

A Qualitative Study of Alcohol Use Disorder Psychotherapies for Transgender and Nonbinary Individuals: Opportunities for Cultural Adaptation

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ABSTRACT

Background: Transgender and nonbinary (TGNB) populations experience high rates of hazardous drinking (HD) and alcohol use disorder (AUD) as well as unique treatment barriers. This is due, in-part, to discrimination and stigma within and outside of the healthcare system. Cultural adaptation of clinical interventions can improve outcomes for marginalized populations, but no such adapted interventions exist for AUD among TGNB individuals. This study sought to understand how TGNB individuals perceive currently available AUD psychotherapies and to generate knowledge about potential areas for cultural adaptation.

Methods: As part of a qualitative study of HD among TGNB individuals (N=27), participants were asked to imagine that they were clients in psychotherapy vignettes corresponding to cognitive behavioral therapy, motivational enhancement therapy, and twelve step facilitation. Interviews were audio-recorded and professionally transcribed. A coding team used an iterative codebook to guide coding. Categories emerged from this process that reflected participants' perceptions and allowed for the identification of potential cultural-adaptation targets.

Results: Across all three psychotherapies, participants wanted therapists to explicitly discuss gender identity and culturally salient HD risk factors for TGNB individuals (e.g., discrimination, stigma, gender dysphoria). There were also modality-specific recommendations to incorporate principles of trauma-informed care into cognitive behavioral therapy, avoid motivational enhancement therapy exercises that oversimplify decision-making, and recognize that the twelve-step-facilitation concept of "powerlessness" may conflict with how many TGNB people see themselves.

Conclusions: These findings highlight areas for cultural adaptation that can be evaluated in future intervention trials in an effort to improve psychotherapy acceptability and efficacy for TGNB individuals.

Keywords: transgender, nonbinary, alcohol, psychotherapy, gender, gender identity

1. INTRODUCTION

Transgender and nonbinary (TGNB) individuals comprise approximately 0.5% of the U.S. population (Meyer et al., 2017) but experience disproportionately high rates of substance use problems (National Academies of Science, 2020). While findings related to alcohol use are mixed, preliminary research suggests high rates of past 30-day drinking (21-58%) (Coulter et al., 2015; Santos et al., 2014), daily heavy drinking (21-33%) (Gonzalez et al., 2017; Martinez et al., 2016; Scheim et al., 2016), binge drinking (21-51%) (Martinez et al., 2016; Rowe et al., 2015; Santos et al., 2014), and alcohol use disorder (AUD; 26.2% among TGNB veterans) (Blosnich et al., 2017b). These rates are higher than for the general population (16.3% past 30-day binge drinking, 5.9% past 30-day heavy drinking, and 5.6% AUD) (Centers for Disease Control and Prevention., 2018; Han et al., 2021).

Minority stress may partially explain high rates of hazardous drinking [HD; “a quantity or pattern of alcohol consumption that places individuals at risk for adverse health events” (Saunders et al., 1993)] and AUD among TGNB individuals. Minority stress is chronic stress derived from stigma, discrimination, and societal prejudice (Hendricks and Testa, 2012). TGNB individuals frequently experience discrimination (Gonzalez et al., 2017; James et al., 2016), which is associated with higher rates of past 30-day heavy drinking (Gilbert et al., 2014; Rowe et al., 2015) and AUD (Blosnich et al., 2017b). Among TGNB people, there is a dose-response relationship between discrimination and AUD risk, with odds ratios as high as 8.97 for those who experienced discrimination in ≥ 3 areas (e.g., housing, employment, healthcare) (Blosnich et al., 2017b; Martinez et al., 2016).

For TGNB people, healthcare systems can also be sources of minority stress. In a national survey of 27,715 TGNB individuals, 29% of those who had disclosed their identity to their healthcare providers reported delaying necessary medical care because they feared

discrimination (James et al., 2016). This fear reflects the reality in some addiction treatment programs (Nuttbrock, 2012). For example, one study of addiction counselors found that nearly half had negative or ambivalent attitudes about TGNB clients (Eliason and Hughes, 2004). Staff also received little training in working with this population and had little knowledge of relevant institutional policies (e.g., nondiscrimination policies) (Eliason and Hughes, 2004; Mullens et al., 2017). In two “secret-shopper” studies of addiction treatment programs that advertised services for TGNB clients, approximately 70% did not actually offer them (Cochran et al., 2007; Paschen-Wolff et al., 2022).

