

An Exploration of Ethical and Methodological Challenges in Trans-Affirmative Psychotherapy with Filipino Transgender and Gender Non-Conforming (TGNC) Clients

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To spark critical and professional discussion on integrating trans-affirmative psychotherapy in clinical and counseling psychologists' general practice, this paper presents and describes some ethical and methodological challenges in doing trans-affirmative psychotherapy with Filipino transgender and gender non-conforming (TGNC) clients, specifically transgender women. Sources of insight for this paper include: a) case notes and observations from a research-therapy project with two transgender client-participants, b) the author's observations from previous clinical work with LGBT clients, and c) the literature on TGNC mental health outcomes and trans-affirmative practice. The challenges described here pertain both to ethical boundaries that circumscribe the practice of psychotherapy and counseling as well as to principles that undergird methodologically sound or effective clinical work. Some proposed resolutions to these highlight the importance of thinking integratively about the ethical and methodological dimensions of practice work.

Keywords: transgender, trans-affirmative therapy, psychotherapy, counseling

In cis- and heteronormative cultures, i.e. those that consider gender and sexuality to be invariant, to be lesbian, gay, bisexual, or transgender (LGBT) means to be constantly at the receiving end of prejudice and stigma (Bockting, et al., 2013; Macapagal, 2013; Walch, et al., 2012). These take the form of microaggressions or everyday, interpersonal, experiences of discrimination based on perceived marginalized status (Nordmarken, 2014), and macroaggressions, or institutional discrimination (APA, 2015). Transgender and gender non-conforming (TGNC) persons, i.e., those whose gender identity does not fully align with sex assigned at birth (SOC, WPATH, 2011) or whose gender expression differs from norms related to sex assigned at birth (Treatment Guidelines, APA, 2015), are not only socio-economically disenfranchised but are also at high risk for a host of negative psychological health outcomes such as depression, anxiety, suicide, etc. (see Gamarel et al., 2014; Reisner et al., 2014; Bockting et al., 2013).

Unfortunately, prejudice against TGNC individuals also extends into health care, with TGNC individuals typically experiencing discrimination and limited access to physical and mental health services (Frederiksen-Goldsen et al., 2013) due to institutions' and professionals' inability and/or unwillingness to offer health care that respects gender diversity (Mikalson, Pardo, and Green, 2012) and is sensitive to the health and well-being needs of TGNC individuals. In the Philippines, for example, TGNC persons experience discrimination from medical professionals and personnel who fail or even refuse to provide gender-affirming treatments (UNDP, USAID, 2014).

That the mental health and well-being needs of TGNC Filipinos are underserved by clinical psychologists is underscored by the virtual lack of information on how and where TGNC Filipinos could access services such as transpositive or trans-affirmative psychotherapy and counseling, which "accepts and validates all experiences of gender" (Austin and Craig, 2015, p. 21) and which specifically seeks to work with TGNC clients in a manner that affirms their gender identity and expression (Ali, 2014).

While the Psychological Association of the Philippines has taken an official stand against discrimination on the basis of sexual orientation and gender identity (PAP, 2011) and has a thriving special

interest group that continues to artfully balance LGBT rights advocacy with systematic research on the voices and experiences of Filipino LGBT individuals (Ofreneo, 2013), it seems that Filipino clinical and counseling psychologists have yet to make a significant contribution to the endeavor of increasing LGBT, particularly TGNC, individuals' access to psychotherapy and counseling.

The Clinical Psychology division of the Psychological Association of the Philippines (PAP) has no database to use as reference in ascertaining the number, qualifications, locations, and contact information of clinical psychologists in the Philippines who can, and do, offer transpositive mental health care to TGNC individuals. Moreover, no research has been done on Filipino clinical psychologists' attitudes towards gender identity and their willingness to offer psychotherapy and counseling to TGNC persons. What this means is that at best, Filipino clinical psychologists' transpositive practices and services remain undocumented via information management and/or research. At worst, perhaps majority still subscribe to conventional gender norms that assume gender to be invariable and the same as sex-assigned-at-birth (Burdge, 2007, cited in Burdge, 2014), with such prevailing attitudes having a negative impact on both competence and willingness to do trans-affirmative psychotherapy and counseling.

It is also possible that some clinical psychologists in the Philippines may have transpositive attitudes but may feel *unprepared* to integrate trans-affirmative psychotherapy and counseling into their general clinical practice. An examination of the websites of Philippine higher education institutions (HEIs)¹ that offer graduate programs in clinical and counseling psychology reveals a lack of courses on how to cultivate a trans-affirmative approach to counseling and psychotherapy. We can surmise that, at best, the particular challenges in doing clinical work with LGBT individuals more generally, and TGNC individuals in particular, are summarily dealt with in discussions of "special issues" in psychotherapy and psychopathology. Which means that these topics have to compete for airtime with other "special issues" that need to be

¹ The following HEIs had online copies of their graduate curricula accessible through their websites: ADDU Ph.D. Psychology, major in Clinical / Counseling Psychology; ADMU Master in Counseling Psychology, Ph.D. in Clinical Psychology; DLSU MS in Psychology; PUP Master in Psychology; UP Diliman MA Psychology, with area of interest in Clinical Psychology, Ph.D. Psychology, major in Clinical Psychology; and UST MA in Clinical Psychology, Ph.D. Psychology, major in Clinical Psychology.

discussed.

