Dr. Lisa Dixon (00:07):

Welcome to our podcast, Psychiatric Services From Pages to Practice. In this podcast, we highlight new research or columns published this month in the Journal of Psychiatric Services. I'm Lisa Dixon, editor of Psychiatric Services. I'm here with podcast editor and my cohost, Josh Berezin.

(00:26):

Hi, Josh.

Dr. Josh Berezin (00:27):

Hi, Lisa.

Dr. Lisa Dixon (00:28):

Today I'm really pleased to introduce our session, in which we're talking with Maggi Price about an article that describes the development of gender-affirming psychotherapy.

Dr. Josh Berezin (00:42):

We're happy to have Dr. Maggi Price, who is an assistant professor at Boston College School of Social Work, come to talk about the paper Gender-Affirming Psychotherapy (GAP): Core Principles and Skills to Reduce the Mental Healthcare Gap for Transgender Youth.

(00:59):

Dr. Price, thank you so much for joining us.

Dr. Maggi Price (01:01):

Thank you for having me.

Dr. Josh Berezin (01:03):

I was noting just before we started recording that we don't actually usually ask our guests about what their pronouns are. I think the paper, for me, obviously wasn't about podcast practices, but I think it did point that out to me. Why don't we start there, with my pronouns are he/him/his. What are yours?

Dr. Maggi Price (01:24):

She/her. Thank you for asking.

Dr. Josh Berezin (01:27):

Tell us a little bit about your professional path, and how it led you to this particular project and this particular paper.

Dr. Maggi Price (01:34):

Absolutely. I'm a licensed counseling psychologist. I currently work as an academic researcher and assistant professor at Boston College. I primarily trained as a child psychologist. I specialize in trauma. And later in my training, got a lot of experience and clinical training in working with transgender youth in particular. Across my training, and later my professional practice as a psychotherapist, I worked in inpatient and outpatient settings. Across these places, I witnessed a multitude of barriers, and heard about all sorts of discrimination happening to my transgender patients.

(02:14):

I should clarify that I am, myself, cisgender. Although I have friends and loved ones who are transgender, I don't have any lived experience myself, so I couldn't draw on that for my clinical practice. I really had to learn about the experiences of transgender folks through training, through my community. And of course, my patients were super informative in that training journey.

(02:38):

For example, when I was working on an inpatient adolescent unit, I was struck by how my patients were mistreated inside the unit. There was one patient that constantly comes to mind when I think about what inspired me to pursue this project, and [inaudible 00:02:54] scope of work, much of which focuses on helping transgender youth. This patient, they were on this unit and they weren't allowed to use the bathroom that aligned with their gender. They just held in their urine all day. Obviously, this created a lot of physical discomfort. Ultimately, they got a UTI because of it.

(03:13):

The reason they weren't allowed to use this bathroom is because of the unit's policy. At the time, I was still a psychology trainee, but I was fortunate to have a really good supervisor. When I asked about these policies, and I asked to advocate for change, ultimately we were able to do so. That gave me the self-efficacy and confidence I needed to pursue this in an academic setting.

(03:37):

Certainly, all of these clinical practice experiences really opened my eyes to the ways that mental healthcare itself can be harmful to transgender patients. A big reason for that is because providers aren't uniformly or universally trained in how to support transgender patients. That really inspired me to define what best practices look like, and then figure out how to disseminate them broadly.

Dr. Josh Berezin (04:05):

That's a great segue towards the paper. I really liked the front section, where you talk about the gap that needs to be filled. You alluded to that a little bit in what you just said. Can you flesh that out a little bit? What is the gap in care here?

Dr. Maggi Price (04:20):

Transgender youth, they face more mental health problems compared to any other health equity population. For example, they're six times more likely to attempt suicide than cisgender youth. Just to be clear, cisgender youth are kids who identify with the sex they were assigned at birth.