Cultural adaptation improves treatment for marginalized populations by considering “language, culture, and context” to increase compatibility with clients’ cultural norms/values (Bernal et al., 2009). Previous studies have evaluated culturally adapted substance-use interventions among racial/ethnic (Valdez et al., 2018) and sexual minority (e.g., lesbian, gay, bisexual) people (Baskerville et al., 2017; Pachankis et al., 2015). Aside from conceptual discussions (Austin et al., 2017; Budge, 2013), there are no culturally adapted interventions for TGNB individuals with AUD. In this study, we used qualitative descriptive methods to investigate the acceptability of three currently available AUD psychotherapies when presented to TGNB individuals engaged in HD to identify potential targets for cultural adaptation.

2. METHODS

2.1. Participants, recruitment, and sampling

We recruited TGNB individuals engaged in hazardous drinking ($N = 27$) from an ongoing longitudinal cohort study of transgender identity development (Project AFFIRM) in New York, San Francisco, and Atlanta. At baseline, inclusion criteria for AFFIRM were age ≥ 16 , TGNB identification, and English or Spanish fluency. This sub-study was restricted to individuals who

spoke English. We purposively sampled individuals, stratified by sex assigned at birth and age (18-24 and 25+), who screened positive for HD on the 3-item Alcohol Use Disorder Identification Test-Concise (AUDIT-C) (Bush et al., 1998) at Wave 3 of the AFFIRM study (2018-2019). The AUDIT-C is a widely used screening instrument for HD with sex-based cut-offs validated for cisgender populations (≥ 3 for cisgender women; ≥ 4 for cisgender men; scores range 0-12). There is no consensus for applying these thresholds in TGNB populations (Gilbert et al., 2018). After finding no difference in HD prevalence in the larger AFFIRM cohort when AUDIT-C cut-offs were applied using sex assigned at birth or current gender identity (for those with binary identities), we applied cut-offs using sex assigned at birth for this study. Of note, all individuals in this study met the higher AUDIT-C cut-off (score ≥ 4).

2.2. Data collection

Three psychotherapy vignettes and exercises (Table 1) were developed in consultation with three AUD psychotherapy experts. Vignettes were designed to resemble the type of non-tailored, non-TGNB-specific therapy available in most community treatment settings (Cochran et al., 2007; Paschen-Wolff et al., 2022). Vignettes corresponded to psychotherapy modalities found to be effective for AUD in the Project MATCH trial (Project MATCH Research Group., 1998): Cognitive Behavioral Therapy (CBT), Motivational Enhancement Therapy (MET), and Twelve Step Facilitation (TSF). CBT focuses on relationships among thoughts, feelings, and behaviors to help clients reduce drinking (Kadden et al., 2003). MET helps clients understand and act on their intrinsic motivation for behavior change (Miller et al., 1999). TSF, based on the principles of Alcoholics Anonymous (AA), is a manualized psychotherapy that helps clients understand and engage with community-based 12-step programs (Nowinski et al., 1999). At the beginning of the interview, participants were provided with this background information about

the three therapeutic modalities. Vignettes were constructed to focus on an exercise (e.g., functional analysis in CBT) or topic (e.g., Step 1 of AA in TSF) that might arise early in treatment. We used information from the Project MATCH Monographs Series of treatment manuals for each modality to construct a brief scenario that introduced a key concept and an exercise to explore that concept (Kadden et al., 2003; Miller et al., 1999; Nowinski et al., 1999). For MET, in particular, we incorporated the communication skills of open-ended questions and reflection statements.

In each vignette, participants were asked to complete an in-session exercise that is characteristic of that psychotherapy modality. For CBT, participants completed a “functional analysis” to identify “triggers” (e.g., people, places, events, thoughts, feeling) that preceded and followed drinking or urges to drink. For MET, participants completed a “decisional balance” in which they chose a drinking-related behavior change and then considered the pros and cons of making or not making this change. For TSF, the therapist introduced Step 1 of AA in which individuals admit they are powerless over alcohol and that their lives have become unmanageable. The TSF therapist then asked participants to consider how they use rationalizations to avoid accepting help for their drinking (Wallace, 2012).

Using a standardized interview guide, a single interviewer (a cisgender, queer-identified man and clinician trained in AUD psychotherapy and qualitative research with TGNB populations) conducted the 90-minute individual, semi-structured interviews (face-to-face or via video) focused on drinking and perceptions of AUD treatment. Probes were used to explore how the interaction could be more affirming or relevant for the participants.

2.3. Data analysis

Interviews were audio-recorded, professionally transcribed, de-identified, and uploaded to Dedoose software (2016) for data management. The analytic team consisted of both clinicians and researchers with a variety of gender identities, including TGNB individuals. The team used a directed approach to analysis (Hsieh and Shannon, 2005), identifying codes that captured answers to questions from the interview guide; similar codes were organized into categories. To ensure consistency in the application of the codebook, 10% of the transcripts were double coded. The team met frequently to discuss findings. When conflicts arose in classifying material, they were resolved through group discussion.

