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Dialectics, power dynamics, and undercurrents of meaning: using psychotherapeutic strategies in primary care with trans and gender-diverse clients

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ABSTRACT

Trans and gender-diverse individuals experience poor mental health, and face significant barriers when trying to access appropriate mental health care. Most seek treatment from mainstream primary care services, who have an ethical duty to provide care to all. Primary care practitioners can ameliorate traumatic harms by identifying helpful strategies and avoiding inappropriate or harmful strategies. However, there is limited robust, culturally sensitive evidence informing clinicians about the appropriateness and efficacy of psychological interventions for trans and gender-diverse clients. This forum article argues that the epistemological and ontological frameworks underlying psychotherapies can impact the therapeutic relationship, and are therefore important factors to consider in primary care practice with trans and gender-diverse clients. Our paper synthesises selected psychotherapies into four clusters. Each cluster is accompanied by discussion of the potential or demonstrated benefits and limitations of the underlying framework, in the context of primary care with trans and gender-diverse clients. We also explore power dynamics in therapeutic relationships with trans and gender-diverse clients, and the challenges these factors pose to developing a shared understanding of the client's needs and preferences. The article concludes with some practical considerations for managing these issues in primary care.

Keywords: access, barriers to care, healthcare disparities, health services: needs and demands, mental health, minority health, primary care, quality of health care, transgender.

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Introduction

Trans and gender-diverse (TGD) Australians report disproportionately poor mental health (Strauss *et al.* 2017; Hill *et al.* 2020). This can manifest in complex interactions between harmful sociocultural systems and individual factors such as medical or psychiatric conditions (Riggs and Treharne 2017). Limited availability of robust research on TGD health, particularly regarding outcome evaluation (Budge *et al.* 2017; Catelan *et al.* 2017), limits primary care practitioners' (PCPs) ability to confidently offer culturally sensitive, evidence-based support for TGD clients. Consequently, although primary care seeks to be a site of healing, inequalities persist in access to care and quality of care received (Strauss *et al.* 2017; Bretherton *et al.* 2021).

Background: the inverse care law

Hart's Inverse Care Law posits that populations' access to good health care tends not to match their relative need (Tudor Hart 1971). Understanding how selective redistribution of care affects TGD Australians involves interrogating what their needs are, and what barriers they face in accessibility and appropriateness of care.

Needs

TGD Australians face a range of mental health challenges (Strauss *et al.* 2017; Hill *et al.* 2020), and unique systemic and psychosocial stressors such as cisgenderism that further increase the coping burden of their daily lives (Hendricks and Testa 2012; Riggs and Treharne 2017). These unique stressors can also affect how, and how many, TGD individuals experience non-unique stressors. For example, TGD individuals are more likely than cis individuals to experience houselessness in their lifetime, *and* to find their housing security impacted by direct and indirect socioeconomic effects of transphobic discrimination (Hill *et al.* 2020). Thus, PCPs may find their TGD clients present with unfamiliar concerns *and* familiar conditions with unfamiliar manifestations.

Availability

TGD Australians face direct and indirect barriers to accessing health care at individual and structural levels (Strauss *et al.* 2017; Bretherton *et al.* 2021). Barriers can be significant for gender-affirming care, but TGD individuals with needs as simple as medical certificates must assess the risk of discriminatory or culturally unsafe treatment before they enter the waiting room (Bauer *et al.* 2009; Rosenstreich *et al.* 2011; Strauss *et al.* 2017; Bretherton *et al.* 2021). Such factors deeply influence clients' care-seeking behaviours *and* the types of care they can access (Israel *et al.* 2008; Bauer *et al.* 2009; Rosenstreich *et al.* 2011). PCPs and TGD Australians have consistently advocated to improve training funding and quality, to develop PCPs' cultural competence with lesbian, gay, bisexual, transgender, queer or questioning, intersex and asexual (LGBTQIA+) communities (Rosenstreich *et al.* 2011; Bretherton *et al.* 2021). However, less than half of TGD Australians felt their gender was very respected by mainstream health services in 2019, and uncertainties in assessing the riskiness of different providers persist (Hill *et al.* 2020).