To be sure, facilitating coherent and critical discussion on these special issues relating to gender identity and sexual orientation is basic ground that needs to be covered by graduate clinical and counseling psychology programs. However, if we deem it a worthwhile endeavor to bring clinical and counseling psychology in the Philippines to the point where a significant number of its practitioners are competent, confident, and willing to do trans-affirmative psychotherapy, then a much needed step is to spark critical discussion — both in graduate classrooms and within professional circles — on the challenges of doing clinical work with TGNC individuals. It is with this simple goal in mind that I present some ethical and methodological challenges to doing psychotherapy and counseling with Filipino TGNC clients.

These challenges pertain both to ethical boundaries that circumscribe the practice of psychotherapy and counseling as well as to principles that undergird methodologically sound or effective clinical work. My position is that ethicality and methodological soundness are not independent dimensions of clinical work. Questions about the ethicality of psychotherapeutic moves and strategies are also pertinent to the question of soundness, and ethicality is a prerequisite to soundness. Hence, those doing clinical work must think integratively, rather than in piece-meal fashion, about these issues.

The sources of insight for this paper come from the literature on trans rights and trans-affirmative mental health care, personal observations and reflections of having done what I hope is LGBT-affirmative psychotherapy with past clients, and case notes and observations from a recently concluded “research-therapy” project that I called *“Urong Sulong: Therapeutic Encounter for Filipino Transgender Women.”*

I do not consider myself to be an expert in trans-affirmative psychotherapy and counseling. While my doctoral level training and clinical experience have equipped me to handle a range of mental health concerns and problems for both adolescent and adult populations, like most Filipino clinical psychologists, I do not have specific training in delivering mental health services to TGNC individuals. I consider myself a beginner in the endeavor of integrating TGNC client work in my private clinical practice. This treatise is part of my own attempts

to observe and document — as systematically and holistically as I can — how I am grappling with issues inherent in establishing a clinical practice that can service many varied client populations given that not all client populations have the same resources and opportunities to access the kind of service that I am trained to deliver.

As a researcher-practitioner, I conceived of the *Urong Sulong* project as a means to explore the learning opportunities for Filipino clinical psychologists such as myself as regards special therapeutic issues that could arise with TGNC clients, as well as to offer free psychotherapy to an underserved population. *Urong-sulong* is a compound Filipino word that denotes a backward-and-forward movement (Tagalog-English Dictionary, bansa.org, n.d.) and connotes vacillation. I used the term to refer to the feeling of “neither here nor there” or being “stuck” that pervades experiences of life transitions and developmental challenges. The project ran for a period of four months, and was geared towards client-participants who were grappling with serious life concerns, were feeling “stuck”, and needed to navigate developmental challenges, such as entering the workforce, shifting careers, changes in relationship, etc. Two adult transwomen, one aged 25 and the other aged 37 years old, participated in the project. The project used a brief psychotherapy approach, with each client-participant undergoing three main psychotherapy sessions, each lasting an average of 1.5 hours, with two weeks in between each session, and one follow-up session 6-8 weeks after the last main session. The two client-participants were informed of the project objectives, gave their informed consent to undergo the sessions, and completed all four sessions each. I recorded the first, in-take, session (with consent from the client-participants) and kept case notes for each session. Both accomplished an in-take questionnaire and some mental health measures prior to the sessions, and accomplished a post-project questionnaire after the follow-up session.

What follows are challenges that I have encountered not just in my recent work via the *Urong-Sulong* project but also in my work with previous clients. I describe each challenge and how I attempt(ed) to resolve these. I also make some recommendations for what could guide the resolution of these challenges. Lastly, I end with some recommendations for enhancing professional clinical practice and

doing research on trans-affirmative psychotherapy in the Philippines.

Challenge 1: Scrutinizing therapist attitudes on issues that have an impact on the ability to deliver competent and caring trans-affirmative psychotherapy

The World Professional Association for Transgender Health (WPATH) has published the seventh version of its Standards of Care guidelines for health professionals assisting transsexual, transgender, and gender non-conforming people in achieving “long-lasting comfort with their gendered selves” (WPATH, 2011, p.165). Other professional organizations, such as the American Psychological Association and the British Psychological Society, have also published guidelines for psychologists working with gender and sexual minorities (APA, 2015; BPS, 2012).

All these are in response to the growing body of research evidence that points to the need for a “culturally responsive approach to working with TGNC clients” (APA, 2015, p. 2) given the exacerbated mental health detriments of minority stress (Meyer, 2003, cited in Austin and Craig, 2015), the heterogeneity of the LGBT community (Austin and Craig, 2015), and “the complexities of negotiating lives that do not fit neatly into the dominant two sex / two gender paradigm” (Burdge, 2014, p. 356). The BPS, for instance, states the purpose of its published guidelines to support applied psychologists working with gender and sexual minorities “to enable their inclusion in clinical practice at a high standard” (p. 3).