3. RESULTS

Table 2 presents identification numbers and demographics for each of the 27 study participants. On average, participants were 36.9 years old ($SD=13.7$); five (18.5%) were age 21-24 and 22 (81.5%) were age 25 or older. Ten participants (37.1%) identified as transmasculine, nine (33.3%) as transfeminine, and eight (29.6%) as nonbinary. Ten (37.1%) participants identified as White, non-Hispanic; five (18.5%) as Black/African American; six (22.2%) as Hispanic or Latino/a/x; four (14.8%) as biracial or multiracial, and two (7.4%) individuals were of another race/ethnicity. No participants were currently in treatment for alcohol or other drug use. Two individuals had previously participated in community-based 12-step groups; one of these individuals had also received treatment in an inpatient rehabilitation setting.

3.1. Cross-cutting categories.

Table 3 provides exemplar quotes for each of the cross-cutting and psychotherapy modality-specific categories. There were no differences in the types of information participants reported in in-person versus video interviews.

3.1.1. Direct acknowledgment of TGNB identity

Participants expressed a desire for therapists to demonstrate familiarity with issues faced by TGNB people and how these can impact drinking. Without proactive and direct acknowledgment of gender identity by the therapist, most interviewees reacted to the treatment vignettes as Participant 17 did: “I feel like it [the therapy] has no consideration of that [being transgender].” Several participants felt that the absence of a direct discussion of gender identity communicated hostility toward or discomfort with TGNB people: “Like whatever Brad [the psychotherapist in this vignette] feels, I don’t care about any of that sh*t. Like do not make me feel, like on top of being worried of my alcoholism, I have to worry about like being confronted about being trans as well” (Participant 15).

Participants made specific suggestions for how therapists could establish an alliance before engaging in more structured discussions of drinking. These suggestions included asking the client about their gender identity, as opposed to waiting for them to self-disclose. Participants also stressed the importance of the therapist using the client’s correct name and pronouns.

3.1.2. Addressing distinct aspects of hazardous drinking among TGNB individuals

Several participants used the phrase “root causes” to describe sociocultural factors related to their drinking that they felt were necessary to discuss in treatment. For example, Participant 3 stated, “When someone’s comin’ in with addiction and want to change, where’s the root?... Let’s get to know you...to solve that puzzle.” Interviewees felt that addressing “root causes” required therapists to explicitly ask about antecedents for heavy drinking that might be unique for TGNB individuals (e.g., transphobia, gender dysphoria). These participants also noted that the therapist may need to help TGNB clients make connections between these experiences and drinking. Related to this, participants felt that between-session contact and mindfulness strategies could help them regulate emotional responses to stressful life experiences.

3.1.3. Preference for TGNB or LGBTQ+ specific group therapy over more general groups

After each of the three vignettes, participants were asked how they would feel about receiving that therapy in a group format, rather than one-on-one. For all modalities, participants preferred TGNB or LGBTQ+ specific groups to general groups. Participants felt they could be more open and less worried about judgment in a group with other TGNB or LGBTQ+ individuals. They also felt they would be more comfortable disclosing their TGNB identity if they knew the group was TGNB-focused.

3.2. Cognitive-Behavioral Therapy (CBT)

3.2.1. Self-reflection as a tool for change

Participants described the utility of the functional analysis exercise and handout in helping them reflect on their drinking behaviors. They reported that this exercise helped them “get to the root of [drinking]” (Participant 21) and to challenge their thoughts, feelings and behaviors related to drinking. Participant 6 stated, “I like the challenge of those thoughts, and I like the homework for paying attention [to them].”

Participants also felt that this exercise provided them with practical insights. Participant 27 stated that the exercise “...made it visible, like the process that’s happening in my head.” This view was shared by others, who reported that externalizing their thought process allowed them to share their experience with the therapist, while also deepening their own understanding of their drinking behaviors. Participant 2 explained how this type of self-reflection encouraged them to develop better coping skills by slowing the decision-making process and facilitating more intentional behavior: “I guess being educated on your thoughts, and recognizing them is helpful in sort of dealing/fighting with them.” Similarly, Participant 1 stated: “I think it would make me

more aware of... what's triggering me to drink... it'll help me, maybe solve my issues and not drink anymore.”

3.2.2. Trauma-informed care

Participants spoke of their own trauma and the high rates of trauma in TGNB communities. For example, Participant 1 stated, “...a lot of us trans folks, especially trans women and trans women of color, we've all experienced at some point in our lives sexual violence, domestic violence, or even a hate crime, you know?” A statement from Participant 23 summarizes how she and other participants felt that therapy could address the impact of trauma: “I guess being able to like work on coping mechanisms... things like reframing mindsets and how to cope with things that you're dealing with, like discrimination... I can see that being like more helpful... being able to like express what happened and those emotions properly instead of channeling them into drinking.”

