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College of Allied Health

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Walden University
2025

Abstract

Psychologists' Competency and Training Regarding Treating Transgender and Non-Conforming Youth with Gender Dysphoria

by

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MS, Walden University, 2018

MS, University of Phoenix, 2016

BS, I.E.S.T- Anahuac, 1998

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

May 2025

Abstract

There is limited evidence-based research on required competency, training, assessment, and treatment practices for psychologists who treat transgender and non-conforming (TGNC) youth with gender dysphoria. Eleven licensed psychologists with at least 5 years of experience treating TGNC youth were recruited through social media and snowball recruiting to participate in this qualitative Delphi study. Using multicultural competency theory as a guide, these experts were asked to develop a consensus regarding the minimum competencies and training to treat TGNC youth, as well as what they thought the standards should be for assessment and treatment. Data were collected in three rounds of online questionnaires and analyzed using thematic and content analysis to identify themes, concepts, and categories. Findings of each round were shared until an 80% consensus was reached. Experts agreed that competence entails empathetically supporting gender development as well as social and physical transition to an affirmed gender. The concurred minimal level of training to treat this population without supervision was a master's degree, 2 years of experience, and a lifetime commitment to continued training. The most useful assessment method was found to be clinical interviews, and the best treatment practices included gender affirming-care, family systems therapy, feminist therapy, and cognitive behavioral therapy. These findings may be used to develop training programs as well as inform the professional treatment of TGNC youth, which may contribute to social change by enhancing treatment access and effectiveness for an underserved population as well as providing vital information to the TGNC population, their families, and healthcare providers.

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Dedication

This research work is dedicated to God all mighty who makes all things possible. To my beautiful family who encouraged and supported me throughout this journey, thank you for the love, understanding and prayers. To everyone who this work could serve as a foundation for further research to help others and make the world a safer and better place.

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Chapter 1: Introduction to the Study

Introduction

In the last decade, the number of adolescents seeking gender-affirmative treatment and being referred to specialized gender identity clinics to alleviate gender dysphoria has increased (Jessen et al., 2021). Although not all transgender and gender-nonconforming (TGNC) individuals experience gender dysphoria, which refers to distress originating from an existing incongruence between one's gender identity and sex assigned at birth (APA, 2022), TGNC clients often seek treatment for mental health issues (Nokoff, 2022; Stewart et al., 2023). Researchers have conveyed that early interventions and working within a trained interdisciplinary team of mental health and healthcare professionals in diverse areas (or disciplines of study) might improve outcomes for TGNC individuals experiencing distress (Drescher & Byne, 2013; Tordoff et al., 2022). However, due to the lack of psychologists' experience or training in working with this population, clients often report taking on the role of educators because their mental health needs are not being met in therapy (Stewart et al., 2023).

Increased awareness of the mental health disparities of TGNC individuals has led to the Endocrine Society (Hembree et al., 2017), the World Professional Association for Transgender Health (WPATH, 2022), and the American Psychological Association's (APA, 2015) recognition that there is a need for mental health professionals to provide quality services and advocate for TGNC individuals. The development and endorsement of the Guidelines and Standards of Care for the Health of Transgender and Gender-Diverse People (Coleman et al., 2022), the Guidelines for Psychological Practice with

Transgender and Gender Nonconforming People, (APA, 2015), and the Multicultural Counseling Training Competencies (see also Chae et al., 2006; Chiu et al., 2013; Gallardo et al., 2009) all aimed to reduce disparities in mental healthcare for clients associated with a lack of training and competence (APA, 2003; Cochran & Robohom, 2015; Clauss- Ehlers et al., 2019; Gallardo et al., 2009). However, there is little to no evidence regarding how these guidelines are perceived or utilized in clinical practice.

Despite multicultural training being incorporated into most graduate programs and the advance in the new affirmative framework under which many mental health professionals now practice, there continues to be limited evidence-based research regarding guidelines for professional competencies and empirically-supported treatments for the treatment of TGNC youth with gender dysphoria (Budge et al., 2017; Chen et al., 2018; Chou & Johnson, 2022; Edwards- Leeper et al., 2016; Lev, 2009; Levine & Abbruzzese, 2023; Lytle et al., 2014; Pachankis, 2018; Pantalone,2015). There is also a lack of longitudinal research regarding the outcomes that follow TGNC youth in adulthood after gender-affirmative care (WPATH, 2022).