Good care

TGD Australians struggling with mental health may seek support in primary care. The therapeutic relationship is a key determinant of outcomes (Alessi *et al.* 2019), and Australian primary care disciplines generally encourage partnership models of care that focus on strengthening the client–clinician relationship to promote safety and quality of care (Australian Commission on Safety and Quality in Health Care 2017). However, common partnership-building processes can be unhelpful for TGD clients (Budge *et al.* 2017), particularly for those who expect that their experiences and agency will not be validated or respected. Medical systems and psychological interventions bear legacies of social and psychological harm and breaches of trust for TGD clients (Rosenstreich *et al.* 2011; Catelan *et al.* 2017; Riggs *et al.* 2019). The role of medical discourses and the clinical gaze in gatekeeping gender-affirming care and 'authorising' identities can interact with non-medical marginalising structures and narratives to imbue consultations with unspoken power dynamics that influence the meaning of the interaction (Hendricks and Testa 2012; Mizock and Lundquist 2016; Riggs *et al.* 2019). If the client feels their opportunities for self-realisation are held hostage by medical systems, a PCP's attempts to establish mutual understanding through exploratory questions may be received as interrogations undermining the client's reality (Mizock and Lundquist 2016). What is spoken as an offering of partnership may be heard as a threat of invalidation. These unspoken dynamics can pose challenges for PCPs' efforts to build strong therapeutic alliances with TGD clients.

Approaches

The following section describes four key clusters of psychotherapeutic strategies, and illustrates the ontological and epistemological frameworks underpinning their development and implementation. These frameworks contain ideas about the nature of human existence that influence the definitions of 'wellbeing' that inform and complement the goals of associated interventions. A PCP's choice of psychotherapeutic strategy 'says' something about their vision for an ideal life for the client, and about their definition of the client's problem (Fromme 2011). This can interact with what is 'said' by the context of the consultation, generating an undercurrent of meaning amplified by the consultation power dynamics to profoundly influence clients' perceptions of the intended purpose of interventions. PCPs may begin to compensate for these effects in practice by considering these frameworks and undercurrents of meaning when choosing interventions or strategies.

Programming approaches

Programming approaches assume that thoughts and behaviours are learned and can be unlearned, that basic 'adaptive' patterns of cognition or behaviour exist and can be defined and measured, and that behaviours and cognitions are the primary means by which human experience can be measured, understood, and managed (Fromme 2011; Dobson and Dozois 2019). This approach informs psychological interventions including Cognitive Behavioural Therapy (CBT), Mindfulness-Based Cognitive Therapy (MBCT), Dialectical Behaviour Therapy (DBT) and Acceptance and Commitment Therapy (ACT) (Dobson and Dozois 2019).

Programming approaches are underpinned by positivist frameworks and objective monist philosophies, which assume empirical research can produce a universal model of causal relationships underpinning human experience (Fromme 2011). These frameworks, coherent with traditional research methods, have fostered a wide research base for the development of a range of broad and targeted interventions

(Dobson and Dozois 2019). Trans affirmative CBT (Austin *et al.* 2017), for example, adapts traditional CBT techniques to manage specific minority stressors experienced by TGD individuals. The emphasis on targeting specific causal pathways to change clients' cognitions also enables defining specific strategies and skills for clients to practice independently, which can improve self-efficacy (Dobson and Dozois 2019). For example, a trans man may experience temporary amplification of dysphoric distress during pregnancy due to increased vulnerability to transphobic violence targeting visible 'gender incongruence', or due to misgendering in order to access pregnancy-related health services or procedures, or due to embodied aspects of the pregnancy itself (Bauer *et al.* 2009; Rood *et al.* 2016). Successfully independently managing his own distress while navigating such unavoidable situations outside his direct control can be empowering (Dobson and Dozois 2019).

However, this individualistic emphasis casts clients as both the solution to and the site of 'the problem' (Dobson and Dozois 2019). When 'the problem' is the product of marginalising forces, this act of situating 'the problem' within the individual can imply the client is responding to reasonable situations in unreasonable ways, which risks reinforcing internalised stigma (Riggs and Treharne 2017). TGD clients may also feel 'homework' outside consultations burdens them with an impractical responsibility to increase their cognitive load above the excessive load of managing marginalisation (Riggs and Treharne 2017). Furthermore, the objective monist philosophy underpinning Programming strategies can mask the importance of context, and the practitioners' interpretive roles, in categorising behaviours or cognitions (Fromme 2011). Care must be taken to prevent drifting into a didactic 'tutoring' mode (Dobson and Dozois 2019) that can be disempowering to clients, particularly where cisgenderist transnormative disciplinary norms contribute to client–clinician intercultural divides (Bauer *et al.* 2009; Riggs *et al.* 2019).

Systems aproaches

Systems approaches conceive human experiences as structured by interactions and relationships within a complex, multi-level 'system' that includes individuals' biological, physical, and social environments (Fromme 2011; Edwards *et al.* 2019). These interactions can be particularly salient for TGD individuals, whose sociocultural and institutional environments profoundly shape their possibilities for self-realisation and endurance of harm (Riggs and Treharne 2017; Edwards *et al.* 2019). Systems strategies such as interpersonal therapy or family therapy may offer particular benefit for TGD individuals struggling with relational dynamics of social transition or social isolation (Budge 2013; Edwards *et al.* 2019; Barbisan *et al.* 2020).

