Reimagining Schema Therapy: A Queer Approach to Trans and Gender Diversity-Inclusive Practice

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For transgender clients, societal stigma often leads to adverse formative experiences rooted in gender experience and expression, potentially resulting in early maladaptive schemas related to disconnection and rejection. Schema Therapy offers a powerful avenue for healing through emotionally corrective experiences. However, many therapists have not been supported in recognising how social and cultural factors, such as cisgenderism and heteronormativity, impact the therapeutic needs and opportunities for healing when working with marginalised communities. This influence extends well beyond individual and family-of-origin issues. This underrepresentation of LGBTQIA+ therapists may also create therapeutic blind spots and biases, potentially affecting treatment effectiveness. This paper describes the aims and impacts of a half-day Schema Therapy Workshop on adapting the modality for trans clients. The purpose of this workshop was to explore treatment approaches that actively challenge biases and incorporate social and cultural factors into every facet of therapy, from formulation to treatment implementation. This paper reflects on how we aimed to fulfill this purpose, the lessons learned, and potential ways forward by reimagining Schema Therapy through a queer lens to enhance its therapeutic potential in the mental health care of clients with diverse gender identities.

Keywords: Schema Therapy, LGBTQIA+, Transgender, Queering, Minority Stress, Oppression

Queering, or interpreting a theory through a Queer lens, is an active and nuanced process involving the embrace of fluidity and complexity, and the deconstruction of established binaries. It involves disrupting and subverting established norms, fundamentally reshaping societal constructs and establishing space for the acknowledgment and affirmation of marginalised voices and perspectives. It is derived from Queer theory, championed by scholars such as Judith Butler (2006) and Sara Ahmed (2006), which offers a transformative lens through which to scrutinise and challenge normative structures of identity, gender and sexuality.

Schema Therapy, an established psychotherapeutic approach, operates as an integrative framework, incorporating elements from various therapeutic modalities such as Psychodrama, Attachment Theories, Psychodynamic therapies, Cognitive Behavioural Therapy, and Gestalt therapy to tailor interventions to individual needs (Young et al., 2003). It uniquely emphasises attunement to the client's internal reality and encourages therapists to explore their own schema activation. The infusion of a Queer lens into Schema Therapy necessitates a critical examination of societal norms and heteronormative biases, which may contribute to the development and perpetuation of maladaptive schemas within trans clients. In Schema Therapy, maladaptive schemas are viewed as deeply ingrained patterns that develop in response to unmet emotional needs during early life, often leading to difficulties in one's current well-being and relationships. We acknowledge that the term maladaptive, though technical in schema therapy, has historically been used in ways that pathologise the coping strategies of

individuals—particularly those from marginalised communities. In this paper, we use the term with care, referring specifically to patterns that were once protective but may now limit a person's capacity to meet their needs or form fulfilling relationships.

Adapting Schema Therapy through a Queer perspective is an evolution that not only contributes to dismantling historical pathologisation but also propels the field towards more equitable and affirming mental health care practices. While acknowledging the expansive nature of Queer theory, this paper intentionally narrows its focus to the tailored application of Schema Therapy for people of diverse gender identities. Note that we use the term 'trans' as a shorthand for clients who identify as transgender or as people of diverse genders. Transgender and diverse genders encompass all forms of gender identity and expression that differ from cisgender experiences, such as those that differ from the gender assigned at birth. This includes transgender, non-binary, genderqueer, agender, Two Spirit, Sistergirls, Brotherboys, and more. This definition aligns with the guidelines set forth in the American Psychological Association's Sexual Orientation and Gender Diversity research manuscript writing guide (Veldhuis, et al., 2024).

This transformative shift is vividly reflected in a client's articulate testimony: "*It's the first time I've experienced therapy that didn't require me to fit into a preexisting structure. For someone like me, who is nonbinary, there is no social trajectory. So there's something radical about having therapy that can fit around me as I am*," (personal communication, May, 2023). This testimonial not only highlights the promising avenue Queering Schema Therapy presents for addressing issues related to trans clients but also underscores the historical deficiency in explicitly integrating social and cultural factors affecting those subjected to intense marginalisation.

As we delve into reimagining Schema Therapy through a Queer lens and its transformative impact, the potential for significant promise, especially for marginalized clients, becomes apparent. However, within the broader context of mental health, specifically trans experiences, the imperative to confront sanism emerges. Sanism, a pervasive form of discrimination against those with mental health conditions, perpetuates harmful power dynamics and biases in therapeutic spaces.

The discussion led by academics such as Judith Herman (1992; 2023) and Robert Whitaker (2002), as articulated in his book, "Mad in America" emphasises the perpetuation of pathologising clients experiencing mental health issues, deflecting attention from a thorough examination of systemic and structural factors that contribute causally. The medical, legal and social structures have perpetuated prejudice and marginalisation to the extent where gender nonconformity is pathologised and treated as a mental disorder (Lev, 2014). Gatekeeping practices, influenced by sanist attitudes can be seen in cases where trans clients are required to undergo extensive psychological assessments, oftentimes humiliating, and where there is an onus on the person to "prove" that they are trans or maintain a narrative of intense distress in order to access gender affirming interventions. This process can be stigmatising, reinforcing harmful stereotypes and creating additional barriers for trans people seeking affirmation for their gender identity.

In combatting sanism, the integration of trans narratives and voices into mental health training becomes a powerful strategy. Notably, two of the authors of this paper are trans, providing a unique perspective that enriches the discourse and contributes to a more inclusive and informed dialogue.

A supplementary approach to address sanism entails integrating authentic client vignettes that portray the intricate experiences of trans clients, fostering a deeper understanding and compassion among mental health professionals. This practice is exemplified in our workshop, where we incorporate client stories and vignettes reflecting the complexity and intersectionality of identities often held by trans clients. Gender nonconforming poet and

performer Alok Vaid-Menon underscores the importance of shifting the focus from mere comprehension of issues to compassion in discussions about trans rights. Vaid-Menon (2021b) challenges potential allies who, using a lack of understanding as a shield, may refrain from supporting the LGBTQIA+ community, asserting, "Why do you need to understand me to say that I shouldn't be experiencing violence?".

Aligned with Gonzalez's (2018) emphasis, Schema Therapy's primary objective in working with trans clients is to affirm their gender identity—a goal intricately intertwined with the principle of attunement within the Schema Therapy framework. This approach underscores the importance of tailoring therapeutic interventions to align with the client's distinct gender experience.

Workshop Outline

This paper documents a series of workshops conducted by Liu and Callegari (2022, 2023) during the International Society of Schema Therapy Conference in Copenhagen and Melbourne, focusing on the adaptation of Schema Therapy for trans clients. The present paper aims to extend this discourse by outlining training needs and Schema Therapy adaptations for working specifically with trans clients. The workshop covers diverse topics, including: the historical context of engaging with trans clients; the evolution of gender dysphoria as a mental health diagnosis; how to conduct affirming gender history interviews; and the role of trans therapists. To provide further context, the paper delves into the impact of the Minority Stress Model on schema development and offers insights into Schema Therapy strategies when working with trans clients. The inclusion of a vignette illustrating a Schema Therapy formulation enhances practical insights for therapists. The workshop's commencement involved a theatrical role play featuring a "Gender Assessment" session with a fictional trans male client named "Luke Nguyen". This scenario underscores the harm that can arise when therapists lack knowledge or humility, leading to unintended schema triggers. The role play aims to evoke empathy among therapists for the psychological impact of misattunement, highlighting the importance of assessing gender in a consent-based, affirming manner. The subsequent sections elaborate on the workshop's content, shared through training, role play, and discussions with delegates. See Appendix 1 for a transcript of the role play.