A basic challenge to doing psychotherapy and counseling with TGNC individuals is for the therapist to intentionally scrutinize and clarify his or her own attitudes regarding issues pertinent to trans experiences, and specifically, to determine whether or not he or she agrees with assumptions underlying articulated guidelines for mental health work with TGNC individuals.

APA Guideline 5 (2015) states that “Psychologists recognize how their understanding of and attitudes about gender identity and gender expression impact the quality of care they provide to TGNC clients and their families.” Similarly, BPS Guideline 2.1. (2012) encourages psychologists to “reflect on their own understanding” of gender and

sexuality, while Guideline 2.2. encourages psychologists to “reflect on the limits to their practice when working with sexual and gender minority clients”.

APA’s Guidelines 1 and 4, moreover, view trans identities as normal and non-pathological, and specify that it is prejudice against TGNC individuals, rather than transgender identity per se, that has a negative impact on mental health and well-being, whether it is developing a host of negative mental health outcomes or experiencing an exacerbation of existing mental health issues.

Competent clinical work with TGNC individuals requires that those doing the work are clear about their personal position on important matters such as the nature of trans- identities and the relationship among stigmatized identities, non-stigmatized identities, and psychological health.

The foregoing paragraphs make it seem as if scrutiny of one’s attitudes is an academic and impersonal exercise, and therefore, should be easy to accomplish for psychologists trained to think scientifically, that is to say, with a value for skepticism and self-correction, even—or especially—about their own thoughts and notions. However, it is not easy to train a critical eye on our own attitudes at the risk of uncovering personal prejudices that threaten our image of a moral self. It is not easy to render explicit heretofore implicit, automatic assumptions about what it means to be a girl or a boy, man or woman, and what it means to relate with people whose gender identity and expression do not conform to what we *personally* think and expect girls and boys, women and men, to act and *be*. This is because privilege typically maintains the implicitness of our assumptions, and it is those who have to struggle in the day-to-day with the reality of having a stigmatized identity who are typically more motivated to clarify, articulate, and compel discussion on matters deemed a non-issue by those of us with privileged identities (Israel, 2012).

For cisgender, heterosexual clinicians such as myself, a basic challenge that must be overcome is the tendency *not* to think about and dwell on the ways by which our own clinical practices are informed and circumscribed by binary gender and sexuality norms precisely because cisgender and heterosexual privilege lends the illusion that clinical practices are gendered only in terms of “male” and “female”,

“straight” and “not straight”. Smith, Shin, and Officer (2012) assert that even “well meaning, egalitarian” counselors and therapists could unconsciously engage in microaggressions through therapist gestures and language in the therapeutic setting that reflect and reinforce cis- and heteronormativity.

The challenge to dwell long enough so that we could get to know our own potentially prejudiced notions, and to do so as a continuing, lifelong, process, is both ethical and methodological. Scrutinizing one’s own attitudes towards TGNC individuals—which is profoundly personal and requires commitment and self-honesty—squares well with various approaches to psychotherapy such as narrative, contextual/relational, and existential therapies. These approaches view the therapist as playing an important role in the co-construction of reality in the therapeutic relationship (see Lieb & Kanofsky, 2003; Richert, 2003), such therapeutic reality having an impact on clients’ constructed reality outside of the therapeutic relationship. Contextual therapy, for instance, argues for the serious consideration of the ethical dimensions of relationships (Ducommun-Nagy & Schwoeri, 2003). Meanwhile, trans-affirmative adaptations of cognitive-behavioral therapy entail that the therapist help clients to recognize and understand how their negative mental health outcomes are related to experiences of discrimination, so that they could replace a view of self as “pathologic” with a more positive view of self as making the best out of objectively hostile circumstances (Austin & Craig, 2015).

From an ethical standpoint, this relates to the principle of determining the boundaries of clinical competence. This principle enjoins psychologists to provide services “only within the boundaries of our competence” (PAP, 2010). However, this is by no means a straightforward prescription because it may likewise be unethical to refuse service to individuals and groups on account of not having “existing competence”. The PAP Code of Ethics, in fact, enjoins Filipino psychologists to “make a reasonable effort to obtain the competence required by undergoing relevant research, training, consultation, or thorough study” (Section IIA.4, PAP, 2010). To me, “thorough study” includes continuing self-scrutiny.