Across the United States, there are a large number of anti-transgender laws that impact the future of the mental health and overall well-being of TGNC youth. In 2022 and 2023, Texas, Kentucky, and Florida were among the 23 states where legislation was introduced that would criminalize the provision of certain transition-related medical care services to TGNC youth (APA, 2022). Under these bills, healthcare professionals would be investigated and penalized with the revocation or suspension of their license if they provide gender-affirmative care to youth under 18 years old (Kraschel et al., 2022; OAG

Opinion No. KP-040, 2022; SB 254, 2023). This creates a crisis not only for transgender and gender-nonconforming individuals but also for the healthcare professionals that treat them. Hence, there is a need for research that supports training and treatment guidelines for this population.

While mental health professionals are striving to meet the needs of the TGNC population, there are ongoing legal efforts that increase the stress of simply being TGNC that further increases those needs. In some states, anti-transgender bills passed into law allow parental rights to be temporarily taken away by the state from parents who support their transgender children to seek gender-affirmative care as some legislatures perceive it as "child abuse" (OAG Opinion No. KP-040, 2022, p. 1). Senate Bills such as Florida's 254 (SB 254), referred to as the "abduction bill," provide parents who are not supportive of gender-affirming treatments the legal ability to take a child across state lines away from the parent who supports gender-affirming care to protect the child who is "subjected" or "threatened" to therapies and surgeries to treat gender dysphoria (SB 254, 2023).

In other states, anti-transgender laws restriction has not only prohibited and suspended gender-affirmative care to minors and adults, but the issue has escalated to restrict TGNC students' access to restrooms that match their gender identity and sports participation for transgender youth (Barbee et al., 2022; Kinney et al., 2022). These bills also propose increased clinician training and consent from all parents or legal guardians to treat TGNC youth (Kraschel et al., 2022). The potential legal challenges that exist for mental health providers make the need for research regarding competency, training,

assessment, and treatment approaches imperative.

Treatment for TGNC youth has become a conflicted and controversial topic and mental health professionals are left not knowing what course of action to take (Turban et al., 2021). In this qualitative Delphi study, I explored the perspectives of doctoral-level psychologists in the United States who are experts on required competency, training, assessment, and treatment practices when treating TGNC youth with gender dysphoria. It was essential to conduct this study to address the gap in the literature regarding the need for information about the necessary and sufficient specialized training to develop clinician competence when working with the population of interest, as well as the need for information about what the standards for assessment and treatment practices should be in working with this population.

This study aimed to gain valuable information from experts within the United States who work with TGNC youth regarding efficacious and culturally sensitive treatment, guidelines, and best practices based on their current knowledge, skills, and experiences. The findings of this study can guide mental health professionals in improving their clinical competency to provide mental health services to TGNC youth with gender dysphoria and avoid harm caused by outdated, inhumane, harmful treatments such as conversion therapy (Turban et al., 2021). Despite the publication of the standard of treatment for this population, it was unknown what expert clinicians who work with TGNC youth think about training or practice after applying assessments and treatments. The qualitative Delphi research sought to fill this gap by developing an expert consensus regarding what the minimum level of competency and training should be to work with

this population as well as what should be included in the assessment and treatment of TGNC youth.

Background

Throughout history and across cultures, gender incongruence has been a topic of interest in the medical and mental health fields. Understanding gender and gender identity development has been researched and debated. In 2007, the first multidisciplinary pediatric gender clinic in the United States was established at Boston Children's Hospital to provide medical transition services to TGNC youth (Edwards-Leeper et al., 2016). Since then, the number of multidisciplinary pediatric clinics in the United States has increased due to the growing numbers of TGNC youth presenting for treatment to address gender dysphoria (Edwards-Leeper et al., 2016; Jessen et al., 2021; Stewart et al., 2023). Gender dysphoria is defined by the *2022 Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision* (*D*SM-5-TR) as experienced incongruence between the individual's inner gender identity and their assigned gender at birth. Mental health professionals are called upon to provide services to gender-diverse and transgender youth as a part of an interdisciplinary care team (Chen et al., 2016; Janicka & Forcier, 2016; Tishelman et al., 2015).