Exploring Historical Discrimination against Trans Clients

Following the roleplay, the workshop presenters provide a contextual orientation, underscoring the crucial need to grasp the historical and political backdrop of engaging with trans clients. This awareness emanates from a protracted history marked by the pathologisation, infantilisation, and erosion of autonomy experienced by those identifying as trans. The imperative of Queering Schema Therapy becomes strikingly clear, especially when confronted with the alarming prevalence of mental health issues within the trans community (Nobili et al., 2018; Pinna et al., 2022). Throughout history, Western culture has subjected trans people to pervasive discrimination, characterised by systemic prejudice and societal marginalization (Hughto et al., 2015). Gender nonconformity has been commonly pathologised in medical and psychological realms and labelled as a mental disorder (Lev, 2014). The struggles for recognition, acceptance, and fundamental human rights by trans communities have been formidable, with the lasting legacy of historical discrimination continuing to impact these individuals today.

Pivotal moments, such as the 1969 Stonewall Riots in the United States and the initiation of homosexuality decriminalisation, notably starting with Denmark in 1992, have significantly influenced public perception and advocacy for LGBTQIA+ rights. The pressure on the American Psychiatric Association resulted in the removal of homosexuality from the

Diagnostic and Statistical Manual of Mental Disorders (DSM-III) in 1973, followed by its removal from the International Classification of Diseases (ICD-10) in the 1990s, two decades after the removal from the DSM (Cochran et al., 2014; Drescher & Merlino, 2007). Acceptance of homosexuality and the pace of its depathologisation vary due to diverse cultural, religious, and political contexts across countries. In Australia, the fight for marriage equality gained prominence in the 21st century, with a national postal survey in 2017 resulting in a majority in favour of legalising same-sex marriage.

Despite the aforementioned strides in acknowledging rights for sexual diversity, progress in trans rights specifically has significantly lagged behind. In many countries around the world, including Australia, sterilisation and divorce from preexisting marital relationships are required before trans people can obtain recognition of their gender identity in cardinal identification documents. This is despite the 2006 Yogyakarta Principles (Corrêa & Muntarbhorn, 2007), along with its 2017 supplement (Grinspan et al., 2017), stating that "no one shall be forced to undergo medical procedures, including sex reassignment surgery, sterilisation or hormonal therapy, as a requirement for legal recognition of their gender identity". At the time of writing, the requirements of forced divorce and gender affirmation surgery for official documents to recognise gender identity continues to be addressed across different states in Australia (Human Rights Law Centre, n.d.). Further, nonbinary identity is only acknowledged on birth certificates in a small handful of states.

Historical discrimination against trans individuals continues to impact healthcare today, with cisgenderism creating significant barriers to safe medical access. Cisgenderism refers to a system that privileges cisgender identities and marginalises trans identities, shaping societal norms, institutions, and healthcare settings in ways that create an unequal landscape for trans people (Ansara & Hegarty, 2013). This systemic bias invalidates trans experiences by reinforcing the notion that only cisgender identities are "normal," thereby restricting access to care for those who do not conform to these norms (Newman et al., 2021). Additionally, cisgenderism fuels contentious debates around laws regulating access to gender-affirming treatments, such as hormone therapy for minors, further increasing the stress experienced by those seeking care (Newman et al., 2021). Even in cases where such care is legally accessible, trans individuals face a complex mix of social, financial, and demographic challenges to accessing it, often requiring significant personal effort to secure appropriate support (Newman et al., 2021).

The impact of cisgenderism extends beyond gender-affirming care to general healthcare. For instance, the assumption that only specialist providers should handle gender-affirming care isolates trans healthcare needs from general settings, reinforcing marginalisation (Bartholomaeus et al., 2020). Misconceptions and a lack of information around cervical screening have led to lower screening rates among transmasculine individuals, despite their ongoing risk for cervical cancer (Agénor et al., 2016). Anxiety and fear surrounding these procedures further delay screenings, which is concerning given that most cervical cancer cases in Aotearoa (New Zealand) occur in those who have never been screened or are screened infrequently (Carroll et al., 2023). These barriers contribute to healthcare avoidance, including among transgender cancer survivors, resulting in poorer outcomes compared to cisgender individuals (Lisy et al., 2023; Vermeir et al., 2017). Additionally, there is a lack of research on the risk of cancer in chest tissue and screening recommendations for trans women and men on hormone therapy, as well as trans men who have undergone chest surgery (Braun et al., 2017). Trans individuals often encounter healthcare providers who ask irrelevant questions about their gender, dismissing the potential trauma these conversations can evoke (Newman et al., 2021). Discrimination following the disclosure of their gender identity is also common (Eder & Rizwana, 2023). Trans-inclusive care requires proactively restructuring healthcare systems to address trans patients' needs, not merely "accommodate" them after disclosure (Alpert et al.,

2021). This includes degendering specialty care, applying affirming theoretical frameworks, and ensuring validating, sensitive communication (Alpert et al., 2021; Eder & Rizwana, 2023; Kerr et al., 2020).

History of diagnostic criteria

The DSM serves as a foundational framework in understanding mental health, particularly in the context of gender identity. The evolution from DSM-IV diagnosis of Gender Identity Disorder to the diagnosis of Gender Dysphoria in the DSM-V in 2013 marked a significant improvement. Shifting the focus to Gender Dysphoria emphasised the distress resulting from the incongruence between an individual's gender identity and societal perceptions, steering away from pathologising the identity itself. In a monumental move in 2019, the World Health Organisation (WHO) endorsed two new diagnostic codes for the ICD-11: Gender Incongruence in adults/adolescents and childhood. This endorsement is transformative as it no longer mandates that trans clients demonstrate distress to access gender affirming care. By recognising that mental health issues are appropriately addressed in other ICD-10 codes and are not inherent to the trans experience, this shift challenges the misconception that being trans is synonymous with misery or pathology. This alteration was a game-changer, dismantling a problematic narrative that has been dehumanising and infantilising.

Many working within the trans health and rights space have argued that these changes do not go far enough, as the DSM-V criteria continue to pathologise gender diversity by framing it within a diagnostic category, emphasising distress, and potentially contributing to gatekeeping practices. Critics also highlight the binary understanding of gender that continues to underpin this framing, as well as the use of stigmatising language, advocating for more affirming terminology and the privileging of a patient-centred, informed consent model (Riseman, 2022). However, an understanding of the DSM diagnostic criteria remains crucial, as it is often required in order to access insurance coverage, and gender affirming medical care, including hormone therapy and gender affirming surgeries.

The Psychologist's Role in Trans-Inclusive Care

In the pursuit of fostering a safe therapeutic environment that diverges from perpetuating oppressive dynamics, therapists with cisgender identities need to acknowledge potential blind spots regarding gender that may elude their awareness. This necessitates engaging in a process of Queering their work, involving professional humility and curiosity to scrutinise their own gender training, including societal norms dictating behaviours for boys and girls, as well as the traditional notion of binary genders. During the workshop, delegates are encouraged to explore their gender training through an exercise that prompts them to answer the question: "How do I know what my gender is?" This exercise is adapted from Rochin (1972)'s Heterosexual Questionnaire. Through facilitated discussions, cisgender delegates are encouraged to critically examine how their understanding of their own gender is shaped by how society treats them. This is also based on how their primary and secondary sex characteristics fit with society's expectations of masculinity or femininity. The process aims to deepen their awareness of how society attributes gender to these characteristics. Understanding the limitations of relying solely on these factors is crucial when determining gender for trans clients, highlighting the potential psychological impact when these attributes inaccurately shape the narrative of gender for the clients.