Several participants reacted specifically to CBT's use of the word “trigger” to describe antecedent events, emotions, or circumstances of an alcohol craving. This is exemplified by Participant 9's discussion of how this word evoked images of guns and past trauma: “There are so many people who have had trauma around firearms.” Other participants specifically cited the high prevalence of trauma among TGNB individuals as a reason to avoid this type of language.

3.3. Motivational Enhancement Therapy (MET)

3.3.1.1. Facilitating decision-making and behavior change

Participants appreciated how the MET approach helped them make their own choices about drinking. They also viewed the therapist in the MET vignette, Rita, as collaborative: “...if Rita's therapies can guide me to things like pros and cons [of making changes] and then I can

understand it's within me to change, or be better... I definitely will feel that she's working with me" (Participant 7).

3.3.1.2. Nonjudgmental stance by the therapist

Many participants felt that both the decisional-balance handout and in-session exercise were nonjudgmental. They described these as "neutral" (Participant 9) and as granting equal importance to positive and negative aspects of drinking. The MET therapist was seen as "patient" and "not judgin [sic]" (Participant 3).

3.3.2. Alternative exercises to avoid oversimplifying decision-making

A common criticism of MET was that the decisional-balance exercise and handout were constrained by a binary, pro versus con view of decision-making. The phrase "black and white" was used by several participants, who noted that this conceptualization limited their ability to reflect on their drinking. For example, as Participant 18 noted: "The problem with this worksheet is that there isn't really room for self-reflection." Related to this criticism, nearly half of participants ($n = 13$) felt this exercise oversimplified drinking behaviors: "It just seems obvious...and not getting to... what the root of my issues would be" (Participant 14).

Participants offered two suggestions for improving the decisional-balance exercise. First, they suggested framing it as an exercise that would be repeated throughout treatment as goals and motivations changed: "Maybe doing the pros and cons over, like, a period of time, to, kind of, see if any of the pros and cons changed... especially if you're somebody that's struggling with becoming sober, and then drinks more, and then becomes sober, and then drinks more... to see, like, a pattern" (Participant 4). Second, participants suggested incorporating other exercises that could facilitate creative expression of how they feel about their drinking (e.g., journaling, drawing).

3.4. Twelve Step Facilitation (TSF): Criticism of “Powerlessness” as a 12-step concept

Nearly all of the participant comments about the TSF vignette focused on the 12-step concept of “powerlessness” in the context of being a TGNB person. While reactions to this concept ranged from hostile to ambivalent, the majority of participants ($n = 22$) had negative reactions and felt that it conveyed a “defeatist” or “judgmental” attitude. For example, Participant 5 remarked: “I don’t like the word powerless....I would feel disempowered because the therapist told me that I was powerless. That sounds really defeating to me... and unacceptable. That to me is another judgment term.” Some participants suggested eliminating the concept of powerlessness altogether: “Yeah. I think I would just get rid of that powerless thing” (Participant 8).

For several participants, the concept of powerlessness conflicted with their self-image and ways that they have demonstrated agency in their lives. Other participants reported discomfort with the term “powerless” in the context of a transgender identity: “Like, for me, coming into my trans-ness has been realizing I have the power to do what I need to with my body, you know?” (Participant 25).

Participants also reacted negatively when asked to imagine TSF being conducted in a group format: “Uh. I wouldn’t like it at all. I bet everyone would be beating themselves up and feeling worthless and then believing they’re powerless. I don’t think that would be a positive thing at all” (Participant 18). Participants specifically related their disapproval of the concept of powerlessness to their transgender identity and the presumed transgender identities of other group members: “Oh my God, that would be so depressing. Just to hear a bunch of... trans people in this group talk about how we’re powerless... I don’t think I would leave the session feeling more capable at all...” (Participant 25).

4. DISCUSSION

To our knowledge, this is the first qualitative study of how transgender and nonbinary (TGNB) people perceive evidence-based psychotherapies for alcohol use disorder (AUD). Our findings suggest several areas of cultural adaptation that may improve treatment for this population: incorporating culturally distinct alcohol-related risk factors (e.g., minority stress), responding to the high rates of trauma in this population, expanding conceptualizations of decision-making, and focusing on resilience and strengths of TGNB clients instead of deficits and risk. These findings expand on previous epidemiologic research (Blosnich et al., 2017a; Martinez et al., 2016; Matsuno and Israel, 2018) by highlighting how alcohol risk factors (e.g., trauma, gender dysphoria) and resilience factors (e.g., advocacy on behalf of the TGNB community) can be incorporated into culturally adapted AUD psychotherapy and evaluated in future clinical trials.