(04:37):

Now the reason we have these striking mental health inequities is because transgender youth experience so much discrimination and victimization. The levels of victimization, the severity of this mental health inequity problem is only getting worse as our society becomes more openly intolerant of transgender people, and as policies become more harmful to transgender youth specifically.

(05:01):

Obviously, as providers, we need to help these kids. We know from the research that the best way to do that is to support their gender journey. But how to support that gender journey exactly, meaning what to say, what to do as a clinician in the therapy room, it's rarely something that people are trained in. That's in part because no one, until this study, has really clearly compiled a list of best practices that are comprehensive and actionable. That's why we did this study, to really create a clinician friendly list of

best practices that folks can use with transgender patients. We call that gender-affirming psychotherapy, or the acronym is GAP.

Dr. Josh Berezin (05:47):

All the papers that we talk about on the podcast have really interesting subject matter. That's why we choose them for the podcast. But it's rare, not to throw shade on our former method sections, but it's rare to have a method section that is equally engaging to read in a paper.

(06:05):

Tell us a little bit about-

Dr. Lisa Dixon (06:06):

Now, wait a minute, wait a minute, Josh. Speak for yourself.

Dr. Josh Berezin (06:09):

Yeah, okay.

Dr. Lisa Dixon (06:09):

It's a great method section. But it's a little bit individualized, in terms of one's methodological preferences.

Dr. Josh Berezin (06:21):

Indeed. I will speak for myself. Again, all method sections have been scintillating, but human-centered design really did catch my eye.

(06:32):

What is human-centered design? What are the 10,000-foot basic steps of it? We can get into a little bit more of the details as we go along.

Dr. Maggi Price (06:41):

Yeah. Great question, and thank you for that nice compliment. Human-centered design often, in the layperson world, it's often called user-centered design. It's a really efficient process for solving a problem by collaborating with the people or the humans that are affected by the problem. Usually, this process results in a product or a program that solves the problem.

(07:07):

A lot of businesses use human-centered design. Probably the most famous example of this is the iPhone. Every version of the iPhone is created through human-centered design. Apple works directly with the people using the iPhones to figure out, "How do we improve this thing?" Asking questions like, "What are you thinking when you press that button? What is confusing about that button?" Then they use that information to solve any problems that the humans using iPhones are having.

(07:39):

I chose this method for two reasons. The first is that it's fast. Transgender youth mental health needs are on the rise because of the increasingly intolerant society we live in. I mentioned that. They really need good care, and they needed it yesterday. Human-centered design is both scientifically rigorous and it's efficient. Of course, it was also really important that it's human-centered. As a cisgender person, I

have no idea what is best to do in a therapy room for transgender patients based on my own lived experiences. Even though I might have lots of clinical training and experience doesn't mean I should be creating an intervention for a community that I'm not a part of.

(08:24):

Just like the iPhone, we wanted to create an intervention that was for the humans using it and by the humans that are implicated and affected by it. That's why we centered the needs of those humans. For this particular product, meaning the intervention, the humans that were more relevant were transgender youth, their providers, and transgender youth parents.

Dr. Josh Berezin (08:47):

Lisa, is human-centered design on your radar, as a methods aficionado? I think we've talked on previous papers about some stakeholder, corporation, into even research methods and things like that. Have you heard about human-centered design in the past? Is it gaining traction or have traction?

Dr. Lisa Dixon (09:09):

Yeah. It definitely is emerging as a best best practice. Actually, I think I attended a Grand Rounds, I don't know, something like six months or a year ago, where Pat Areán used human-centered design to develop an intervention. It's out there.

Dr. Josh Berezin (09:28):

Part of the process is there's a very focused literature view, where study of others will develop a framework for an intervention when you're applying this to developing something like a psychotherapy. Then they hone these during a series of focus groups. You were mentioning who some of those stakeholders were.

(09:44):

Tell us a little bit more about those focus groups. Who exactly was in them? How did they work? What questions were being asked and answered? How did they function?