Data on psychologists' gender identity were presented to illustrate the issue, highlighting how inadequate data collection on psychologists' sexual and gender identities impedes a comprehensive understanding. A 2015 American Psychological Association (APA)

survey (*N* = 5325) revealed minimal gender diversity, with only 0.1% identifying as trans (Hamp et al., 2016). In Australia, a 2023/2024 Australian Health Practitioner Regulation Agency (AHPRA) survey with 46 347 psychology registrars similarly found less than 0.1% identifying as indeterminate/intersex/not stated (Psychology Board of Australia, 2023). Limited gender options in surveys, focusing on binary classifications, neglect non-binary and genderqueer clients, perpetuating the invisibility of these groups. A 2021 APA survey indicates a gap in familiarity with trans communities, with only 30% of psychologists reporting familiarity with the needs of trans clients (Chang et al., 2018). The scarcity of quantitative research exacerbates the underrepresentation of gender-diverse therapists and hinders effective cultural competence in treating trans clients, highlighting the urgent need for further exploration in this area (Walch et al., 2020).

The lack of representation of LGBTQIA+ therapists and insufficient understanding of the experiences of LGBTQIA+ clients can result in therapists possessing their own gender bias and a lack of awareness, fostering misattunement. This misattunement, in turn, conveys to the client that their needs are marginalised, portraying them as distinct and estranged from both the healthcare profession and society, consequently leaving them feeling undeserving of understanding or acceptance. This discordant dynamic contradicts the principles of Limited Reparenting, which underscores the therapist's commitment to empathetically attune to the unique needs of the client. Anecdotal complaints from trans clients working with Schema Therapists and general trained mental health practitioners include:

- Therapist holding outdated beliefs such as the idea that issues with parental relationships or trauma as a pathway to diverse gender identity;
- The perpetuation of a singular narrative of being "born in the wrong body," which does not encompass the full range of trans experiences;
- Gatekeeping, which can stem from a therapist's perception that clients are incapable of making decisions about their gender identity due to comorbid conditions such as autism or borderline personality disorder.

In the realm of therapeutic practice, Schema Therapy offers a robust framework enabling therapists to delve into their own schema triggers, especially in the context of gender dynamics, given that each person undergoes unique gender training from birth. This framework proves valuable for comprehending the influence of societal norms and biases on the therapist-client relationship, fostering more attuned and empathetic therapy sessions.

Minority Stress and Mental Health

To grasp the development and persistence of early maladaptive schemas resulting from unique experiences in the childhoods of trans people, the Minority Stress Model proves invaluable. This model reveals the enduring elevated levels of stress arising from prejudice and discrimination faced by marginalised groups, encompassing both distal and proximal stressors (Meyer, 2003). While this model has been instrumental in understanding stressors in marginalised populations, it primarily focuses on sexual minorities and does not sufficiently address unique stressors faced by gender minorities, such as gender-specific victimisation and the non-affirmation of one's gender identity (Testa et al., 2015). In response, Testa et al. (2015) developed the Gender Minority Stress and Resilience Measure, which presents an adaptation of the model that specifically considers these unique gender-related stressors. The internalisation process, influenced by societal factors, underscores the necessity for a social-cultural critic mode within the Schema Therapy model, as advocated by Manktelow (2023). Incorporating such a mode allows both clients and therapists to comprehend the impact of prejudice on schemas, particularly in the context of trans and gender-diverse experiences.

Cardoso et al. (2022)'s notion of the social-cultural critic mode further accentuates the cumulative effects of Minority Stress on gender and sexual minority populations, illustrating the need for tailored therapeutic approaches.

Furthermore, the societal pressure to "pass" as the affirmed gender identity, discussed by Cardoso et al. (2022), poses significant mental health challenges for trans clients, while variations in experiences are observed for non-binary trans clients. For trans people who identify as binary male or female, this can mean adhering to the gender presentation standards that cisgender women and men are held to by society in order to be seen as the gender they identify with, to "pass". The act of "passing" as cisgender frequently entails adhering to heteronormative and patriarchal gender norms, a reality that is inherently problematic and oppressive.

This pressure can have significant impacts on clients' mental health. However, this experience is slightly different for non-binary trans people. There is no societal blueprint dictating how a non-binary person is expected to appear and behave so, for non-binary people, the idea of passing is "unattainable" (Fiani & Han, 2018). Instead of facing the pressures of conforming to a gender expression associated with their identified gender, non-binary people are forced to decide on a preference of being seen as a man or a woman to pass, neither of which reflects their gender identity.

The mental health struggles faced by LGBTQIA+ clients, particularly the trans community, are significantly influenced by the intersection of unmet emotional and sexual developmental needs with societal prejudice and family of origin (the family in which a person is raised and where they spend their early developmental years). Gender incongruence and its influence on personality development are often traced back to adolescence and early childhood, emphasising the importance of early childhood needs such as secure attachment, identity development, and freedom of expression. Research, including studies by Puckett et al. (2019), underscores the impact of family attitudes towards gender identity formation and experiences of rejection during crucial developmental stages on the core emotional needs of trans people. This is echoed in broader discussions such as a podcast with Maurer's (2023).

Childhood experiences for trans clients often involve the enforcement of gender-assigned clothing by caregivers, leading to forceful, shaming, and punitive behaviours associated with critic modes. Media portrayals further exacerbate these challenges by perpetuating harmful stereotypes, contributing to a lasting impact on the development and maintenance of their schemas, as highlighted by Feder (2020). It is also important to understand that family responses to gender nonconformity do not occur in isolation. Parents often express a need to moderate their children's behaviour in an attempt to protect them from societal judgment and potential harm, fearing social repercussions for their children's gender nonconformity. Therefore, examining these factors also involves applying the concept of minority stress to the family network.

This convergence of familial attitudes, societal prejudice, and media representations forms a complex web that significantly affects the mental health and well-being of LGBTQIA+ people, emphasising the need for targeted interventions and societal awareness.

Schema Therapy

Schema Therapy is an integrative model that synthesises elements from various therapeutic approaches, such as Cognitive Behavioural Therapy, Gestalt, Psychoanalysis, and attachment theory. The primary objective of this approach is to address personality disorders and rigid or pervasive life patterns that may not be responsive to conventional treatment methods. The therapy targets early maladaptive schemas (EMS), which can be defined as "self-defeating emotional and cognitive patterns that originate in early development and persist throughout an individual's lifespan" (Young et al., 2003, p. 7). These schemas are believed to

emerge when essential emotional needs, such as acceptance, secure attachment, freedom of expression, autonomy, and play, are consistently unmet during a person's formative years. Considering the considerable societal stigma, familial discomfort, and discrimination faced by many trans clients, a substantial portion of this population undergo adverse formative experiences within their families and peer groups as a result of their gender expression (Bretherton et al., 2021; Casey et al., 2019). Consequently, it is reasonable to anticipate a high prevalence of early maladaptive schemas within this community as identity formation needs may remain largely unaddressed during critical stages of gender identity formation.

Working with schema modes is one of the most effective clinical tools within Schema Therapy (Flanagan et al., 2020; Young et al., 2003). Schema modes refer to the moment-to-moment emotional states and coping responses elicited by specific life situations to which individuals exhibit heightened sensitivity (Edwards, 2022). This is particularly useful when working with clients with an extensive number of schemas. Common modes frequently observed through clinical work with trans clients are described in Table 1.