4.1. Incorporating gender identity and the impact of minority stress into treatment

Asking about and consistently using the name and pronouns that affirm a TGNB person's identity is a fundamental part of care that improves health outcomes (National Academies of Science, 2020). Our findings indicate that therapists can further strengthen their alliance with TGNB clients by explicitly acknowledging minority stressors and other factors that distinctly relate to drinking among TGNB people (e.g., discrimination, stigma, gender dysphoria) (Bockting et al., 2013; Gonzalez et al., 2017; Johnson et al., 2021; Kidd et al., 2018). For example, after exploring and validating a client's emotional reaction to discrimination, a CBT therapist might use a functional analysis to elucidate how this experience relates to heavy drinking in social settings (e.g., alleviating anticipatory anxiety). Further research is needed to evaluate interventions that incorporate gender identity and minority stress-related topics into

currently available, evidence-based, manualized treatments. One such intervention is ESTEEM, a CBT-based intervention developed to mitigate the impact of minority stress that has been shown to improve depressive symptoms and alcohol-related outcomes for sexual minority men (Pachankis et al., 2015).

4.2. Importance of trauma-informed approaches to AUD treatment

Clinicians who practice “trauma-informed care” assume that clients may have a history of trauma and actively incorporate strategies to mitigate its impact on clients’ lives (Mills and Teeson, 2019). Traumatic experiences were common among study participants and other transgender people in their lives, which is consistent with epidemiologic findings from other studies of transgender individuals. For example, one recent study of 27 high schools in the Northeastern U.S. found that 86% of TGNB students reported past-year peer victimization and bullying (Norris and Orchowski, 2020). In the 2015 US Transgender Survey (USTS) (James et al., 2016), a national study of over 27,000 TGNB adults, 10% of respondents had experienced transphobic violence from a family member and 47% had experienced sexual assault in their lifetime. In the past year, 46% of USTS respondents were verbally harassed and 9% were physically attacked. Among TGNB individuals, trauma is associated with increased risk for HD (Coulter et al., 2015; Kidd et al., 2018) and AUD (Smith and Cottler, 2018). Therefore, it is important for therapists to explicitly acknowledge trauma as a “root cause” of HD for many TGNB individuals. Treatments for co-occurring PTSD and AUD, such as Seeking Safety (Schafer et al., 2019), may be particularly helpful for TGNB individuals.

Trauma-informed care involves avoiding language that unnecessarily evokes images of violence. For example, CBT and related therapies traditionally refer to feelings, thoughts, or events that precede or precipitate negative health behaviors as “triggers” (Kadden et al., 2003).

Participants noted that this word was associated with violent imagery (e.g., the trigger of a gun). While this criticism is not unique to TGNB individuals, TGNB clients may find this particularly distressing due to the high rates of discrimination and hate violence they experience (Bockting et al., 2013; James et al., 2016). Alternative phrases include “prompting event” or “cause.” Further research is needed to identify other considerations when delivering trauma-informed care to TGNB clients.

4.3. Self-reflection exercises may resonate particularly well with TGNB clients

Self-reflection, such as that undertaken in CBT’s functional analysis, resonated with participants in this study. This makes sense given the degree to which many TGNB individuals engage in self-reflection about their identity, often from an early age. This process typically involves exploring understanding of their gender; challenging assumptions about their gender and the sex they were assigned at birth; and, for many, undergoing a process of changing their gender expression (i.e., gender transition) to alleviate gender dysphoria and achieve self-acceptance, which Ashley and Ellis (2018) refer to as “gender euphoria.” Similarly, the self-reflection process in CBT is designed to challenge assumptions about drinking and redefine the role of alcohol in one’s life. Emphasizing this approach in therapy might allow clinicians to draw on a strength of many TGNB individuals.

TGNB individuals may prefer self-reflection exercises because they target the impacts of discrimination and stigma, which participants wanted emphasized more in therapy. In particular, research suggests that identity-based discrimination and stigma can lead to emotional dysregulation and impulsivity, which contribute to HD (Nuttbrock et al., 2014). Through self-reflection, CBT and related therapies seek to help clients shift from impulsive, habitual, cue-driven drinking to intentional, goal-directed decision-making (Kadden et al., 2003). Future

studies should examine the potential for self-reflection techniques to mitigate the impact of minority stress on TGNB individuals with AUD.