Family therapies can be complex. Ideal family therapy outcomes develop a family's capacity to cultivate a truly mutually supportive and safe environment, which may involve intervening in harmful caregiver behaviours (Edwards *et al.* 2019; Clark *et al.* 2020). This can be particularly important for TGD youths, who depend on the continual consent of all caregivers until the age of 18 years for access to gender-affirming care (Ouliaris 2022), and who may feel increasingly frustrated, disempowered, and distressed by delays, particularly where pubertal changes exacerbate their dysphoria (Clark *et al.* 2020). The power dynamics of access and refusal embedded in the process of requiring, then working towards, caregiver consensus and consent, implicitly remind young TGD clients that the locus of control over their embodied and gender agency lie wholly within the power of other parties to deny (Strauss *et al.* 2017). Clients may anticipate that PCPs' ability to help is constrained by the gatekeeping requirements of their roles, or may fear that family involvement will increase their vulnerability to transphobic abuse, as family violence is unfortunately common in TGD populations (Strauss *et al.* 2017; Clark *et al.* 2020; Hill *et al.* 2020). Consequently, although some youths may recognise potential benefits to their relationships and long-term wellbeing from family therapy, many are likely to resent the process (Clark *et al.* 2020) or conceive it as a 'test' they must pass in order to access desired interventions. Negative therapeutic interactions may reinforce the association between the role of 'healthcare provider' and 'gatekeeper', which can profoundly damage trust in health professionals and impact clients' future opportunities to develop helpful therapeutic relationships (Budge *et al.* 2017). Thus, systems approaches offer language, techniques and frameworks to support better relationships, but care must be taken to ensure that these benefits are not outweighed in practice by this hostage factor.

Insight approaches

Insight approaches, informed by psychoanalytic or psychodynamic theories, conceive psychopathology as arising from inner conflict or tensions within a layered 'self' (Bloch 1979). Conflicts develop in response to individual experience in the context of their developing personality, causing distress and impeding the individual's ability to manage their feelings, thoughts, actions and relationships (Bloch 1979; Fromme 2011). The 'inner-ness' of these conflicts often renders them difficult to articulate. This necessitates working in levels of abstraction in therapy, considering clients' emotions and actively making links to the client's past in order to construct hypothetical models that may help understand and articulate that inner, unspeakable world (Bloch 1979).

The Insight approach offers tools for leveraging the therapeutic relationship to heal clients' cycles of rupturing relationships. When clients communicate with PCPs in consultations, they share the facts *and* the emotions and expectations they have developed through that journey. 'Transference' tells clinicians about these journeys, as clients

re-enact relational frameworks developed in past relationships (Bloch 1979). TGD clients who have experienced negative therapeutic encounters may expect that their needs for nurturing, empathy, and validation will not be met in therapeutic relationships, or healthcare contexts in general (Mizock and Lundquist 2016; Budge *et al.* 2017). They may participate in communities for developing, sharing, and learning defensive strategies for TGD individuals to navigate hostile social and healthcare systems; this can counterintuitively lead to negative outcomes due to hypervigilance against expected harms if unsupported (Rood *et al.* 2016). Such clients may find it difficult to develop therapeutic relationships due to transference casting new PCPs in an untrustworthy or malicious light.

However, transference also enables good therapeutic relationships to facilitate 'corrective emotional experiences' (Bloch 1979; Fromme 2011). PCPs can compensate for negative experiences by offering a compassionate and forgiving space in which therapeutic relationships are healing and supportive of safe and positive self-exploration (Fromme 2011). This 'good enough' relationship can be extrapolated as a model for future possibilities in clients' relationships with others and themselves (Bloch 1979). Thus, Insight approaches provide a model of experiential learning, in which therapeutic relationships are a place for clients to access, participate in, and practice relationships that disconfirm their previous models and develop their skills for mentalisation and insight.

Practitioners' active roles in interpreting abstract internal experiences pose challenges for psychosocially and culturally safe practice. When conducted safely and purposefully, open-ended self-exploration can empower TGD individuals to affirm an agentic gender expression beyond transnormative determination (Israel *et al.* 2008; Ashley 2019). However, exploration easily becomes invasive when clients resist an interpretation or line of inquiry that the practitioner is invested in or expects the client will eventually 'accept' (Israel *et al.* 2008). This can lead to questioning that inappropriately and harmfully violates clients' boundaries, such as pursuing the 'truth' or 'cause' of a client's identity regardless of its relevance to their presenting concern (Israel *et al.* 2008; Ashley 2019).