The guidelines for cultural diversity in psychotherapy research with sexual and gender minorities are inadequate to address the needs of this vulnerable population. Understanding TGNC youth's gender development and identities, as well as their social gender transition and physical transition to an affirmed gender, has been a priority of multidisciplinary care teams (Chen et al., 2016). Researchers indicate that to help TGNC

youth with their gender affirmation process, medical and mental health professionals must address several areas of perspective, such as psychological, legal, social, medical, and surgical, before deciding the best route for treatment (APA, 2022; Hsu, 2023; Turban et al., 2021). Researchers conveyed that mental health providers must employ cultural humility to adequately address the unique mental health needs of TGNC youth to demonstrate respect, empathy, and compassion elements that are missing in current practice (Portz & Burns, 2020).

In the last decade, the preferred approach to treating TGNC youth in multidisciplinary pediatric clinics has been based on the gender-affirmative model of care (Ashley, 2022; Hembree et al., 2017). Gender-affirming care consists of various components including social transitioning and medical interventions for youth (Keo-Meier & Ehrensaft, 2018; WPATH, 2022; Zucker, 2019). Social transitioning is an individualized process where TGNC children and adolescents take several different steps to align their gender identity with their gender expression, which may include using a new name and pronouns and expressing their gender through clothing and haircuts (Keo-Meier & Ehrensaft, 2018). Medical interventions such as puberty blockers, hormones, and, in some cases, surgery, are also steps that help youth decrease the distress experienced by their gender incongruence (Turban et al., 2021).

It is worth noting that prominent researchers specialized in affirmative care and gender dysphoria have suggested that because some children who experience gender dysphoria will not continue to experience it through adolescence, it is not recommended for complete social transition to occur at the early stages of puberty (Block, 2023;

Coleman et al., 2022; de Vries & Cohen-Kettenis, 2012; Hembree et al., 2017; Drescher, 2014; Stetson, 2022). In children diagnosed with gender dysphoria, researchers recommend watchful waiting and carefully observing how gender dysphoria develops in the first stages of puberty for a complete transition to occur (de Vries & Cohen-Kettenis, 2012). There are debates among researchers over the optimal age when youth are considered old enough and mature enough to consent or verbalize their need to undergo gender transition (D'Angelo et al., 2021; Kraschel et al., 2022; Turban et al., 2021; WPATH, 2022). But there is little to no evidence-based research on the inherent risks and uncertainties that social transition with or without medical interventions might bring to TGNC youth (Ashley, 2022; D'Angelo et al., 2021; Turban et al., 2021).

With limited longitudinal research on gender dysphoria and the developmental trajectories of socially-transitioned youth, mental health professionals cannot predict the psychosexual outcome for any specific child (de Vries & Cohen-Kettenis, 2012). Mental health professionals should be aware that there is a lack of research regarding TGNC youth who *detransition*, which refers to an individual's decision to return to their sex assigned at birth before choosing an approach to treatment (Turban et al., 2021). The DSM-5-TR (APA, 2022) provides diagnostic criteria for children and separate diagnostic criteria for adolescents and adults, which they must meet to be diagnosed with gender dysphoria. Clinically significant distress caused by gender dysphoria must be present in children, adolescents, and adults, hindering their social, occupational, and other areas of functioning in order to qualify for the diagnosis (APA, 2022).

In adolescents and adults with gender dysphoria, the DSM-5-TR criteria specifies

that clients must experience a significant incongruence between their experienced or expressed gender and assigned gender at birth for at least 6 months, as manifested by at least two of the following:

1. A marked incongruence between one's experienced/expressed gender and primary and/or secondary sex characteristics (or, in young adolescents, the anticipated secondary sex characteristics).
2. A strong desire to be rid of one's primary and/or secondary sex characteristics because of a marked incongruence with one's experienced/expressed gender (or, in young adolescents, a desire to prevent the development of the anticipated secondary sex characteristics).
3. A strong desire for the primary and/or secondary sex characteristics of the other gender
4. A strong desire to be of the other gender (or some alternative gender different from one's designated gender).
5. A strong desire to be treated as the other gender (or some alternative gender different from one's designated gender).
6. A strong conviction that one has the typical feelings and reactions of the other gender (or some alternative gender different from one's designated gender). (APA, 2022, p. 513).