Table 1

Sample of definitions and observations of modes experienced by trans clients

Modes	Definition and observations
Compliant Surrenderer	Engages in other-oriented compliance to avoid further experiences of rejection.
Detached Self-Soother	Engages in self-harm or excessive drug use to alleviate intense distressing emotions.
Approval Seeker	Amplified gender expression used to seek belonging and shield against feeling not enough.
Aggrandiser	Behaviours entitled, grandiose or status-seeking. An overcompensatory drive for status or specialness to soothe deeper feelings of inadequacy and alienation.
Defective Child	This mode encompasses the distress and pain of rejection from attachment figures, peers or society. It can include feelings of grief and loss.
Angry Child	A deep sense of anger that manifests as a response to societal injustices, unfair treatment, and rejection.
Punitive Critic	Characterised by internalised harsh critical voices based on external experiences of attachment figures, peers and family. It punishes and attacks oneself, resulting in intense feelings of shame, self-loathing, and self-criticism.

Social-Cultural Critic*	This mode is based on the internalisation of societal stigma, oppression, and prejudice, causing the person to assume the oppressive experience is a problem with their own self.

Note. These are standard examples, whereas individual modes are nuanced and developed from the multifaceted intersections of the client's identity and experiences.

* This mode is not included in the commonly accepted theoretical framework of the Schema Therapy Mode model.

The therapeutic strategies of Schema Therapy hold the potential to reconfigure deeply ingrained dysfunctional patterns by altering the neural pathways that encode self-blaming and self-limiting beliefs (Roediger et al., 2018). The approach is characterised by a profound respect for the internal realities of clients, acknowledging that individuals do not engage in dysfunctional behaviours out of manipulative intent. Instead, these behaviours make sense in light of their early formative experiences. Moreover, Schema Therapy encourages therapists to examine their own schema activation when working with clients, which can contribute to a more comprehensive and empathetic therapeutic process (Farrell et al., 2014; Young et al., 2003;). While Schema Therapy traditionally explores family of origin contributions to mental health struggles, the weight of societal stigma needs to be carefully understood in regard to its contribution to schema development and maintenance.

Common Schemas and Their Development

Transitioning to specific schemas observed in trans clients, it is noteworthy that Rahimi et al. (2019) highlight a higher prevalence of maladaptive schemas (Emotional Inhibition and Mistrust/Abuse) among trans men seeking assistance from a medico-legal organisation in Iran. Similarly, Gonzalez (2018) reports significantly elevated endorsement of maladaptive schemas among trans women, particularly within the disconnection and rejection domain. These include schemas related to Emotional Deprivation, Defectiveness/Shame, and Social Isolation, which align with both the authors' clinical observations and the anticipated effects outlined in the Minority Stress Model.

When working with trans clients, it is crucial to consider the prevalent schema maintenance factors that are inherent to the common trans experience. Those who visibly challenge society's gender norms often face persistent danger and exhaustion due to daily encounters with harassment. Alok Vaid-Menon (2021a) powerfully encapsulates this experience: "*I am not a person who is capable of hearing them (transphobic slurs) or being hurt, I am a thing*". This routine harassment frequently escalates into violence and discrimination (Fiani & Han, 2018; Hughto et al., 2015; Millar & Brooks, 2022; Pinna et al., 2022).

Gonzalez (2018) explores the distinction between actual and perceived rejection experienced by trans clients from a schema maintenance perspective. When individuals are aware of society's negative stance towards them, drawn from previous encounters and negative media representations, it can foster an anticipation of rejection, thereby reinforcing dysfunctional patterns of interpersonal interactions. The interplay of discrimination and both experienced and expected rejection further exacerbate the challenges faced by trans clients, leading to reduced access to healthcare, employment opportunities, and the ability to start a family or engage in dating.

How to do Therapy

In therapy with trans clients, it is crucial to recognise that not all trans people seek therapy to discuss gender-related concerns. Clients may come with various intentions, which may or may not include addressing gender dysphoria. Therapists must signal allyship and inclusivity from the beginning by engaging in practices such as using intake forms that encompass all genders/pronouns and appropriately using gender affirming language. If therapy involves addressing gender dysphoria, the therapist should assess the client's gender history, which may involve exploring family dynamics, parental responses to gender non-conformity, and societal pressures and expectations. This process may also involve examining how parental performance of gender roles, cultural influences, and the client's experience of gender history all contribute to their schema and mode formation. The therapist should collaboratively explore how the client's needs for gender identity formation have been met or unmet by family, peers, and societal expectations. This comprehensive approach allows therapists to address the intricacies of gender identity within the broader context of the client's life.

Conducting Gender History Interviews

When inquiring about gender development history, it is crucial for therapists to have the utmost respect for the client's subjective report. This approach aims to prevent any undue pressure, whether overt or covert, on the client to prove their trans identity before they can receive gender-affirming care (Chang et al., 2018). Recognising the implicit assumptions behind questions that suggest a single, predefined path to being trans is crucial. For instance, inquiries such as "when did you first know you are trans" or "what toys did you play with as a child" employed as evaluative tools place the onus on the client to validate their trans identity.

In fostering a supportive therapeutic environment, discussions between therapists and clients are vital for assessing progress in social or physical transitions. Exploring the advantages and disadvantages of transitioning helps raise awareness of psycho-social impacts, while goal setting involves evaluating realistic objectives and potential body image concerns. Additionally, the therapist should explore aspects of the client's self or body that align or misalign with their gender identity, addressing associated distress. The therapist's role is pivotal in addressing isolation by assessing the attitudes of family, peers, and the community, and establishing essential support networks.

At this stage, delving into the correlations between a client's gender history and their early childhood experiences proves advantageous within the framework of Schema Therapy. Through an examination of family, peer, and community responses to the client's gender identity and roles, crucial connections emerge, shedding light on whether their core emotional needs in the process of gender identity formation were fulfilled or neglected within familial, peer, and societal contexts.

Highlighting the impact of social experiences on gender-related schema development is crucial, given that Schema Therapy tends to emphasise narratives formed within family contexts where needs may be inadequately addressed. Failing to underscore the influence of society might inadvertently perpetuate the misconception that distress experienced by trans clients solely stems from parental non-acceptance. It is imperative to recognise the broader reality that societal structures, deeply ingrained in patriarchal gender binary roles, contribute to challenges and distress for a wide spectrum of individuals (Manktelow, 2023). This approach facilitates a more holistic comprehension of the client's internalised beliefs and memories linked to gender formation, laying the foundation for precise and targeted interventions. See Appendix 2 for a list of useful questions for exploring gender identity and development.

Schema Therapy Interventions

Limited Reparenting sentiments

Limited reparenting within the framework of Schema Therapy involves therapists assuming the role of gender-affirming, healthy adult figures for clients, facilitating the internalisation of nurturing support to address unmet emotional needs and foster healthier coping mechanisms. Hence, therapists must take on a role similar to that of an elder, demonstrating the ability to offer personalised therapeutic care, advocate for clients in external interactions, and identify/address instances of transphobia in society affecting their well-being. This approach is crucial when working with trans clients, helping navigate and heal potential emotional challenges tied to identity development and societal norms. See Table 2 for ideas of Limited Reparenting strategies for Gender Affirming Care.

Table 2

Limited Reparenting and Gender Affirming care.

Core Emotional Needs	Ideas of how they can be met in the therapy context
Safety Nurturance, and Acceptance	Advocate for the client and provide ongoing support to counter minority stress, rejection, and alienation. Encourage connection to social groups to reduce social isolation.
Sense of Identity	See the client in the gender they identify with, take delight in their development, and celebrate milestones in their transition journey.
Encouraging and Development of a Holistic Sense of Self	Encourage the client to see themselves through a range of identities, including abilities, culture, profession, interests, etc.
Freedom to Express Valid Needs and Emotions	Validate experiences of minority stress and transphobia, messages of shame or alienation.
Spontaneity and Play	Explore and encourage playfulness with gender, facilitate connection to accepting communities, and where appropriate, reduce hypervigilance.