Dr. Maggi Price (09:54):

Yeah, great question. Yeah, that's an excellent summary that you just gave. We started with that scoping review of the literature. It was research and practice-based guidance on best practices that we were reviewing, and coding, and compiling. Then we distilled that literature into a pretty long list of skills and principles. By principles, I mean things that you should know to use the skills.

(10:20):

Then we conducted the focus groups, after we created that list. We presented those focus groups with the list so that they could edit it. That was part of the work that we did with focus groups. We met with focus groups. I think there was 19 in total, over about one year or so. We met, like you said, Josh, with key community stakeholders. That included transgender youth between the ages of 12 and 25, so a pretty large age range. As well as parents of transgender youth. And providers with expertise working with transgender youth, and those who do have any expertise and very little experience working with trans youth.

(11:01):

That last group I mentioned, providers without expertise, they were really key because they were really our target audience, our target users. We wanted to figure out what questions they had about working with this population, what problems have come up when they worked this population, et cetera.

(11:17):

For the kids in the focus group, we asked questions like, "What do you wish your therapist did in therapy? What do you like that your therapist does? What don't you like? What do you wish they wouldn't do?" For the parents, questions like, "What are some problems that have come up with your child's therapist?" In fact, we include all the questions that we asked in the appendix of the paper for any methods nerds that wants to check that out.

(11:44):

Part of the work was asking these semi-structured interview questions. Then part of it was actually live-editing this list that we created based on the literature together during these groups. The final version of that is published in the paper. It's in box one. The stakeholders made lots of great additions to that list. Those are flagged, I think an asterisk, in box one.

(12:09):

The process basically, just to wrap you the methods used piece, since I'm sure we have people interested in the methods who are listening. Between each of these focus groups, my project coordinator and I reviewed our notes and the recordings, and made edits to that list. So that by the time we were done, we had that concrete list that we now call gender-affirming psychotherapy.

Dr. Josh Berezin (12:32):

We definitely point all of our listeners to check out box one in the paper, because there you have it. That's what the product is.

Dr. Maggi Price (12:42):

Yeah.

Dr. Josh Berezin (12:42):

Which is another nice thing about the process that you went through, is you have this very clearly identifiable product at the end of it. The box is organized into 10 different domains. Each domain is listed in order of complexity. Then within each domain, there are key principles and there are key skills associated with them.

(13:05):

Maybe, just to give people a sense of what this looks like, could you go over one or two of the domains to give people a sense of how this looks?

Dr. Maggi Price (13:14):

Absolutely. Yeah. As you said, the intervention or the product, just like a chair, it's pretty concrete. It's really just a list of practices that can be used by literally any mental health provider. It's not specific to psychiatrist, or psychologists, or social workers. It's also not specific to any theoretical orientation or treatment modality. It's just basic things that you can do to modify whatever you're already doing in therapy. What to do, what not to do, and we call them skills in the paper.

(13:47):

As you said, there's 10 domains. Each represent a basic content area, like diagnosis, language to use and avoid, how to help parents be supportive. I'll flag a couple here, just to get into the nitty-gritty and give some concrete examples.

(14:03):

The first one. This one I chose because our provider participants love this one especially. It's our top-rated domain. It's language to use and avoid. It includes really straightforward skills like share your name and pronouns with your patients, just like we did at the beginning of the podcast. Another concrete skill within this domain is mirror the language patients use to describe themselves. For example, if your patient calls themself genderqueer, you should use that term, too.

(14:33):

The second domain I want to highlight, just because I imagine the listeners might be interested in this one, is diagnosis and psychotherapy. It covers some key information about psychotherapy, like how to educate your patients about how anti-transgender discrimination affects their mental health. In the diagnosis realm, it includes information like how to explain the limitations of and uses for the gender dysphoria diagnosis.