Pope and Vasquez (2011) make a distinction between intellectual competence and “emotional competence for psychotherapy” (Pope and

Brown, 1996, cited in Pope and Vasquez, 2011). Emotional competence pertains to the therapist's recognition of oneself as unique and fallible, bringing to therapy one's personal history, including prejudices, values, and even experiences of trauma and stigmatization. Competence as an ethical requirement means that the counselor or therapist recognizes his or her power in the therapeutic relationship and does not use it in an uncritical and uncaring manner (Pope & Vasquez, 2011). The determination of therapist attitudes towards TGNC individuals can be viewed as an application of this principle. Sound and ethical therapy requires that therapists engage in a continuing reflexive process of knowing how they can have an impact on their clients' experiencing and construing of their realities. It requires acknowledging one's privilege (Israel, 2012), and critically exploring and reflecting on how privilege influences the ways by which the therapist relates to TGNC clients in therapy.

To illustrate, the Urong-Sulong project I undertook required me to clarify my competency boundaries as well as personal and professional assumptions. I consider myself privileged to have had early encounters, friendships, and therapeutic relationships with LGBT persons, which cultivated in me a continuing need to know about my personal beliefs on gender and sexuality as well as the related issue of psychological practice and social responsibility. When I was conceptualizing the project, I had done some depth work and I had enough self-efficacy to embark on a project that would put me in close, intimate contact with transgender women. However, since I do not have targeted training on the unique challenges of supporting transitioning clients pre- and post-surgery, I did not want to risk prospective clients' well-being because of inexperience in this area. Hence, my decision was to focus on current struggles in navigating developmental life challenges.

My hope in working with transgender women rested on my continuing commitment to, as Israel (2012) aptly put it, explore the *unearned* advantages of my privilege and use such insights to facilitate my own clients' exploration of both the oppression and privilege inherent in their own experiences (Israel, 2012), even as I learn from my own clients' stories of navigating life in a cisnormative world. Beyond the project, and given the PAP Code of Ethics' recommendation regarding work with underserved populations, the challenge remains

for me to work on the limits of my knowledge and training as regards issues unique to physical transitioning.

I also clarified, to myself and my client-participants, the two guiding principles for the project. One, while transgender people face the same developmental life challenges as everyone else, the added stressor of having a stigmatized identity as transgender makes navigating, resolving, and finding meaning in these dilemmas more difficult for TGNC individuals. Two, the experience of being transgender is not simply a source of problems due to stigma and discrimination, but could also become a valued aspect of experience (Burdge, 2014) and a source of life-affirming and health-enhancing meanings.

To reiterate, a basic recommendation for the first challenge described here is continuing self-scrutiny, creative questioning of the self, and willingness to work on one's prejudices and limitations. As a last note on this challenge, given the religiosity of Filipino culture (see Abanes, Scheepers, and Sterkens, 2014; Dy-Liacco, et.al., 2009), an important task for Filipino clinicians would be to reflect on their attitudes about gender identity and expression alongside their religious faith. Perhaps for many Filipino clinicians, their gender belief systems could be embedded in, and informed by, their religious beliefs. Clarifying their gender beliefs, then, would also entail a clarification of their unique and personal religious expressions and asking the question of what it means to be someone of a particular religious faith.

Challenge 2: Differentiating problems that stem from stigmatized identity/ies from those that are largely independent of TGNC status

APA Guideline 3 states that "Psychologists recognize that gender identity intersects with other cultural identities and may not always be the most salient aspect of a TGNC person's life, experiences, or current concerns." A recommended application of this guideline is for psychologists doing psychotherapeutic work with TGNC persons to recognize that not all problems currently being experienced by a TGNC client are reducible to their identity as transgender.

To me, the challenge has been to display clinical judgment in discerning how my clients' problems are nuanced by various aspects of

their identity which include not just their gender identity but also such variables as age, socio-economic status, religion, and relational status. These intersecting aspects of identity may have important effects on clients' risk and resilience (MacFadden et al., 2013, cited in Austin and Craig, 2015), and could also have therapeutic implications (Austin and Craig, 2015).

To protect client confidentiality, I refer to one of the client-participants in my Urong-Sulong project as Jane. Jane is 37 years old, single, employed, and bread winner of her family. When I asked her what she was struggling with, she said: "*Ang tanda-tanda ko na, wala pa rin akong na-achieve.* (I am so old, and I still have no achievements to show for it.)".

In our first session, Jane shared her dream of achieving stability and security for herself, and the barriers that have kept her from achieving this dream at her age. Her ideal future was one where she had a high-paying job, no money problems, and a family. She noted that her being transgender and the economic difficulties that come with it are barriers to her achieving what she wants in life.

Jane came across as struggling with feelings of frustration and inadequacy. She talked about comparing herself to her cisgender co-workers as well as to her transgender women friends, and finding so many reasons why these co-workers and friends are much better off than her. Her co-workers are younger and yet have more money than she had when she was their age. Her transgender women friends have lucrative careers and relationships, whereas she is single and, while she has a regular job, she rarely has money for extra personal expenses. Certainly, the reason she participated in the project was because she felt that she needed counseling but did not have the extra money to pay for such sessions, so she grabbed the opportunity to get counseling for free. Jane also compared herself to cisgender women more generally, and noted that her imagined future would very well be within her grasp now had she been born genetically female. All in all, Jane seemed dissatisfied with her current life but was hoping for good opportunities to come along.

