without generalizing about why someone is seeking services. These recommendations would be important for any therapeutic relationship, not just for those persons who identify as TGNC.

A Whole-Self Assessment

The assessment process could benefit TGNC clients by assessing the whole self and not overly focusing or avoiding topics related to gender identity. Valid and reliable assessments rely on integration of comprehensive measurement processes that examines the whole self (ACA, 2010; Coleman et al., 2012). Most of those who participated in this study had aspects of both mental health and gender identity they wanted to focus on. It will be important for counselors to develop competency for working with TGNC persons as it relates to both mental health and gender identity (Ellis et al., 2015).

Fusion Horizon

Recommendations from the researcher for future and further research are based on gaps and limitations found within this study. The purpose of this study was to understand the lived experiences as a snapshot in time for TGNC persons. Counselor educators and counselors can use this information to inform and guide their own practice of assessments to help implement more positive and beneficial aspects of care to better serve TGNC persons who seek help for mental health concerns. On an equally important note, counselors should remember to develop the therapeutic alliance with their clients even during the assessment process. The formation of a strong therapeutic alliance during assessment can help create an environment that is open to discussion about treatment options (Ackerman, Hilsenroth, Baity, & Blagys, 2000). Some negative experiences shared by participants revolved around counseling micro-skills such as active listening, body language, respectful terminology, and a helping relationship.

Future Research

This study prompted additional questions that deserve more attention in the future from the field of counseling. One area for further research may include exploring the kinds of assessments being used with TGNC persons and how they are used by clinicians to inform treatment. Also, the examination of quantitative data could show how many people complete assessments and of those, who continued or discharged from services due to their experiences. This qualitative study is an introduction into experiences of the TGNC persons to know what direction to head for future qualitative, quantitative, or mixed methods research.

Conclusion

Counselors have a responsibility to provide ethical and culturally sensitive assessments to TGNC persons (ACA 2014; WPATH 2011). The field needs to be especially cautious to not add additional barriers to TGNC persons seeking help. The purpose of this study was to share the experiences of TGNC adults with counseling assessments. According to Ackerman et al., (2000) a collaborative, caring, and comprehensive assessment provides a smooth transition to therapy. The participants in this study all shared that their assessment impacted their desire to remain in counseling. Negative experiences with counseling assessments can influence someone to discontinue care (Ellis et al., 2015; Mizock & Lundquist, 2016). The results of this study, although not able to be generalized to larger populations, warrants examination of the counseling assessment; a critical part of the counseling experience.

The assessment is usually the introduction to the counseling process; it informs treatment, diagnosis, and the client about the assessment process (Hays & Hood, 2014; Hood & Johnson, 2007). To lay a strong foundation for diagnosis and treatment planning individuals need to feel safe and supported throughout the process. TGNC persons may experience fear of discrimination and stigma and avoid seeking treatment (Ellis et al., 2015; Mizock & Lundquist, 2016). Counselors should educate clients about the purpose of assessment and work to develop a strong therapeutic alliance to reduce anxiety and fear (ACA 2014; Ackerman et al., 2000). The experiences of TGNC persons, their lived truths, can help to inform ethical and effective assessment standards of care.

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Appendix A: Prescreen Survey

These are required responses for participation

1. **Age:** ____ (Must be 18 or over)

2. **I self-identify as Transgender or Gender Non-Conforming:** YES or NO (must be yes to participate in this study)

3. **I have participated in a counseling-related assessment:**

a. Within the last 3 months

b. More than three months but less than 12

c. More than 12 months

4. **I would like to participate in a:**

a. Online Questionnaire

b. Individual Interview

c. Focus group

Appendix C: Questionnaire, Interview, and Focus Group Questions

1. What motivated you to have a counseling assessment completed?
2. Share any benefits or positive outcomes of the counseling assessment.
3. Share about any barriers or challenges that you encountered during the assessment.
4. What was the experience like with the individual giving the assessment?
5. What parts of the assessment were culturally sensitive to your individual needs?
6. How did your experience impact your desire to remain in counseling?
7. How did you experience the assessments overall impact on the course of your treatment?
8. What recommendations do you have for improving cultural sensitivity within the counseling assessment process when they are used with persons who identify as transgender or gender non-conforming?