In children's gender dysphoria, the DSM-5-TR indicates that children must experience a significant incongruence between their experienced or expressed gender and assigned gender at birth for at least 6 months, as manifested by at least six of the

following:

1. A strong desire to be of the other gender or an insistence that one is the other gender (or some alternative gender different from one's assigned gender).
2. In boys (assigned gender), a strong preference for cross-dressing or simulating female attire; or in girls (assigned gender), a strong preference for wearing only typical masculine clothing and a strong resistance to the wearing of typical feminine clothing.
3. A strong preference for cross-gender roles in make-believe play or fantasy play.
4. A strong preference for the toys, games or activities stereotypically used or engaged in by the other gender.
5. A strong preference for playmates of the other gender.
6. In boys (assigned gender), a strong rejection of typically masculine toys, games, and activities and a strong avoidance of rough-and-tumble play; or in girls (assigned gender), a strong rejection of typically feminine toys, games, and activities.
7. A strong dislike of one's sexual anatomy.
8. A strong desire for the physical sex characteristics that match one's experienced gender. (APA, 2022, p. 512).

Despite the progress made within the field with the development and endorsement of the Guidelines and Standards of Care for the Health of Transgender and Gender-Diverse People (WPATH, 2022), the Guidelines for Psychological Practice with Transgender and Gender Nonconforming People (APA, 2015), and the Multicultural

Counseling Training Competencies (Sue et al., 1992), mental health professionals have not reached a consensus regarding the adequate clinical approach and assessment methods to treat TCNC youth with gender dysphoria in practice. Existing guidelines and standards of care may be inconsistent in the minds of mental health professionals whose training or theoretical orientation takes a more cautious developmentally-informed approach rather than a gender-affirmative approach (Ehrensaft, 2017).

There are also different perspectives among clinicians, scholars, researchers, and legislators on the benefits versus the negative outcomes of early gender-affirmative care (Block, 2023; Tordoff et al., 2022). Also, although not all gender-nonconforming youth who self-identify as transgender will meet DSM-5-TR (APA, 2022) diagnostic criteria for gender dysphoria or experience persistent gender dysphoria, these individuals may seek treatment from therapists and psychologists to address the feelings and phenomena of isolation, stigma, discrimination, victimization, anxiety, depression, or suicidal thoughts (APA, 2015; Blackwell, 2012; Janicka & Forcier, 2016; Kaltiala- Heino et al., 2018; Zucker, 2017).

There is a need for clinical training to gain more understanding and knowledge to address transgender and nonconforming individuals' mental health needs (Stewart et al., 2023). Researchers have provided valuable knowledge to develop trans-affirmative practice (i.e., Rutherford et al., 2012; Zucker, 2019), but some researchers also continue to lump TGNC individuals together in one group when this diverse group is composed of individuals with unique needs and struggles that must be addressed individually (King, 2019; Lytle et al., 2014; Pachankis, 2018; Pantalone, 2015). Most researchers have been

focused on clinicians with adult clients, and several have noted that there is a lack of information regarding best practices for clinicians working with TGNC youth (e.g., Arora et al., 2016; Rutherford et al., 2012; Zucker, 2017), in particular there is a dearth of research regarding treatment of youth with gender dysphoria (Avella, 2016; Bradly, 2015; Linstone & Turoff, 2002). Assessment and treatment guidelines for minors are fundamental, as developmental considerations and consent/assent requirements need to be taken into account. Researchers agree that although affirmative care is not a one-size-fits-all model, coercive tactics to force a change in gender identity in youth have no place in the treatment of TGNC youth (D'Angelo et al., 2021; Turban et al., 2021). D'Angelo et al. (2021) stated that:

> Given the risky and irreversible nature of gender-affirming treatments, it is concerning that for many years now, there has been a lack of systematic research into the role that developmentally informed psychotherapy can play in the amelioration of gender dysphoria, especially among young people (p. 13).