The economic and occupational disenfranchisement resulting from the intersection of one's stigmatized identity and socioeconomic status is a theme that I have encountered in the narratives of past

LGBT clients born into families that are not well off. For Jane and my past clients, the stigmatization of their gender identity and sexual orientation is worsened by not having economic means. For my past clients, being poor meant they had to become breadwinners. Being transgender meant restricted access to, and discriminatory treatment in, heteronormative industries and work contexts. Not earning enough meant considering self-care, such as taking care of one's physical and mental health, a *luho* (luxury expense). It also meant not having money to migrate to countries where their identities are less or non-stigmatized, places where they deem their chances of finding meaningful work and relationships to be infinitely better, or not being able to afford gender affirming surgery and other means by which they could "pass". It is no wonder, then, that many negative meanings come to be associated with the stigmatized identity.

In the case of Jane, such negative meanings included the notion of her being transgender as a *hadlang* (barrier) to achieving her dreams and grappling with feelings of failure and being left lagging by time ("*Napag-iwanan na ako ng panahon*. [Time has passed me by.]"). She felt that she had expended so much energy and spent such a long time in her coming-out process that she is now left, at the age of 37 years old, little more than a beginner in her career and life, at the same level as a straight natal female with only a few years under her belt.

The challenge for me, as Jane's therapist, was to balance the following needs: 1) to affirm the feelings of regret, frustration, and loneliness fueling Jane's narrative, reflected in negative meanings of her being transgender vis-a-vis being "*matanda na*" (having aged) vis-a-vis "*walang pera*" (having no money); 2) to help her accept that living in a largely cisnormative society has exacted and continues to exact a toll on Jane's well-being not just in terms of actual disenfranchisement but in terms of the reinforcement of self-defeating attitudes and response styles; and 3) to help her approach her current life with a sense of power and self-efficacy.

The challenge was not just how but *when* to integratively address these needs. The risk of precipitously framing, i.e., right then and there, her situation positively was that she may not have been ready to hear such positive meanings that could ring hollow in the face of her objective circumstance. The risk of talking about what I perceived to be

her self-defeating thinking and response style was that I would reduce her legitimate reactions to sustained disenfranchisement to little more than individual differences. The risk of waiting until the next session was that she would be spending two more weeks in between sessions laboring under a cloud of depressed mood and negative self-related meanings.

Given these, my decision was to offer an alternative framing to the life narrative she presented, setting the stage with two questions. About her current life, I asked, "*Ano sa palagay mo ang maganda sa buhay mo ngayon?*" ("What is good about your life right now?"). And about her coming out history, I asked, "*Ano ang naging benefit sa iyo ng coming out mo?*" ("What are the benefits to your coming out?"). These questions compelled Jane to, right then and there, think differently about her current situation and personal history. She expressed surprise that she could identify what's good about her current life: "*May trabaho akong regular. Nakakatulong ako sa pamilya ko. Nakaka-travel naman ako paminsan-minsan, kahit siyempre kailangan tipid.*" ("I have a regular job. I am able to help my family. I can travel every now and then, even though of course it has to be on a budget.").

And because part of Jane's narrative was that she did not know what else she was good at, apart from the course she had studied in college, I also asked her whether she had, in fact, asked herself what other things she is good at and what activities give her joy. She noted that she had not really thought about those questions. I then offered the notion of a "trade-off", starting by saying, "*Kung tutuusin mo, achievement yung nakapag-come out ka kasi I'm sure hindi naging madali yon para sa iyo, at in fact, maraming tao hirap na hirap gawin yon. That takes courage. Achievement yon.*" ("If you think about it, it was an achievement that you were able to come out because I'm sure it couldn't have been easy for you, and in fact, many people find it very difficult to do. That takes courage. That's an achievement.").

I then said that because her gender identity was the most basic, most deeply felt, aspect of her identity, it was understandable that she spent so much time working on it. The trade off is that she is now at a point in her life, as an older person, and she is finding that there are other aspects of who she is that perhaps need her attention and focus

now. I reiterated the notion that she had to work on her gender identity because it was urgent and necessary for her to do so, because comfort in her gender identity is fundamental to her psychological well-being.

I ended by asking Jane to imagine what it would be like for her had she not come out, had she continued to live her life as a “man”. This question made Jane pause. Then she replied, “*Miserable ako. Kasi noon naaalala ko, nung lalaki pa’ng bihis at dating ko, ni hindi ako makangiti! As in. Hindi talaga!*” (“I would be miserable. Because I remember back then, when I was still dressing and acting like a man, I couldn’t even smile! I couldn’t!”).

This first exchange between Jane and me helped to set the therapeutic goals for our next sessions, which were to help Jane increase her self-efficacy so that she could more effectively handle the particular challenges she encounters as a transgender woman in the Philippines, and to help her manage her feelings of frustration and inadequacy while she is “in the valley”, i.e., while she is still working to fulfill her dreams.