(15:04):

For example, this diagnosis is sometimes needed to facilitate other kinds of affirming care for transgender folks. But it could also be stigmatizing for patients to receive this diagnosis. So including that information, as you're talking about the diagnosis with patients, is a key gender-affirming skill.

Dr. Josh Berezin (15:22):

One thing, I was reading this, and there were some things that popped out at me. I was like, "Oh, I would totally remember to do that in every session. That, I've got down." Then as you say, the things at the later end are a little bit more complex. I harken back to my own medical training. When everybody always said, "When you're on the spot, your training will come back to you." That never happened. I would be on the spot, my training would just exit the building. I'd be like, "Okay, training, come on back."

(15:59):

I'm just wondering if you have a higher order, or a couple things that you could pull out that would be key themes, or a therapeutic stance that could reorient someone? And you'd always be on good footing, if you always had these three things in mind.

Dr. Maggi Price (16:21):

Yeah, absolutely. I completely relate to your experience, Josh. I think a good mantra is always useful.

(16:30):

Let me think. I'd say if you're frozen in the therapy room, you have your patient right in front of you, and maybe put this on a sticky note or something, on the other side of the room. But I think the fundamental question is something like, "How can I support this patient's gender journey?" Because the bottom line is support and affirmation. Most of the time, it's doing what you're already doing with any patient. Be empathic, mirroring their language, and letting them lead the way.

(17:04):

Gender-affirming psychotherapy really just highlights the gender part. You empathize with their gender-related feelings and experiences. You mirror your patient's gender-related language. And you let them

tell you what they want. Again, asking both your client and yourself, "How can I support you on your gender journey?" I think that's the mantra.

Dr. Josh Berezin (17:29):

Would it be fair to say it's like just basic therapy best practices, but keeping in mind that the gender aspect might be, and might not be, an incredibly key aspect to why they're there with you, and has a lot of implications for the rest of your work with that person?

Dr. Maggi Price (17:51):

Yeah, exactly. I like that you said it may or may not be why they're there with you. You might have a transgender patient and not know it. They don't need to disclose their identity to you, and it might not be at all relevant. Maybe they're working on grief, maybe they're working on a divorce. They might not want to be talking about their gender experiences.

(18:08):

I think with our young people, it's sometimes more salient because they might be in the process of transitioning, or they might be exploring different gender identities.

Dr. Lisa Dixon (18:17):

I completely understand the notion that the individual may or may not be bringing that problem, or bringing that issue, or addressing that issue be a goal of therapy. But is it sufficiently ... Can you ignore it? Does it make sense that one should explore the possibility that this could be the person's feelings of isolation or discrimination, that those are sufficiently common and ever-present in what we know about people's experience that it would be a mistake to just not even touch on it?

Dr. Maggi Price (19:07):

That's an excellent question. I think something that we include in the principles part of the intervention is this notion of always, no matter what, vocalizing your gender-affirming stance. I think to your point, Lisa, voicing that you understand that discrimination and isolation is ubiquitous among this population can be a really affirming thing to do.

(19:36):

Now the patient can say, either directly or via their behavior, that they don't want to engage in further conversation about that. But indicating to them that you have this knowledge and this understanding is a hugely affirming practice that wasn't endorsed by our community. That's an excellent ... There is a tightrope. I guess, it's a both and.

Dr. Lisa Dixon (20:05):

Yeah.

Dr. Maggi Price (20:06):

That we want to respect patients' autonomy by saying, "You don't have to talk about these things." While also saying, "And we know about these things, and welcome the conversation whenever you're ready to have it, if you're ever ready to have it, or want to have, or would find that beneficial."

Dr. Lisa Dixon (20:22):

One of my favorite things is never say never, and never say always. There are always going to be exceptions, I think, even to the acknowledgement rule, because never say never, and never say always. But what you're saying makes sense to me.

Dr. Josh Berezin (20:38):

Generally, I think people can sense when a provider, or just another person, is comfortable in a space. And that a lot of this work is creating an environment that says, "I am comfortable with this. I want to support you in this," even if you're not saying that explicitly.