The minority stress model (Meyer, 2003), particularly in its adapted form for trans clients (Testa et al., 2015), emphasises the importance of resilience factors. Highlighting pride, celebration, and community connection serves as a powerful antidote to counteract the pervasive influence of critical messages. Focusing deliberately on these aspects in therapy can be transformative, helping clients overcome internalised criticism and fostering a healthier, more resilient self-perception. Clients navigating identity challenges benefit greatly from explicit affirmation of their achievements and unique qualities. When confronting the social-cultural critic, a reparenting message can address the irrationality of cisnormative assumptions. For example, therapists might say, “I understand that you think there’s a ‘normal’ way to be, but ‘normal’ is just a setting on a dishwasher. We can be different and still be accepted. We don’t need to be the same to deserve respect and acceptance” (Liu & Callegari, 2022; 2023).

Imagery Rescripting

In the context of therapeutic practice, psychoeducation plays a crucial role in providing a framework for experiential work, particularly when engaging in imagery exercises. It is of utmost importance to approach the discussion of the Vulnerable Child Mode (VCM) with sensitivity, as clients may have varied reactions or feelings when contemplating their younger selves. Some individuals might experience dysphoria when connecting with their past, necessitating caution in selecting appropriate pronouns and names when referencing this aspect of the client. For instance, therapists may inquire about the client's preferred terms, using questions such as, "If we were to explore this side of you, how best should we refer to it?" or addressing potential gender-related concerns with statements such as, "I'm aware that when you were younger, people referred to you with a different gender pronoun and name. How would you like me to refer to this side of you now?" Offering examples such as "Little X," "Lonely X," "Insecure X," or "Little (chosen name)" can provide a starting point for this exploration.

Connecting with the VCM poses a significant challenge for some clients, emphasising the importance of establishing a secure imagery foundation, akin to all imagery work. To enhance therapeutic outcomes, creating a safe image is crucial, with an early introduction in therapy and encouragement for clients to independently visualise the safe image between sessions. A gradual approach to engaging with the VCM may involve experimenting with proximity, such as viewing it from a distance, employing another child or an animal for empathy, and customising the image to evoke feelings of safety and acceptance. Clinical observations suggest that while many clients find working with their VCM manageable, those facing difficulties often exhibit stronger dysphoria, possibly linked to trauma. The concept of the "Window of Tolerance," defining the optimal state of arousal for clients to function effectively, becomes paramount in trauma processing. Strategies include mindful observation of hyperarousal and hypoarousal, along with teaching resourcing and grounding techniques for clients to practice independently, such as deep breathing and positive event statements. These efforts aim to modulate arousal levels and keep clients within their therapeutic "Window of Tolerance."

The Magic Mirror Technique

This is an approach for introducing and engaging with both the VCM and the Happy Child Mode (HCM) in imagery work. The process involves several steps, starting with the establishment of a safe image. The client is then guided to visualise their VCM standing alone in front of a full-length mirror, exploring thoughts and feelings associated with their reflection. The therapist prompts the client to imagine their preferred reflection, guiding the transformation of the image based on the client's wishes. This preferred reflection often manifests as the HCM. The client is then encouraged to imagine interacting and playing with their happy child, exploring associated thoughts and feelings. It is noted that some clients may respond negatively, activating critical modes, and therapists are advised to explore and address these reactions to ensure a constructive therapeutic experience. Additionally, if the client's critic is identified, the therapist can integrate them into the imagery, assessing their response to the VCM/HCM interaction and, if necessary, providing limited re-parenting to protect the VCM. Chair work outside of imagery can also be employed to address the critic and distinguish whether it represents an attachment figure or a social-cultural critic, or both. Refer to the Troubleshooting section of this article if the client expresses grief and regret that "it didn't happen".

The Love Posse Technique

This is another approach in imagery work. This multi-step process can be implemented as a float back (utilising an emotion bridge based on the prevailing negative affect in a current trigger) or a memory associated with schemas of social isolation, emotional deprivation, or defectiveness. For instance, a client may float back to a memory in a classroom where they experienced isolation and humiliation due to their gender expression. Subsequently, the client is prompted to imagine their current "chosen family" of peers and key figures, either in child or adult form based on their preference, acting as a Love Posse. This Love Posse serves to embrace, celebrate, and heal messages of rejection and social ostracism related to their childhood traits, gender identity, or expression. The therapist encourages the client to interact with their HCM, allowing playful or sassy responses to the antagonists in the imagery. The Love Posse, characterised by love and playfulness, can then lead the client into a new desired scene, whether it be a peaceful natural setting, a Pride or Mardi Gras Parade rally, and so on. The therapist can further guide the client to envision their body as it should be, feeling free and moving with ease, surrounded by the supportive Love Posse. They can dance to the beat of their favourite anthem, frolic in nature, and ultimately be seen and loved for who they are.

Chairwork for Gender-Related Dilemmas: Polarity Dialogues/Decision-Making

Chairwork can be understood as an experiential technique, as used in Schema Therapy, or as a standalone psychotherapeutic modality. It involves patients (a) imagining someone from their past, present, or future in an empty chair and speaking to them, or (b) using multiple chairs to give voice to different parts of the self and have dialogues among and between them (Kellogg & Garcia Torres, 2021).

Chairwork is suited for working through inner conflicts. Utilising an Internal Dialogues structure, or polarity dialogues (Zinker, 1978), we can set up dialogues located within the healthy adult mode, so individuals identify the values driving their dilemma (Kellogg & Garcia Torres, 2021). For a client struggling with a decision to pursue gender affirming surgery, we would use two chairs setup across from each other, and the patient would speak freely from each perspective: "I want surgery, I want to embrace who I am," or "I worked hard for some stability, I want to maintain the status quo." As they move back and forth between the chairs, we would encourage the client to speak from their heart; what are their desires, fears, and values? In the next rounds, each side would directly engage with each other: "I hear what you are saying, but I want to be at home in my body. I want surgery." The therapist should also allow for exploration of the consequences of each decision: "I understand the family will be upset; however, I refuse to live my entire life in anguish. I choose my well-being. I choose surgery." After shuttling between the chairs a few times, the client would stand in the centre of the chairs to assess the split of their decision and identify how they may want to move forward (Kellogg & Garcia Torres, 2021).

How to do a Schema Therapy Case Formulation

The following is an example of a Schema Therapy case formulation that encapsulates the social-cultural critic mode using a case vignette of a fictional client mentioned earlier, "Luke Nguyen".