My conversations with Jane were guided by the basic assumption that I had previously articulated, about transgender experiences as sources of both problems and solutions, stigmatization and affirmation. It allowed for exploring both positive and negative aspects — and meanings made out — of transgender experiences. It also helped me to exercise judgment about the role of my client-participants’ transgender identity and experience in the development and maintenance of whatever wellbeing concerns they may have.

Challenge 3: Determining pragmatic boundaries and sustaining beneficial services especially for chronic problems

APA’s Practice Guideline 7 enjoins psychologists to “create TGNC-affirmative environments” and “assist their clients in accessing and navigating systems”. One basic application of this guideline is for practitioners to help TGNC individuals gain sustained access to the services that they typically offer to cisgender clients. For instance, Treloar (2010) notes that clinicians have an ethical responsibility to critically evaluate their financial practices and the impact of such on the effectiveness of their clinical practice. This means asking questions

such as: Should psychotherapy sessions be offered for free? How many sessions should be offered? How should therapists navigate clients' fluctuating fiscal capacities given their well-being needs?

For my part, a question that has often presented itself was how to balance my personal sense of responsibility to offer psychological care to those who do not have the fiscal capacity to access my services with the pragmatic need to earn a living from my psychotherapeutic practice. The Urong-Sulong project was my attempt to explore my own contributions to the endeavor of delivering psychotherapeutic services to TGNC persons. In this, I was guided by the principle of mutual beneficence. The PAP Code of Ethics articulates the core principle of "competent caring for the well-being of persons and peoples", and enjoins psychologists to maximize benefits and minimize detriments to individuals, families, groups, and communities. Mutual beneficence compels me to scrutinize not just my competence but also my pragmatic boundaries so that I know the limits of what I am willing to offer, provided that I am willing to reconsider and evaluate my currently known limits.

For instance, I knew that at the time of the Urong-Sulong project, I did not have the fiscal and temporal resources to offer pro bono psychotherapy and counseling for an indefinite period, to any underserved client population. I knew that at best, what I could offer was time-limited engagement but with a commitment to make each session count. Hence, the project was undertaken using a brief psychotherapy approach. I also knew that I needed to ensure that the offer of free psychotherapy would not come across as a dole out as this could disempower potential clients. Hence, my decision was to treat the project as a small scale research opportunity albeit an exploratory one. In this way, I could communicate to my client-participants that I was also benefitting, as both researcher and practitioner, from our encounters.

The question remains, however, whether offering a limited number of sessions is the only efficient and beneficial way by which one could continue to offer psychotherapeutic services to TGNC persons. The brief approach seemed to have worked for the project. Based on the symptom and well-being measures that I asked my two client-participants to accomplish as well as their narratives, I could infer

that they did not have diagnosable conditions even though they both had serious emotional concerns. Hence, we could do targeted work, focusing our sessions on helping them work through the emotional issues that fuel the current life challenges they identified.

The question to me now is whether the brief approach would have sufficed had I inferred chronic diagnosable conditions from my client-participants' outcome measures. Moreover, some would also argue that emotional work requires long-term rather than brief psychotherapy, meaning that it is up for serious consideration whether, in fact, much could be done in three to four sessions. My position is that while there are no cut-and-dried solutions to the dilemmas clinicians face, the point of grappling with dilemmas is for us to clarify our position on issues that affect both the regularity and the quality of psychotherapeutic service that we can offer to underserved populations.

Pro bono psychotherapy is both an ethical and methodological concern because while the prevailing notion seems to be that giving psychotherapy for free causes clients to devalue it and, hence, diminishes effectiveness, the research evidence is, in fact, mixed on the issue (Treloar, 2010). Some clinicians could offer time-limited pro bono services, i.e., a certain number of sessions for a definite period of time, in an effort to engage as many clients as possible. Other clinicians could opt to offer sessions, which would run indefinitely depending on the amount of work needed for set therapeutic goals, at a sliding scale.

Either way, the therapist's choice of approach should not just benefit clients in economic terms, by receiving service pro bono or at discounted rates, but should also encourage them to "own" the sessions (no matter how many) and share in the responsibility of ensuring that they maximally benefit from each session. The recommended guiding principle here is respect for clients' autonomy (Treloar, 2010), which would include straightforward communication with clients about available options.

Another important principle to guide decision-making on these practical considerations is that clinicians have a professional and social responsibility to ensure continuation of services if the client is in crisis, regardless of clients' changing financial circumstances (Treloar, 2010). Taking the Urong-Sulong project as an example, if either of my client-participants had test scores and narratives that indicated urgent

mental health issues such as suicidality, the proscription against abandonment, or the early termination of services when a client is in crisis (Treloar, 2010), means that it would have been my responsibility to continue psychotherapy beyond what was indicated by the project. The appropriate clinician stance, then, is to know one's pragmatic limits and to also be willing to stretch one's limits when a particular therapeutic situation calls for it.