The psychology field is undergoing radical changes regarding its approach to diagnosing and treating TGNC youth. Across the United States, many anti-transgender laws impact the future of TGNC youth mental health and the way mental health professionals will offer services (Kraschel et al., 2022). Several researchers have highlighted that mental health professionals doubt their competency and training to treat TGNC youth with or without gender dysphoria (Block, 2023; Ratts et al., 2016; Jessen et al., 2021). There is a lack of expert-driven research determining best practices and assessment protocols in therapy with TGNC youth. A qualitative Delphi study discovered

consensus between experts in filling this research gap by gathering the opinions of doctoral-level psychologists specialized in gender identity services with TGNC youth with gender dysphoria. This qualitative Delphi study explored the perspectives of psychologists who are experts in the required competency, training, assessments, and treatment practices when treating TGNC youth with gender dysphoria.

Problem Statement

In the last decade, there has been a significant increase in TGNC youth seeking clinical and medical care (American Psychological Association, 2022; Kaltiala et al., 2020, Stewart et al., 2023), with approximately 300,000 children and adolescents identifying as transgender from 2017 to 2020 compared to 150,000 previously reported cases from 2014 to 2015 (Herman et al., 2022). Recent studies from the Williams Institute, a research center at UCLA's law school, reported that in the United States, one out of five people who identify as transgender are between the ages of 13 to 17 years old (Herman et al., 2022). The prevalence rate of youth identifying as transgender in the United States has increased from 0.17% to 1.3% of youth (APA, 2015; Chen et al., 2018; Kaltiala-Heino et al., 2018, Zucker, 2017; Zucker, 2019) to 1.8% of children and adolescents across the United States (Nokoff, 2022; Turban et al., 2021). TGNC youth currently comprise a significant percentage of the identified transgender population, with an estimated 18% increase across the United States in 2016-2017 (Herman et al., 2022).

Despite the growing numbers of diagnosed gender dysphoria cases in TGNC youth in the United States (Hilton et al., 2022), graduate programs in psychology continue to have limited resources when training future psychologists to treat these

patients (Bidell, 2014; Chae et al., 2006; Pantalone, 2015; Rutherford et al., 2012). Hence, there is a lack of available specialized gender identity services and support for TGNC youth because of the scarcity of adequately trained psychologists (Busa et al., 2018; Chen et al., 2016; Chen et al., 2018). Although there is limited evidence-based research regarding the application of best practices and protocols for psychologists to treat this vulnerable population, TGNC youth with gender dysphoria continue to require care, especially as this population grows (Arora et al., 2016; Block, 2023; Jessen et al., 2021; Rutherford et al., 2012; Zucker, 2017).

Current legislation efforts in the United States to ban gender-affirming care have been associated with professional disagreement among practicing psychologists regarding the assessment and treatment involved in gender-affirmative care (Block, 2023). WPATH (2022) updated their standards of care for TGNC people by adding new chapters on children and adolescents; these standards have no minimum age requirements for hormonal and surgical treatments, leaving mental health professionals with questions regarding best treatment practices and protocols to follow with TGNC youth (WPATH, 2022). Disagreement among practicing psychologists over the ideal age when youth are considered mature enough to undergo social and gender transition will continue if there is a lack of evidence-based research with reliable and precise findings to reach a consensus (D'Angelo et al., 2021; Kraschel et al., 2022; Turban et al., 2021).

Practicing experts' perspectives regarding how the existing guidelines should be used, modified, or tailored to provide services for this population are needed. Psychologists must seek opportunities to gain training and expertise in providing care to

avoid harm and meet TGNC patients' healthcare needs (APA, 2015; Busa et al., 2018; Rafferty & Committee, 2018). The problem addressed in the research was that although there have been published guidelines regarding the training and best practices for the care of TGNC youth, there is little to no information regarding if or how those guidelines are applied by experts. The qualitative Delphi study focused on exploring the perspectives of psychologists' experts on TGNC care regarding the required competency, training, assessment methods, and best practices when treating TGNC youth with gender dysphoria.

Purpose of the Study

The purpose of this qualitative Delphi study was to discover a consensus regarding competency, training, assessment, and treatment standards of care with a panel of psychologists who are experts in the area of treating TGNC youth. Using a Delphi method, I addressed the gap in the literature regarding the need for information about sufficient specialized training to develop clinician competence when working with the population of interest as well as the need for practical information about assessment methods and best treatment practices in working with this population. The objective of this Delphi study was to gather the opinions of expert psychologists specializing in treating TGNC youth to develop consensus opinions on these issues.