(21:02):

But one thing that you bring up in the paper is also that people who have that stance might not be your target audience necessarily, for the intervention. You talk about potentially recruiting providers who are less supportive, or even potentially hostile toward gender-affirming practices. I'm curious about how you envision working towards improving care for people who see those providers?

Dr. Maggi Price (21:31):

Yeah, that's a great question. I'm often in these spaces, like the conversation we're having right now, where I'm preaching to the choir. I'm a gender-affirming provider who's talking to people who are either actively gender-affirming providers, or want to be those people, or want to have those skills. There's a huge gap in my knowledge.

(21:54):

It is something I really want to figure ... I think from a public health standpoint, it is an incredibly important issue to address. Figuring out how do we change the hearts and minds of providers who are living in places where gender-affirming psychotherapy or gender-affirming practices more broadly are hard to find? We know that transgender youth living in a state with hostile environments are less likely to get affirming care. And their mental health, at baseline, is often worse than those living in states that have more affirming policies and community attitudes. It's incredibly important that they get the best care they possibly can.

(22:41):

That is why, in the discussion section, I talk about this. This work that's reflected in the study primarily took place in Massachusetts, where we have supportive laws and generally supportive attitudes. Of course, the reality is that in many states, at least half of the country, there's at least one policy on the books that hurts transgender youth directly, or takes away some fundamental right that they have. I really am trying to figure out how do we get providers in those more resistant areas to adopt gender-affirming psychotherapy.

(23:18):

In our study so far, and this isn't reflected in the paper but it's part of the subsequent work we've done, one of the biggest barriers we've identified is provider bias. No surprise there. We need to address transphobic or anti-transgender bias in providers if we're going to get them to use these practices. We need to reduce that bias, in other words.

Dr. Lisa Dixon (23:40):

One thing that occurs to me, and I have no idea whether this is a reality, but I could imagine in certain communities where the public opinion and perception about gender-affirming practices is that it's bad.

Dr. Maggi Price (23:57):

Yeah.

Dr. Lisa Dixon (23:58):

And that a provider who offers that could even potentially endanger themself, or be shunned, or lose a practice. I don't know how charged this is, but I can imagine it could get very charged.

Dr. Maggi Price (24:15):

Yes. No, that's an excellent point, Lisa. It is charged. Even I get a fair amount of online hate messages, and I'm in a place ... Because I'm accessible online, I get these. I know colleagues of mine, who adjust. They do academic research on these topics, and they deal with so many more threats than I do. I have provider friends who have gotten threats to their life in Connecticut and Massachusetts. In places where you might not be as fearful. It affects us in these more liberal-leaning places. To your point, Lisa, it also is that much harder in these other spots.

Dr. Lisa Dixon (25:03):

Yeah. It's scary. It's scary, trying to do the right thing.

Dr. Maggi Price (25:07):

Yeah, absolutely. Yeah. Not only is it trying to overcome bias, but trying to convince providers that they should be using these practices despite community sentiment. I think there's some misunderstanding among mental health providers, too. That being gender-affirming is against law or policy, when it is not. There are many states that have legal and policy bans on gender-affirming medical care, but not mental healthcare. Really, it's just talk therapy that you're doing, so no one's bothered, at least in my last search on this, I don't believe there's any attempt at banning what mental health providers do in the office. I think sometimes, they might be that they could get in big trouble. Certainly, having a practice shut down seems like a pretty reasonable fear, if you're in a particularly hostile place.

Dr. Josh Berezin (26:03):

As a researcher, what do you envision as a first step? Are you doing more focus groups? Are you doing more qualitative work? You don't have to solve this here on this podcast, but I'm just wondering how you envision a next step for that really tough, tough nut to crack.

Dr. Maggi Price (26:20):

Yeah. No, I'd love to solve this on this podcast if we could. Yeah.