Recommendations for Enhancing Professional Clinical Practice in the Philippines

The goal of this paper was to instigate and contribute to a critical and coherent discussion on integrating TGNC-affirmative psychotherapy into professionals' general clinical practice. Such discussion has to be set against the bigger conversation about how to enhance professional clinical practice in the Philippines.

Clinical Professional Guidelines

Clinical practice guidelines, or CPGs, have become a popular practice of professional organizations in the last two decades. CPG instruments aim to bridge the gap between research and practice by providing practitioners the best available scientific evidence (Alonso-Coello, et.al., 2011) to help them deliver more competent client care.

One recommended method for the development, and updating, of such guidelines is internationalization, where knowledge and information are shared between scientific- and professional-organizations from different countries. It is in the context of internationalization that Filipino professional organizations could be guided by foreign guidelines in the development of a local CPG instrument. However, context is also important in the development of CPGs precisely because these are meant for "*specific clinical circumstances*" (Alonso-Coello et.al., 2010).

To date, there are no local practice guidelines for Filipino clinical and counseling psychologists, both general and population-specific (Manalastas & Torre, 2016). Given this, Manalastas & Torre (2016) recommend that developing local guidelines for LGBT-affirmative

practice be done alongside guidelines for general clinical practice and other issue- / population-specific practice.

In the case of general psychology practice in the Philippines, local guidelines need to be developed that take into account the particular cultural context of individuals and communities in the country as well as the particular professional context of Filipino clinicians. And in developing local LGBT-specific guidelines, discussion and research are needed on the numerous challenges of LGBT-affirmative clinical practice in the Philippines. The challenges I presented in this paper could be limited in application, for instance, only to a subset of Filipino transgender women. Given the diversity of LGBT persons, it makes sense to think that there would be special challenges unique to working with Filipino transgender men as well as LGB men and women.

One important concern that practice guidelines could help to address relate to practical boundaries and access, given that mental health services are not yet comprehensively covered by health insurance. Mental health coverage by the Philippine Health Insurance Corporation (PhilHealth) is limited only to acute in-patient care, i.e. when individuals with severe mental disorders are confined for short duration (WHO-AIMS, 2006). Reimbursement requires diagnosis of mental disorder (PhilHealth Circular 09, 2010), and services for non-diagnosable *problems of living* – which would include distress due to prolonged discrimination – are not covered by the social insurance scheme.

The current proposed Mental Health Act (Senate Bill 1354, 2017) aims to increase Filipinos' access to mental health care. One means is to make PhilHealth coverage for mental health at par with insurance packages for physical disorders (Article VII, Sec. 22f), but since the bill has yet to be enacted, no implementing rules and regulations (IRRs) are in place to concretize this state responsibility. The Act also contains no provisions explicitly requiring private health insurance companies to cover mental health problems. Hence, for the foreseeable future, counseling and psychotherapy in the Philippines will continue to be an out-of-pocket and, hence, a burdensome expense for those who have less financial resources.

Given this state of affairs, those practicing clinical and counseling psychology in the Philippines must be helped in grappling with the

twin needs to earn a living from one's training and to contribute social services through one's training. The professional organizations, such as PAP, could also partner with LGBT rights organizations in exploring third-party options for funding mental health care of LGBT individuals who could not otherwise afford the services that they need.

Professional and rights organizations, as well as educational institutions, could likewise look into the establishment of mental health and wellbeing services apart from standard clinic- or center-based counseling and psychotherapy, such as online counseling and hotline services, and to weigh the pros and cons of these alternative modalities of care.

Cultural Competence

Affirmative approaches in Philippine psychological practice should be done within the broader context of cultural competence, defined as the constellation of attitudes, knowledge, and skills needed to "place the individual within the socio-cultural context that best helps us to understand and intervene" (Winstead & Sanchez, 2016, p. 216). In turn, discussions about cultural competence need to be made with particularities of Philippine context in mind.

The cultural competence framework developed within an American context, and its focus has typically been the impact of cultural variables such as race, gender, and class on psychopathology and psychotherapy. The questions in this strand of research reflect the challenges that American culture grapples with as a multi-cultural nation with citizens coming from diverse socio-cultural backgrounds. Such attention has resulted in professional guidelines for research, practice, and training (ex. APA, 2002) as well as research on cultural competence in clinicians (see Daniel, Roysircar, Abeles, and Boyd, 2004).

However, similar efforts in the Philippine psychological front have yet to be made. Specifically, there is a need to: 1) determine the unique cultural challenges in delivering quality care to Filipino clients from diverse backgrounds, identities, and social memberships; 2) conduct research on the relative contributions of pertinent cultural variables on mental health and wellbeing outcomes for Filipino clients;

3) develop guidelines for enhancing cultural competence in Filipino clinicians based on identified cultural challenges and pertinent variables / dimensions; and 4) integrate cultural competence into graduate clinical and counseling psychology training with a focus on particularities of cultural dimensions of experience in the Philippine context.