4.4. Expanding how therapists conceptualize decision-making

When reacting to the MET vignette, participants responded positively to what they perceived as the therapist's collaborative and non-judgmental style. These are central elements of motivational interviewing (Miller et al., 1999), and by extension of MET. The therapeutic style in MET prioritizes client-centered decision-making regarding the types changes that would most meaningfully and positively impact a client's life and considers the client to be "the expert" in what would facilitate or impede behavior change. For many TGNB individuals, one consequence of minority stress is fear and anticipation of stigma and discrimination from others (Herek, 2016). While fear of judgment from treatment providers is common among many people seeking treatment for alcohol-related problems, this may be a culturally distinct treatment barrier for TGNB individuals due to the overlap between drinking, gender-identity-related minority stress, and experiences they may have had as a TGNB person (e.g., drinking to meet other TGNB people, drinking cope with discrimination) (Lindley et al., 2021).

MET and related therapies often use a "pro versus con" model when evaluating potential behavior changes (Miller et al., 1999). However, for TGNB people in this study, this binary approach to decision-making was viewed as overly simplistic and limiting self-reflection. This could indicate a misunderstanding by participants of the decisional balance exercise. In this activity, individuals are asked to discuss the pros and cons of making or not making a particular change that they have identified. This exercise allows for considerable flexibility. For instance, if someone sets a goal of reducing their alcohol consumption on weekends, they might cite "spending more time with family" as both a pro (e.g., increased support from their partner and

children) and a con (e.g., their parents live close-by and frequently misgender them) of making this behavior change. The initial, negative reaction of TGNB participants to the pro-con framework of the decisional balance exercise may indicate that MET therapists need to pay particular attention to helping clients understand this nuance, including by using culturally relevant examples.

4.5. Shifting from deficits-based to strengths-based treatment

Nearly all participants reacted negatively to the TSF discussion of Step 1 of Alcoholics Anonymous (AA) (i.e., admitting that one is powerless over alcohol and that one's life has become unmanageable). In AA, and by extension in TSF, accepting one's powerlessness over drinking is intended to prepare the individual for a lifetime of using skills and support (e.g., from an AA group and sponsor) to abstain from drinking (Glassman et al., 2020). However, this approach emphasizes risk and portrays substance-use problems as beyond an individual's control. This type of "deficits-based approach" (Ross et al., 2016) overlooks resilience and strengths of TGNB people, many of whom have already overcome significant challenges in their lives (e.g., high levels of hate violence, unemployment, healthcare discrimination, rejection from family and friends) (James et al., 2016). There is a growing recognition of the need for clinical and public health interventions to shift from deficits-based approaches to strengths-based approaches (Ehlinger et al., 2022; Matsuno and Israel, 2018; Ross et al., 2016). The Transgender Resilience Intervention Model (TRIM) (Matsuno and Israel, 2018) is one framework for incorporating both group-level resilience factors (e.g., social support, family acceptance) and individual-level resilience factors (e.g., self-acceptance, pride, gender transition) into psychotherapy. In applying the TRIM model, TSF therapists can promote group-level resilience by referring clients to AA groups that are known to be affirming of TGNB people, a desire stated

by participants when they voiced a preference for TGNB/LGBTQ+ specific groups over more general groups. To promote individual-level resilience among TGNB clients during discussions of Step 1 “powerlessness”, TSF therapists might first inquire about factors that have previously helped TGNB clients overcome obstacles in their lives. This could allow clients to acknowledge their current powerlessness over their drinking, while also identifying ways that 12-step participation could help them apply their pre-existing strengths to changing their drinking behaviors.

4.6. Limitations

Although notable as the first qualitative study to examine how TGNB individuals perceive evidence-based AUD psychotherapies, this study has limitations. Because participants were recruited from three large U.S. cities, findings may not reflect the perspectives of TGNB people in rural/suburban areas. Second, eligibility was determined using the AUDIT-C, a screening tool for HD that is not diagnostic for AUD and with threshold scores that were established in studies of cisgender individuals (Gilbert et al., 2018). Third, the clinical vignettes in this study presented a single archetypal session from each psychotherapeutic modality and thus did not replicate ongoing treatment with an established therapeutic alliance. Individuals who agreed to participate were likely different than those who did not. There is a risk that social desirability played into their responses.

5. CONCLUSIONS

Previous research has demonstrated that cultural adaptation can increase treatment acceptability and retention for marginalized populations (Baskerville et al., 2017; Pachankis et al., 2015; Valdez et al., 2018). Our findings support preserving certain key components of CBT (e.g., self-reflection through functional analysis) and MET (e.g., nonjudgmental and

collaborative decision-making). TSF may require more significant cultural adaptation, particularly given participants' negative reactions to the deficit-based approach of Step 1 of AA and their preference for TGNB/LGBTQ+ specific groups. All three therapy modalities may benefit from adaptations that incorporate population-specific risk factors (e.g., minority stress), principles of trauma-informed care, and strengths-based approaches to improve acceptability among TGNB clients.