Meaning-making approaches

Meaning-making approaches invoke postmodern philosophical theories and ontological paradigms that consider reality to be subjective and changeable, understood only in terms of the ways we make meaning from our experiences (Fromme 2011). The existence of an innate solitary inner self is not assumed; the narratives we tell about ourselves, each other, and the world in which we live provide scaffolding for making meaning (Riggs and Treharne 2017), and the therapeutic relationship becomes a means of negotiating and boundarying on-stage roles to realise offstage needs (Fromme 2011).

These dialectical constructivist frameworks can be helpful for clients who feel they lack the language to describe or interpret their own experiences. LGBTQIA+ populations may face a double alienation: they may not feel aligned with common identity descriptors, may feel aligned to a descriptor but not its interpretation by others, or may feel aligned to multiple identities that others interpret as mutually exclusive (Riggs and Treharne 2017). Unstable access to meaningful narratives around who we are, who we might become, and our place in the world, can result in feeling profoundly lonely, isolated, or adrift.

Primary care, as a place of pattern recognition, can help by offering narratives for the existentially 'lost'. However, PCPs embedded in transnormative, assessment-centric clinical frameworks may struggle to find coherence in some TGD clients' holistic and gendered existences (Ashley 2019). Understanding the postmodern philosophical underpinnings of meaning-making approaches can help clinicians make space for trans creativity (Ashley 2019) by embracing a fluid multiplicity of context-specific existences, co-constructed on the social scaffolding of language and story. Furthermore, the philosophic dialogue with dramaturgy implicitly acknowledges the positionality of clinical roles and how those roles shape the possible scripts that clients can imagine for any healthcare provider (Fromme 2011). This encourages clinicians to think creatively about effective partnership with peer workers to meet clients' needs. Peer workers can offer clients freedom to explore doubt and uncertainty without fear of therapeutic consequences (Strauss *et al.* 2017). Partnering with TGD peer workers with diverse experiences can help clients find or forge a narrative anchor outside of clinical contexts that constrain their possibilities.

Discussion

Thus, psychotherapeutic interventions can involve complex challenges, as the epistemological and ontological frameworks underpinning different approaches can interact with power dynamics and legacies of harm to create undercurrents of meaning in the consultation, setting the scene and defining the boundaries of the therapeutic relationship. The four broad 'approaches' proposed in this article do not indicate divisions in 'types' of practice; rather, we offer them as a framework to support PCPs' consideration of the models, purpose, and meaning of the strategies they use in consultations with TGD clients in order to manage the consultation more effectively, strengthen therapeutic relationships and improve quality of care.

We also offer two key recommendations. First, we recommend partnership with peer workers. TGD clients rely on PCPs' continued support to preserve and facilitate their access to gender-affirming interventions, and may be reluctant to disclose fears, doubts, or uncertainties to PCPs

due to this hostage factor. PCPs might consider partnering with peer workers to promote and protect a space where what needs to be said can be said, where neither client or clinician need be concerned about potential consequences of disclosure. Partnership with a diverse peer workforce can be beneficial in a range of settings (e.g. Treharne *et al.* 2022), provided peer workers have access to appropriate resources (such as support, training, and funding) to support their practice. Second, we recommend considering the vexed questions of public representations within primary care professions, and the possible functions of PCPs' selective disclosure of facets of their 'personal' self (such as experiences or identities) in consultations. Clients enter PCPs' waiting rooms with prior experiences that build certain expectations for what a PCP is and does, and what kind of person they might be. Actions are not perceived 'neutrally' in this space: PCPs cannot extract themselves from these externally imposed representations, but these representations profoundly affect what happens in the consultation. We believe it is reasonable to question the *self*-representations permitted, normalised, or inhibited in primary care professions, and to consider when and how PCPs may draw on their 'selves' in practice (e.g. Baumann *et al.* 2020).

Summary

This article used Hart's Inverse Care Law to briefly highlight the challenges of accessing mental health support through primary care for TGD Australians, and the complex interacting factors that can imbue the therapeutic relationship with unspoken power dynamics. We then proposed a broad framework to support considering how the philosophies underpinning psychotherapeutic strategies communicate associated ideas through the interventions themselves, particularly by shaping possibilities in the consultation for conceiving different 'core problems' and imagining the kind of 'better life' that could be achieved when core problems are appropriately managed. For each 'approach', we outlined how the power dynamics of the consultation and the dialectics of the intervention can interact to produce undercurrents of meaning that shape the consultation, and discussed some challenges of navigating such currents in practice with TGD clients. With these frameworks, and the two recommendations detailed above, we aim to support PCPs in their practice with TGD clients, and through their crucial role in mental health care, to improve TGD Australians' access to quality psychotherapeutic support appropriate for their diverse range of needs.

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