Luke is a 30-year-old trans masc nonbinary person, presenting with social anxiety and using they/he pronouns. They socially transitioned five years ago and started taking testosterone. Luke underwent assessment through the World Professional Association for Transgender Health (WPATH) with a psychiatrist in order to access top surgery, and this significantly reduced his gender dysphoria. While satisfied with the surgical outcome, Luke reports increased discomfort in social environments dominated by cisgender men, often

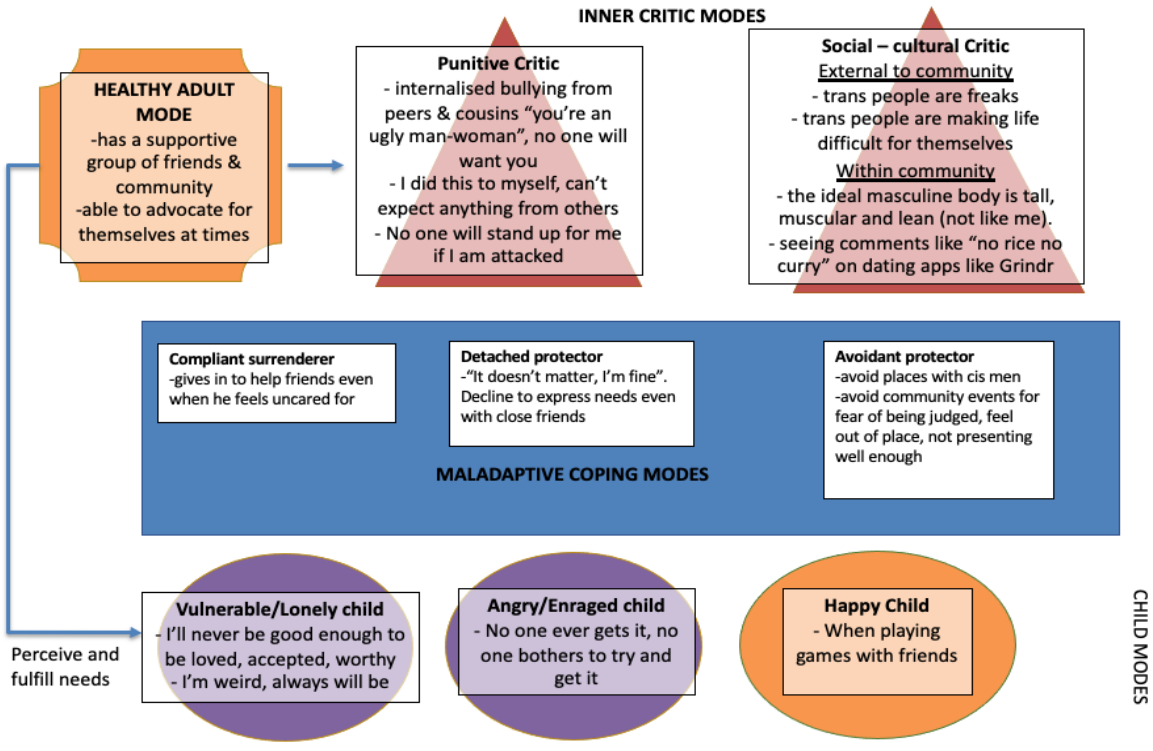
experiencing heightened anxiety in such settings. These experiences contribute to feelings of unattractiveness and self-doubt in the realm of dating.

Luke's parents moved to Australia as refugees from Vietnam and worked long hours in order to provide for necessities and to support Luke in accessing higher education. Luke grew up amongst a large extended family and community where they were raised in Western Sydney. This has influenced his approach to managing his gender expression, particularly during family visits, where he makes efforts to minimise his masculinity. Luke's family adopts a "don't ask, don't tell" stance on his pansexual and trans identity, a dynamic that allows Luke to maintain some cultural connection while generating internal conflict and internalised transphobia. The community relocated to Australia during the 1980s and 1990s, aligning with a substantial influx of Vietnamese migrants. This period, marked by a significant wave of migration following the Vietnam War, also coincided with heightened incidents of racism and increased political commentary regarding their settlement in Sydney, Australia.

Luke's schemas include: Defectiveness, Emotional Deprivation, Social Alienation, Mistrust/Abuse, Punitiveness and Self-Sacrifice. A Schema Therapy formulation is seen in Figure 1.

Figure 1

Schema Therapy formulation for "Luke Nguyen"



Troubleshooting: When Experiential Exercises do not Work

The following section provides a troubleshoot guide on how to address common issues that come up during Schema Therapy interventions.

"It didn't happen."

Therapists often encounter challenges when clients express confusion or disbelief after what appears to be a successful imagery rescripting session, stating, "but it didn't happen." When engaging in rescripting for childhood trauma, it is crucial to consistently remind the client of the purpose of Imagery Rescripting—to address the unmet needs that have led to the persistence of psychological and somatic effects associated with unresolved trauma. This process facilitates the child part feeling cared for and nurtured.

Grief

Clients may subsequently experience grief for a range of gender related issues. For example, they may feel regret and grief that they were not able to pursue gender affirmation earlier, resulting in the development of secondary sex characteristics aligned with their assigned gender at birth, which can impact their ability to pass. In such instances, it is crucial to acknowledge the injustice and normalise these wishes, saying, for example, "Of course, you want that. I know it means the world, and it's so sad and unfair that it didn't happen earlier." Providing the client with adequate time to grieve is essential. Subsequently, encouraging the Healthy Adult Mode to reflect on the progress made since the childhood period when these schemas were initially formed becomes an important therapeutic step.

Client becomes self-critical or avoidant

When working with clients who have experienced multiple and complex traumas, encountering strong internalised critics and coping modes during experiential exercises is common. This may lead to the perception that experiential exercises simply "don't work." To address this, it is crucial to identify and label the critic or coping mode, understand its function, and effectively work to bypass it. Sometimes, the focus of experiential work may need to shift to specifically target the mode that keeps surfacing and interrupting the exercise (Farrell et al., 2012; Roediger et al., 2018). During rescripting, therapists should be vigilant for signs of the client's helplessness, unrealistic expectations, or harshness toward their emotional side. If the client lacks a robust Healthy Adult mode, it may take them some time to develop one and become capable of self-rescripting. In such cases, the therapist can actively enter the image each time to facilitate the rescripting, providing a gradual process for the development of the Healthy Adult mode.

Discussion

The introduction of this paper set the stage by presenting the transformative process of Queering Schema Therapy, grounded in Queer theory principles, and then moved to address the imperative of confronting sanism within the broader mental health context, with a particular focus on transgender experiences. This paper offered a comprehensive exploration of historical and political contexts, emphasising the legacy of discrimination and pathologisation experienced by the trans community. The authors contribute to a transformative shift in mental health practices by emphasising the importance of tailoring interventions to align with the unique gender experiences of clients outside the cisgender spectrum. Overall, the paper adds valuable insights and tools to the ongoing discourse on Queering mental health practices and

Schema Therapy, addressing a critical gap in understanding and affirming the mental health needs of trans communities.

Reflections on the Workshop: What Was Delivered and What Was Learned

The workshop delegates displayed active support and enthusiasm to learn and adapt Schema Therapy to be more gender-affirming. However, there was noticeable passive agreement, prompting questions about whether some delegates hesitated to inquire due to politeness, fear of appearing ignorant, or concerns about judgment. Critiquing one's own gender training is complex and ongoing, given the pervasive cisnormative assumptions ingrained in society. The authors hope this paper will initiate a broader discussion within the schema therapy community.

While most attendees were motivated to learn and gain information, it is conceivable that those with the least awareness of their own gender bias might not have been interested in attending. This raises the possibility that those who would benefit the most from such training may not have been present.

The significant emotional labour involved in creating and delivering this work is noteworthy, particularly in its impact on presenters with marginalised identities. The emotional intensity and the potential for retraumatisation underscore the challenges of addressing these issues. For presenters who identify as trans, there is an additional burden of presenting information for training, facilitating discussions on sensitive topics, and handling potentially inflammatory questions. This demands active engagement from both personal and professional selves, necessitating considerable vulnerability.

Additionally, there is a need to explore whether there are additional measures to foster a more inclusive and supportive environment for Queer therapists and ways to amplify their voices. Presently, there is a Gender and Sexuality Special Interest Group within the International Society of Scheme Therapy (ISST), and efforts are being made to include assessments of gender and sexuality within the Schema Therapy conceptualisation form (personal communication, 2023). Suggestions were also made to the ISST board members to improve the way that Schema Therapy training is delivered to improve accessibility. Whether these measures are deemed sufficient and whether they will be implemented remains to be seen.