The advisory panel of experts that were a part of the study were doctorate- level psychologists who specialize in gender identity services with TGNC youth in the United States. Experts also worked at an established organization or practice that currently imparted a multidisciplinary and affirmative approach to care for TGNC youth diagnosed

with gender dysphoria. Through a systematic process consensus among experts was discovered regarding the required competencies in training, the best assessment methods, and best treatment practices when treating TGNC youth. Moreover, the data collected provided validity, relevance, and application to future developed curricula for doctoral-level programs to meet the therapeutic needs of TGNC youth with gender dysphoria.

Research Questions

To explore the central phenomenon or concept in the study, which is the development of guidelines for training, assessment, and treatment when treating TGNC youth with gender dysphoria, the research questions that guided this study were:

RQ 1: According to an advisory panel of experts, what is the level of competency required to treat TGNC youth with gender dysphoria?

RQ 2: According to an advisory panel of experts, what is the minimal level of training required to treat TGNC youth with gender dysphoria?

RQ 3: According to an advisory panel of experts, what assessment methods are required to treat TGNC youth with gender dysphoria?

RQ 4: According to an advisory panel of experts, what are the best treatment practices (interventions, protocols or guidelines) to treat TGNC youth with gender dysphoria?

Conceptual Framework

To properly frame this study, it was appropriate to explore what accepted published experts in the fields considered the minimum competency and training as well as the best assessment methods and treatment practices required when treating TGNC

youth with gender dysphoria. For that reason, Keo-Meier and Ehrensaft's (2018) gender-affirmative model of care and Sue et al.'s (1992) multicultural counseling training competencies were used as they guide the development of clinicians' competencies and skills when providing specialized gender identity services to the population of interest. What is significant about these models of care is that they are based on specific guidelines that promote training and ongoing education to a team of professionals from both healthcare and mental health fields (Chen et al., 2016; Pantalone, 2015; Sue et al., 1992; Sue et al., 1996).

Keo-Meier and Ehrensaft's (2018) gender- affirmative model supports the development of clinicians' nonjudgmental approach to care that helps TGNC youth feel safe by promoting the exploration of gender identity without presumptions (Chen et al., 2016; Keo-Meier & Ehrensaft, 2018). Sue et al.'s (1992) multicultural counseling training competencies based on Sue et al.'s tripartite model highlights the need to train multiculturally aware, knowledgeable, and skilled therapists with effective interventions to treat culturally diverse clients' specific needs (see also Sue et al., 1996). By looking into the three dimensions of the multicultural training competencies model through the lens of the multicultural competency theory (Sue et al., 1996), interview questions were developed to explore and determine what knowledge, awareness, and skills doctoral-level psychologists must acquire to provide specialized gender identity services. Further, the models served as foundations or guides to organize and code the data obtained from the questionnaires.

Nature of the Study

The nature of this study was a qualitative Delphi method. Opinions were gathered regarding training standards of care, assessment strategies, and treatment approaches with 11 doctoral-level psychologists in the United States who are experts in the treatment of TGNC youth with gender dysphoria. A Delphi research method, whether via paper and pencil or online questionnaire, focuses on a panel of experts' experience to reach a consensus. Opinions from experts in an area(s) are sought by iteration on a particular topic to acquire group knowledge, guide decision-making, or understand a phenomenon in greater depth to forecast future needs (Dalkey & Helmer, 1963).

The Delphi method is known for its practical use in problematic areas "where either statistical model-based evidence is not available, knowledge is uncertain or incomplete, and human expert judgment is better than individual opinion" (Nasa et al., 2021, p. 118) and is utilized as a reliable means of determining group consensus (Linstone & Turoff, 2002). Hence, expert panelists who specialize in gender identity services and work at an established organization or practice that imparts a multidisciplinary and affirmative approach to care for TGNC youth diagnosed with gender dysphoria were the participants of this study.