(26:26):

Let's see, our first steps. I just put in a big grant proposal that tries to crack this nut at least a little bit, or make a little divot. As I was recruiting partners for this proposal, I was targeting the South, or regions of the country that have these laws and policies on the books. It was incredibly hard to get anyone in a very, very hostile state to partner. There were some providers who were like, "I'd love to, but the CEO won't sign this letter of support," whatever.

(27:01):

We ended up having to go into the middle area. We have some partners now in the Midwest who've signed on. There's a mix of laws and community attitudes around gender-affirming practices, and

transgender youth more broadly, in those places. I think we're inching our way over. Methodologically, what we've proposed is to take gender-affirming psychotherapy and evaluate it in those places.

(27:30):

Now I should say that a big piece of the larger study that this paper fits within is a large hybrid implementation effectiveness trial that evaluates not just the intervention and its affects on patients, but also the effectiveness of a training program that is associated with this intervention. Basically, it's an eight-hour online, self-paced training that we created through human-centered design, through the exact same methods, with providers that train folks in all the skills in box one. We used a range of behavioral change techniques, which are evidence-based strategies for changing people's behaviors that we know work with providers, too. Target things, like anti-transgender bias, et cetera.

(28:18):

Preliminary results suggest that those techniques are helping and effective for providers in Massachusetts, and places like Massachusetts. But we do not know whether or not they're going to be just as effective in places with more hostile environments, such as our partners in the Midwest. That grant I mentioned that is in the proposal stage, it's under review. Who knows if and when it'll get funded? That's our longterm strategy is taking these products that we've created, and that we have found to be at least preliminarily efficacious, and moving them into more hostile places and doing that human-centered design process over focus groups, using that qualitative work, and efficiently changing the techniques.

(29:05):

For example, in the training program for gender-affirming psychotherapy, we have many patient stories. What we found, and this is consistent with other literature and research on the power of patient stories, is that they can change attitudes. Whether or not those stories need to be changed for different provider populations is a question that we're asking in our future studies. It's possible there's a multitude of other techniques that would be more effective that we need to identify and test.

Dr. Josh Berezin (29:43):

Is that paper about the hybrid implementation out yet?

Dr. Maggi Price (29:47):

No. We are in the final stages of analysis. We just finished data collection a few weeks ago.

Dr. Josh Berezin (29:55):

Well, I, and I'm sure our listeners, are really looking forward to reading that paper and hearing how this intervention operates out in the world. It's really fascinating. Also, a lot of concrete principles and skills for people, just by reading the paper. Thank you so much for joining us.

Dr. Maggi Price (30:16):

Thanks so much. It's been a pleasure talking to you.

(30:19):

One thing I did want to mention before we wrap up is that the training that I mentioned is available online and to the public. Your listeners might be interested in that. It's available at Affirm Lab, which is my research lab at https://www.affirmlab.org/gaptraining. We created a discount code so that folks can get the training and eight CEs for just $100 if they're interested. That code is PSYCHSERV50. That's P-S-Y-

C-H-S-E-R-V 50 if you're interested. People can always email me, I'm very searchable online, if they lose any of that information.

Dr. Josh Berezin (31:05):

Great. Well, we'll post that to the show notes as well. Well, thanks again, so much.

Dr. Lisa Dixon (31:08):

Yeah, thank you.

Dr. Maggi Price (31:09):

Thank you.

Dr. Lisa Dixon (31:10):

Well, that's it for today. Thanks to Aaron van Dorn for mixing and editing, and Demarie Jackson for additional production support. We invite you to visit our website, ps.psychiatryonline.org, to read the article we discussed in this episode as well as other great research. We also welcome your feedback. Please email us at psjournal@psych.org. I'm Lisa Dixon.

Dr. Josh Berezin (31:34):

I'm Josh Berezin.

Dr. Lisa Dixon (31:35):

Thank you for listening. We'll talk to you next time.

Speaker 4 (31:38):

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