The exploration of the necessity for clinicians to grant themselves the freedom to continuously adapt and personalise their approach, or the Schema Therapy model itself, to better serve the trans community is a crucial consideration. This resonates with the fluidity and spaciousness discussed in the introductory definition of Queering. The ongoing commitment to adaptability and personalisation is vital for clinicians to stay attuned to the evolving needs of the trans community and ensure that therapeutic practices remain affirming and responsive to individual experiences.

Limitations

A key limitation is the current lack of empirical research specifically examining the efficacy and mechanisms underlying the adaptations of Schema Therapy described in this paper. Without robust studies disentangling its various components, our understanding remains preliminary. This gap is further compounded by the inherent difficulties of conducting such research, including the challenges of operationalising and measuring its underlying drivers.

The paper makes a concerted effort to enhance the accessibility of therapy for trans clients by encouraging therapists to deepen their understanding of gender identity and critically examine their own relationships with gender. While the workshop provides valuable initial steps, it is important to acknowledge that developing a nuanced understanding of gender identity is a complex and ongoing process. Expecting cisgender therapists to fully grasp these complexities in a short time frame is unrealistic. Additionally, the feasibility of implementing

this approach may be limited by varying levels of competency, familiarity with queer theory, and access to resources across different clinical settings.

Although the approach centres on perspectives from LGBTQIA+ therapists, the notable underrepresentation of these therapists in the field may restrict the diversity of insights. This limitation could lead to an oversimplified, one-size-fits-all model that fails to address the full spectrum of gender-diverse experiences. Therapists must navigate these challenges carefully to avoid imposing personal beliefs or inadvertently steering therapy toward a particular socio-political agenda. While the workshop promotes individualised care, it may still fall short in accounting for the vast diversity within trans experiences. Therefore, the authors emphasise the need for ongoing, comprehensive education and self-reflection beyond the workshop itself.

Implications for Practice

Incorporating a queer lens into Schema Therapy empowers LGBTQIA+ therapists to challenge traditional therapeutic norms and adopt approaches that more accurately reflect the diverse experiences of their clients. This model can extend beyond Schema Therapy, benefiting LGBTQIA+ practitioners in various mental health, medical, or allied health fields. By identifying systemic issues—such as cisnormativity and heteronormativity—therapists can recognise how the marginalisation their clients experience in society is often reflected within professional therapeutic environments. This not only validates the lived experiences of clients but also affirms the therapist's own identity within their field. In "queering" their profession, therapists are actively creating more inclusive and affirming spaces, not just for their clients but also for themselves. This approach emphasises resilience, pride, and community connection, moving beyond a sole focus on healing individual schemas. By adapting Schema Therapy in ways that honour the multifaceted experiences of individuals with diverse genders, LGBTQIA+ therapists can model authentic engagement and empathy, thereby playing a pivotal role in promoting health outcomes that transcend traditional, often limiting, therapeutic practices.

Future Directions

Artificial Intelligence

A potential future direction for the study involves exploring the integration of technology and artificial intelligence (AI) into Schema Therapy interventions, particularly in conjunction with imagery rescripting. For example, incorporating AI to feminise or masculinise images of their child selves may provide a more realistic and affirming experience during rescripting. Online graphic design tools such as CANVA, which can already modify hairstyles and clothing based on text descriptions, exemplify the existing capabilities that could be harnessed for this purpose.

Autism

Emerging research highlights the intersectional phenomenon of the high proportion of trans clients who are also Autistic. Trans clients are 3.03 to 6.36 times more likely to be autistic than cisgender clients (Strang et al., 2023; Warrier et al., 2020). Autistic trans clients report elevated distress due to discrimination targeting both their gender and neurotype, along with challenges arising from the confluence of these identities (Cooper et al., 2022; Strang et al., 2023; Warrier et al., 2020). For example, Autistic clients navigating gender transitions and therapy may encounter additional barriers and challenges related to sensory processing differences and needs for routine and consistency (Cooper et al., 2022). Acknowledging the diversity within the autistic community and adopting a personalised, patient-centric approach

is vital to improve the accessibility of imagery rescripting for autistic clients (Cooper et al., 2018). See Neurodiversity Affirming Schema Therapy Model for more in-depth discussion (DeCicco et al., 2023).

Intersectionality with Race

Recognition of the intersecting identities of each trans client is crucial for comprehending their unique gender journey and understanding the profound impact on their psychological well-being and encounters with discrimination. The experiences of societal discrimination faced by trans clients, particularly those who also belong to marginalised racial or ethnic groups, are multifaceted (Chang et al., 2018; Levitt & Ippolito, 2014; Millar & Brooks, 2022). The trajectory of impact differs from common expectations, as clients with marginalized racial identities reported fewer cases of gender-related discrimination than their white counterparts (Biello & Hughto, 2021). Whether this is attributed to racial minorities developing resilience through lifelong experiences as minorities or finding cultural connections as a form of resilience needs further exploration.

Moreover, research indicates that Black and Indigenous trans people of colour often encounter less familial acceptance than their white counterparts (Levitt & Ippolito, 2014; Millar & Brooks, 2022). As highlighted earlier, the lack of familial acceptance can significantly impact schema development. An Australian study analysing experiences of First Nations Sistergirls and Brotherboys talks about the unique challenge of navigating racism in queer spaces and transphobia within traditional Indigenous communities (Kerry, 2014). Understanding the intricate interplay of these intersecting factors in schema development is paramount for tailoring Schema Therapy effectively to clients who are not part of the dominant structure, whether it is cis and heteronormative, colonial, ableist, classist, ageist, or influenced by religious hegemony.

Final word

Pilkington et al. (2023), acknowledge that the Schema Therapy model, focusing solely on childhood unmet needs, is theoretical and untested. Hence, we need to explore the various factors, such as culture, society, and laws, that may also contribute to the development of schemas. A more comprehensive understanding of these influences is crucial to developing a therapy framework that does not inadvertently perpetuate systems of oppression. A therapeutic environment that fosters safety and trust is one that consciously avoids replicating the oppressive dynamics of the external world.

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Appendix 1

Transcript of Role Play with Luke Nguyen

Child Modes: Vulnerable Child Mode (VCM) & Angry Child Mode (ACM)

Coping Mode: Detached Protector Mode (DPM)

Critic Mode: Punitive Critic Mode (PCM) and Socio-cultural Critic Mode (SCM)

Therapist: Hi, my name is Ben and I'm a Clinical Psychologists. Have you spoken with a Psychologist before in the past?

Luke: No, I've only seen a Psychiatrist.

Therapist: Ah I see, and what did you see the Psychiatrist for?

Luke: I had to have a mental health assessment so that I could get top surgery a few years ago.

Therapist: Top surgery?

Luke: Yeah, chest surgery?

Therapist: Oh so you had your breasts removed?

Luke: Yeah that's what top surgery is.

Therapist: Of course. Ok so I see you like to go by the name Luke is that correct?

Luke: Yes, that's my name.

Therapist: I see, but I see that Melissa is your real name, is that right?

Luke: No that's my deadname.

Therapist: Oh, I've not heard that term before, that's an interesting way of referring to your name. How long have you gone by the name Luke?

Luke: (Looking uncomfortable) … ah since I was in my early 20's I suppose.

Therapist: Ah that's a long time. And does everyone call you Luke?

Luke: Well people who know me do, but I often get misgendered.

Therapist: You mean people still think you're female?

Luke: Yes, it really upsets me.

Therapist: In what way does it upset you?

Luke: I'm not female… I'm non-binary.

Therapist: I've heard of Nonbinary, it's everywhere these days. Especially social media.

Luke: I don't really want to talk about this.

Therapist: So this sounds like a challenging topic to discuss. I noticed you kind of shut down a little, and stopped wanting to talk about it. Does that happen to you a lot?