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Table 1. Psychotherapy vignettes and in-session worksheets/exercises used in qualitative interviews.

Psychotherapy Modality	Psychotherapy Vignette
Cognitive-Behavioral Therapy	To help you cut-back on your drinking, you are seeing a therapist named Brad in a clinic once a week. In today’s session, Brad asks you to use this worksheet [<i>Show in-session exercise worksheet</i>] to make a list of situations or feelings that “trigger” you to want to drink alcohol. You make a list of 2 or 3 situations in which you find yourself craving a drink. Next, Brad asks you to identify thoughts and feelings that you have in that moment that might make it more likely you’ll have a drink. He tells you that therapy will help you learn to “challenge those thoughts” and “ride out urges” to drink. For homework, Brad asks you to pay attention the next time you have an urge to drink. He asks you to write down on this worksheet some notes about how you were feeling when the urge came on and any thoughts you notice yourself having. In-session exercise: Functional analysis
Motivational Enhancement Therapy	Your therapist is Rita. You arrive at Rita’s office feeling hung over after having at least 5 drinks last night. Last week, Rita had asked you to keep a log of when you drink and how many drinks you have. You and Rita review this log at the beginning of the appointment. She asks you, “So tell me about last night when you had at least 5 drinks?” You explain, “Well... I had a really stressful day at work and needed a drink to cool off... but I feel really terrible today.” Rita replies, “So alcohol helps you cool off but today you feel terrible.” “Yeah,” you reply, “It really helps me unwind, but then it takes me a while to get going the next morning.” Rita says, “So it sounds like for you there are both positive and negative aspects about drinking... I wonder if we could think more about that, using this worksheet as a guide.” [<i>Show in-session exercise worksheet</i>]. Rita asks you to think about the pros and cons of making changes to drinking, imagining what it would be like to do so. In-session exercise: Decisional balance
Twelve Step Facilitation	You’re seeing your therapist Aiden for the first time. He explains that people with alcohol problems usually have them their whole lives and that the first step in dealing with alcoholism is accepting that you’ve lost control over your drinking and are powerless to control it. Aiden asks you look at this worksheet [<i>Show in-session exercise worksheet</i>]. He tells you that “Powerlessness” includes realizing that you are powerless over the amount of alcohol you drink and over the unacceptable results of your drinking. Aiden explains that often people develop thoughts, or rationalizations, that falsely make it seem like they can control their drinking. He asks to you to read some examples of rationalizations at the bottom of the worksheet and to think of ways in which you might rationalize your drinking. In-session exercise: Psychoeducation and discussion of alcohol-related rationalizations

Table 2. Demographic information for qualitative interview participants (*N* = 27)

Id Number	Demographics (age, gender identity, race, ethnicity)
1	40-59 years; Transgender woman/Male-to-Female (MTF); “Another race”, Hispanic
2	25-39 years; Genderqueer; African-American, non-Hispanic
3	25-39 years; woman; African-American, Hispanic
4	25-39 years; Transgender man/Female-to-Male (FTM); White, non-Hispanic
5	40-59 years; Transgender woman/Male-to-Female (MTF); White, non-Hispanic
6	40-59 years; Transgender man/Female-to-Male (FTM); White, non-Hispanic
7	40-59; Transgender woman/Male-to-Female (MTF); “Another race”, Hispanic
8	25-39 years; Nonbinary; “Another race”, Hispanic ethnicity
9	40-59 years; Transgender man/Female-to-Male (FTM); White, non-Hispanic
10	25-39 years; Woman; “Another race”, non-Hispanic
11	25-39 years; Transgender man/Female-to-Male (FTM); White, non-Hispanic
12	60+ years; Woman; White, non-Hispanic
13	60+ years; Transgender man/Female-to-Male (FTM); African-American, non-Hispanic
14	40-59 years; Genderqueer; White; non-Hispanic
15	25-39 years; Transgender woman/Male-to-Female (MTF); African-American, non-Hispanic
16	25-39 years; Transgender man/Female-to-Male (FTM); “Another race”, Hispanic
17	21-24 years; Transgender woman/Male-to-Female (MTF); White, non-Hispanic
18	25-39 years; Nonbinary; Multiracial, no response for ethnicity
19	40-59 years; Nonbinary; Multiracial, unspecified “other” ethnicity
20	25-39 years; Agender; African-American, non-Hispanic
21	25-39 years; Transgender man/Female-to-Male (FTM); White, non-Hispanic
22	60+ years; Nonbinary; White, non-Hispanic
23	21-24 years; Transgender woman/Male-to-Female (MTF); African-American; non-Hispanic
24	25-39 years; Transgender man/Female-to-Male (FTM); Multiracial, non-Hispanic
25	21-24 years; Genderqueer; Multiracial; unspecified “other” ethnicity
26	21-24 years; Transgender man/Female-to-Male (FTM); “Another race”, Hispanic
27	21-24 years; Transgender man/Female-to-Male (FTM); Asian, unspecified “other” ethnicity