In relation to LGBT-affirmative practice in the Philippines, it is important to include in the discussion (and as a focus of subsequent research) affirmative approaches that take into account Filipino cultural constructions, such as *bakla*, *tomboy*, *silahis*, *transpinay/pinoy*, and so on, and that document and address the mental health and wellbeing outcomes of Filipino LGBT individuals. To date, there have been research investigations into the prevalence counts of *transpinay* and *transpinoy*² (see Cruz & Sasot, 2011), mental health and wellbeing outcomes for gay and bisexual Filipinas / Filipinos (see Manalastas, 2016; Rances & Hechanova, 2014; Manalastas, 2013; Rubio & Green, 2009), and negative attitudes towards LGBT individuals in the Philippine context (see Macapagal, 2013; Manalastas & Del Pilar, 2005).

Training and the Role of Higher Education Institutions

Manalastas & Torre (2016) recommend “two approaches for making LGBT topics visible in the psychology curriculum” (p. 65): programs could integrate LGBT topics into existing courses and/or develop stand-alone LGBT psychology courses. Clinical and counseling psychology programs could include courses in their curricula that are designed to help students explore, get to know, and clarify their personal, strongly held, and perhaps in most cases, implicit gender beliefs, the relationship of these beliefs to other personal values and belief systems, and the implications of these beliefs on the ethicality, effectiveness, and practicality of their research and practice endeavors.

Aside from developing and delivering LGBT psychology related courses, clinical and counseling psychology programs could also

² a portmanteau of the words transsexual, someone whose gender identity is directly opposite of his/her sex assignment at birth, and Pinay/Pinoy, the local term for Filipina/Filipino. The term transpinay was constructed by Society of Transsexual Women of the Philippines (STRAP), a non-profit organization, in 2008 (Cruz & Sasot, 2011).

approach clinical supervision according to Manalastas & Torre's (2016) recommendation. One option is to purposely integrate into existing clinical supervision / practicum programs explorations of challenges in doing clinical work with LGBT clients. Another option is to offer clinical supervision specific to LGBT-affirmative clinical work.

Higher education institutions (HEIs) in the Philippines could also contribute both to the discourse on LGBT mental health as well as the expansion of access to mental health care for LGBT individuals. In recent years, major Philippine HEIs have been moving towards establishing mental health and wellness centers. Miriam College has Ilaw Center, Ateneo de Manila University has the Bulatao Center, and the University of Santo Tomas has its Psychotrauma Clinic. These HEIs could include in their purview the provision of socialized mental health care for clients-in-need, including LGBT individuals. HEIs could also contribute to both research and discourse on alternative modalities of care.

Recommendations for Research

The challenges presented in this paper are points to ponder for clinicians who may be grappling with similar concerns in their effort to serve underserved populations, whether it is TGNC persons or members of other marginalized groups. But they could also be starting points for more systematic research investigations to map the terrain of trans-affirmative, and broadly, LGBT-affirmative, psychotherapy in the Philippines.

A basic question that research could help answer is as regards the competence, confidence, and willingness of Filipino clinical and counseling psychologists to offer LGBT-affirmative psychotherapy. This is a crucial information gap that needs to be filled, and coupled with demographic information on LGBT Filipinos, such a research study could help identify and track demand-and-supply for this particular approach to psychotherapy.

Another critical area in trans-affirmative psychotherapy is working with TGNC children and their families. Research could look into the affirming and non-affirming ways Filipino families are raising their TGNC children, the special psychotherapeutic challenges in

working with TGNC children, and how to effectively train clinical and counseling psychologists in work with TGNC children and families.

Research could also look into whether or not more accessible alternative modalities of mental health care could also be at least equally efficacious as clinic- or center-based counseling and psychotherapy in helping LGBT clients achieve gains in mental health and wellbeing.

Lastly, research could focus more broadly on some of the assumptions underlying practical, ethical, and methodological considerations in psychotherapy, with a focus on the considerations that affect how clinical and counseling psychologists in the Philippines work with LGBT clients. For instance, research could be done to investigate LGBT individuals' perceptions of pro bono versus sliding scale versus fully paid psychotherapy, their experiences of counseling and therapy with cisgender and heterosexual therapists, and the integration of LGBT-relevant indices or measures of mental health and well-being in assessment and psychotherapy.

A Final Note

In her reflection, Ofreneo (2013) mapped out an LGBT psychology agenda for the Philippines, one that values cultural specificity, intersectionality, positive psychology, action research, and multiple perspectives and methodologies. A critical and coherent discussion of the challenges that Filipino psychologists face in upholding the well-being of individuals and peoples of “diverse genders and sexualities”, while a step in the right direction, can only happen in atmospheres of care and compassion and in the context of affinity, rather than identity, politics (Ofreneo and De Vela, 2010, cited in Ofreneo, 2013). It begins with the recognition that each of us brings our unique and paradoxical amalgamation of privileges and marginalizations, prejudices and openness, insight and blind spots, to every discourse. We all must grapple with the challenges of delivering competent and compassionate care to those among us who most need it. The challenge for our organizations and institutions, and ourselves, is to allow space for collective, alongside personal, grappling.

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