Luke: I don't know.

Therapist: Have you thought about what top surgery will mean if you ever want to have a baby? That's one of the questions you're supposed to think about when you transition no?

Luke: (ACM) That's not why I'm here today.

Therapist: Well maybe your anxiety is related to your gender issues.

Luke: (ACM) (so triggered, unable to speak, breathing quickly)

Therapist: I can see that there's anger there, and it's not unhealthy. We want therapy to be a place where you can explore the anger because what happens here in the room is always happening in the outside world. We can prepare you for dealing with things better in the world. (smiles benevolently)

Luke: (DPM) I don't think this is very helpful.

Therapist: Ok, how about we just pause for a moment (a little awkward, unsure how to proceed as the client is so closed). I see in your referral that you're having issues with social anxiety. Do these same emotions impact you socially do you think?

Luke: (DPM) Probably, I don't know.

Therapist: Maybe we should try and understand your anxiety a little better, I'm curious about your insights… Are you anxious in all social contexts?

Luke: No, mostly around cis-man.

Therapist: Oh, dear there's another word I've not come across before. What's a cis - man?

Luke: (ACM) Really? A birth assigned a male who identifies as a male. Like you.

Therapist: Ah I see. So, when you're around men… sorry, cis-men, you feel anxious. What is it about cis-men that makes you anxious.

Luke: (DPM: long pause) I just don't feel comfortable, I don't know.

Therapist: Well, I imagine a lot of cis-men and women don't know what non-binary means either, is that true? That must be hard. (let's give the therapist a point for trying, as the intention is good)

Luke: (PCM) Nobody knows, nobody cares, everyone thinks I'm a freak.

Therapist: That seems a bit harsh, I don't think you're a freak.

Luke: (ACM) You don't know me, you're like everyone else no clue. (DPM) I don't think this is helping me.

Therapist: So, there's a part of you that thinks you're a freak?

Luke: (DPM) Sure, yeah, a part of me sure.

Therapist: That must be difficult to hear your mind tell you that you're a freak and that no one has a clue about you?

Luke: (DPM) I'm used to it.

- END -

Appendix 2

Useful Questions for Exploring Gender Identity and Development

How would you describe your current gender identity?

When do you first start identifying this way?

What has helped you work out your gender identity so far? What's made it hard?

What's made you want to present for support/help now?

What was your experience with gender like in your childhood and adolescence?

If you've disclosed your gender ID to anyone, who have you told? Is there anyone you haven't yet told that you'd like to? What's made disclosure hard so far?

Do you have a good sense of your preferred gender expression?

Have you noticed an increased connection or comfort with your sexuality when you present in a more gender-congruent manner?

What have you done already to move yourself towards your preferred gender expression?

Do you have much social connection with other trans people or allies?

What aspects of your physical body are aligned with your preferred gender identity?

What aspects of your physical body are not aligned with your preferred gender identity?

Do you experience any distress associated with your body? How do you feel when you see your body naked?

What are your goals with respect to gender transition?

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Written in 2023 and published in 2025, this paper should be read with the recognition that both the field and the social- political context are continually evolving.

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Author Biographies

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Dr. Xi Liu (they/them) is a Clinical Psychologist, Advanced Schema Therapist, Supervisor, and Trainer. Their passion lies in working with clients from LGBTQIA+ and historically marginalized communities, addressing topics such as grief, trauma, and various mental health concerns. Xi is actively engaged in providing training and supervision sessions throughout Australia and Asia, and they have presented at conferences both nationally and internationally. Additionally, they serve as an Adjunct Lecturer at the University of New South Wales and the Australian Catholic University, where they contribute expertise in Online Therapy and Schema Therapy. Xi is a co-founder of the SchemX Collective, a dedicated community of therapists committed to exploring the impact of, and treatment possibilities for, trauma stemming from oppression and marginalization.

Isis Yager

Isis Yager (he/him) is an undergraduate psychology student at Macquarie University. He is interested in clinical psychology and social psychology, and expanding the discipline to be more inclusive of minority groups previously underrepresented in psychological research.

Amanda Garcia Torres

Amanda Garcia Torres (she/her) is a certified Chairwork Psychotherapist and trained Voice Dialogue Practitioner. She received her Master's Degree in Counseling for Mental Health and Wellness from New York University in 2014. Ms. Garcia Torres began her study of Chairwork in 2013 and completed her Chairwork Psychotherapy certification in 2019. In the same year, she also formally joined The Transformational Chairwork Psychotherapy Project as a Trainer. In 2020, Ms. Garcia Torres became Co-Director of Training at TCPP. She currently teaches and shares her Chairwork Psychotherapy expertise with clinicians in the United States and abroad. In 2023, she co-founded the Chairwork Psychotherapy Initiative with Scott Kellogg, PhD. As Co-Director of CPI, she has recently co-launched the world's first international

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Author Positionality Statements

Dr. Xi Liu

Xi Liu is a queer, non-binary Chinese-Australian Clinical Psychologist with over 15 years of experience in mental health, specializing in complex trauma, grief, and mood disorders within queer and people of color communities. Their lived experiences as a multilingual immigrant navigating intergenerational trauma and moving across urban China, the unceded lands of the Gadigal and Dharawal peoples, Samoa, and beyond, deeply inform their clinical perspective. Holding a Doctorate in Clinical Psychology, Xi is acutely aware of the field's historical marginalization of Aboriginal and Torres Strait Islander peoples, including the harm caused through exploitative research, neglect of Indigenous healing practices, and silence on policies like the Stolen Generations.

Xi also recognizes the unearned privilege granted by societal and institutional structures—such as being a business owner, having access to education, healthcare, and professional networks—that have elevated their professional and personal position. This awareness compels them to approach their work with a commitment to decolonizing practice, guided by queer, feminist, and BIPOC (Black, Indigenous, and People of Colour)-centered perspectives. Grounded in their own and others' lived experiences of marginalization, Xi seeks to challenge the ways psychology often perpetuates harm through its neutrality. They are dedicated to advocating for and actively engaging in community-driven social justice initiatives.

Isis Yager

Isis Yager is a white queer transgender man who holds a Bachelor of Psychology. Isis grew up in a low-income household on the unceded lands of the Guringai, Darug and Dharawhal peoples. Both this background and his lived experience as a transgender person significantly influence his understanding of identity, mental health, and social inequality and allow him to navigate multiple intersections of privilege and marginalisation. Isis aims to acknowledge how gender intersects with race, ethnicity, class, and other identities. He recognises that traditional psychotherapy tends to be exclusionary and is committed to rectifying this through methods, practices, and ideas discussed in this paper.

Amanda Garcia Torres

Amanda Garcia Torres is a queer Mexican-American/Latine Licensed Psychotherapist and Certified Chairwork Psychotherapist with indigenous and European ancestry. She was born and grew up in San Antonio, Texas, United States, lands first known as Yanaguana by its original indigenous inhabitants. Amanda is the owner of her private practice, Chairwork Therapy NYC, and is the co-founder and co-director of the Chairwork Psychotherapy Initiative. She has been in the psychology field for over 10 years and focuses much of her clinical work on complex trauma, depression, grief, and identity issues. Amanda received her Master's Degree in Mental Health Counseling from New York University. As a mental health clinician, she understands the difficult history of the psychology and medical fields and the ongoing links between these fields and various forms of oppression and injustice. Amanda seeks to support and facilitate healing for any and all historically marginalized persons. She believes that healing can lay the foundation for mental, emotional, and spiritual liberation and is a way for all presently oppressed and suffering persons to experience a depth of justice, safety, and love in this current lifetime. She also works as a coach at her business, I.N.C. Coaching.