Note: Age ranges are used to protect participants’ confidentiality

Table 3. Cross-cutting and psychotherapy modality-specific themes related to acceptability and potential areas for improvement, along with exemplar quotations from transgender and nonbinary (TGNB) participants with hazardous drinking ($N = 27$).	
Cross-cutting themes	
	Exemplar Quotations
Direct acknowledgement of TGNB identity	Participant 2: “I guess I would like there to be, um, some recognition that gender might play, like, a part in my drinking.” Participant 17: “I feel like it [the therapy] has no consideration of that [being transgender] ... It would probably really upset me, if it [gender dysphoria] was a factor in what was causing it [drinking] ... if it was like, part of the issue, and it just wasn’t being addressed, then that would not be, I wouldn’t feel good.” Participant 27: “I mean name and pronouns is like, uh, I feel like ‘a must’ if you’re seeing patients who are transgender.”
Addressing distinct aspects of hazardous drinking among TGNB individuals	Participant 25: “I think maybe, like, there will be... triggers within the context of, like, homophobia or, like, transphobia, and like, feeling dysphoric, even, you know? Like, a trigger, a major trigger can be dysphoria. Just, like, feeling shitty about yourself, not feeling in alignment.”
Preference for TGNB or LGBTQ+ specific groups	Participant 25: “I would want it [a group] to be, like, a, specifically trans or queer group, just to know that, like, other people are dealing with this, too.” Participant 4: “[I prefer] ... a group ... targeted towards the LGBT community, so then it’s not like I’m just going into a group for, like, you know, substance, alcohol abuse, and then one of my triggers is somebody in my personal life still referring to me as “she” [misgendering] and then me not wanting to necessarily open up about that to strangers who I don’t know if they’re an ally or not.” Participant 2: “But I might be less likely to talk about, like, my trans identity with a group of strangers ... Um, unless I know that it is a safe space. And so that I would need, like, the therapist to sort of set that up.”
Cognitive-Behavioral Therapy	
Self-reflection as a tool for change	Participant 6: “It’s often helpful for me to look at the situation from a logical standpoint ... once I’ve actually thought through it, instead of just acting. Um, it makes it easier for me to act differently the next time, or at least some time in the future.”
Trauma-informed approach	Participant 1: “... a lot of us trans folks, especially trans women and trans women of color, we’ve all experienced at some point in our lives sexual violence, domestic violence, or even a hate crime, you know?” Participant 23: “I guess the issue would be ... therapy is never going to address ... street discrimination ... like you can’t really alleviate someone harassing you in public ... like asking someone to change their behavior ... ‘Get harassed less’ ... that’s kind of shitty, right?”

Motivational Enhancement Therapy	
Facilitating decision-making and behavior change	Participant 19: "I like this approach a lot ... And it's because I feel like it is facilitating, um, my own decision-making."
Nonjudgmental stance	Participant 19: "... it's taking both sides into account ... like, what I'm getting out of the drinking, and also the ... repercussions. There's no, like, judgement about what is more important."
Alternative exercises to avoid oversimplifying decision-making	Participant 18: "And this one [handout] is just like 'Oh, if I make a change, if I don't make a change ...' It's very black and white." Participant 24: "Maybe [the therapist] could've asked her ... what was stressful about work, and helped her cope ... like stress management or something like that ... Like, I know the focus is the drinking, but maybe if she helped the client identify different things that they can do when they feel stressed ... So maybe if they can resort to something else, maybe drinking is not the first thing that they do." Participant 25: "Like, if anything, I would prefer a bit more, like, artistic ... rather than, like, a worksheet ... flexibility in, like, literally, like, drawing outside of the lines, like, writing poetry or something, you know? A bit more artistic ... Like, poetry, honestly, I do think would be, like, really helpful and, like, just getting the feelings out."
Twelve Step Facilitation	
Criticism of "Powerlessness" as a 12-step concept	Participant 21: "Um, uh, not really sure. Um, I do wonder if I -- if I would be bristling a little bit extra at the powerlessness thing if I was thinking about that. Just 'cause it's like, you know, how can you call me powerless? Look at how much I've, like, changed my life." Participant 20: "I feel like if I were to start talking ... about my trans experience, they [the therapist] would try to put something on me like where it's like, 'You've lost control of your drinking to try to gain control of your existence in society.' And I'm like, 'It's not that simple, you know?' I feel like it's an over simplification-- that's what it is." Participant 6: "I think I feel judged enough in my life, I don't think I need to feel judgment in this program."