In this Delphi study, data collection involved an asynchronous interaction via e-mail through SurveyMonkey. The study began with an open-ended questionnaire developed based on an extensive literature review of the phenomenon being studied, and experts' opinions were solicited. Findings from the initial iteration were analyzed, summarized, and a new questionnaire was developed. Data from subsequent iteration

rounds were presented in a 5-point Likert type scale format. Experts were able to review the information in each round based on their knowledge, experience, and expertise and ranked to narrow down responses until an 80% consensus was reached. Thematic and content analysis was utilized to identify themes, concepts, and categories to move from the experts' ideas to explanatory ones, taking into account the multicultural competency model and a multidisciplinary model of care, such as the gender- affirmative model (Creswell, 2014). I aimed to attain an understanding of what currently practicing experts believe is needed in regard to competency and training, assessment methods, and best treatment practices and utilize them in clinical practice to treat TGNC youth with competence based on existing guidelines and training opportunities to attain knowledge, skills, and expertise.

It is worth noting that although Likert-type scales are utilized in quantitative studies to measure outcomes, they are also utilized for qualitative purposes. Delphi methodology is not uniform in its application (Nasa et al., 2021). Therefore, researchers use Likert-type scales to evaluate content and expert panelists' responses (Taylor, 2020). Expert opinions are not interpreted statistically; instead, they are organized and tallied into themes to be presented in the subsequent rounds of the questionnaire (Nasa et al., 2021). According to Taylor (2020), in Likert-type scales, "numeric choices may be supplemented with either descriptive endpoints or descriptors for each item along with a free-text comment box for justification for choices, edits, additions, and deletions" (p. 16).

Definitions

Mental health professionals have the ethical obligation to maintain competence when using acceptable descriptions or definitions of terms commonly used for gender and sexual identity within the lesbian, gay, bisexual, transgender or queer/questioning (LGBTQ) community (APA, 2015; Buchanan, 2022). This section includes commonly used terms among mental health professionals to address and identify LGBTQ individuals, groups and communities.

Bigender: Refers to individuals who shift between male and female identity, and *trigender* refers to individuals who shift between female, male, and a third gender identity (Eagly et al., 2004).

Cisgender: Used to describe an individual whose gender identity aligns with the biological sex assigned to them at birth (Nokoff, 2022).

Gender: Refers to the cultural and social distinction between women and men based on traits and behaviors that are considered appropriate to masculine or feminine characteristics (Eagly et al., 2004; Fausto-Sterling, 2000; Fausto-Sterling, 2012; Westbrook & Saperstein, 2015).

Gender-affirmative model of care: Posits that "children should not be denied the opportunity to explore and embrace their identity, socially and medically if they are simultaneously being treated for other presenting problems" (Keo-Meier & Ehrensaft, 2018, p. 72).

Gender-affirming care: Treatment that aims to affirm the gender as stated by an individual by reducing the symptoms of gender dysphoria which may include

psychotherapeutic, medical, or surgical treatments (Keo-Meier & Ehrensaft, 2018).

Gender-affirming surgery: Refers to medical procedures that help individuals align their body with their gender identity by transitioning to their self-identified gender (Nokoff, 2022).

Gender dysphoria: Refers to distress experienced by individuals from incongruence between their assigned sex at birth and gender identity (Beek et al., 2016; Drescher, 2015).

Gender expression: Used to describe how individuals choose to show their gender to others when attempting to self-define their gender identity (American Psychological Association, 2015; Hidalgo et al., 2013; Keo-Meier & Ehrensaft, 2018).

Gender-expansive: Refers to individuals who might feel comfortable with the sex assigned at birth, but do not conform to the roles or stereotypes that society expects from them (Chen et al., 2018; Eagly et al., 2004).

Gender fluid: Refers to individuals who do not identify themselves with a fixed gender, and their identity changes depending on the situation (Eagly et al., 2004).

Gender identity: Refers to an individual's experience of their gender that involves feelings of belongingness to a sex category (Eagly et al., 2004; Fausto-Sterling, 2012; Martin & Ruble, 2010).

Gender incongruence: Is as an umbrella term used when an individual's identities or behaviors do not align with the sex assigned at birth (Beek et al., 2016; Shulman et al., 2017).

Gender non-binary: Refers to individuals for whom gender identity falls outside

of or between the male or female category (Chen et al., 2018; Eagly et al., 2004; Ehrensaft, 2016).

Gender-non conforming: Refers to individuals who do not conform or follow gender norms about what is expected of them based on the female or male sex they were assigned at birth (Ehrensaft, 2016).

Genderqueer: Refers to individuals who feel their gender identity does not match the social norms and expectations associated with their assigned sex at birth (Drescher, 2015).

LGBT: Used as an umbrella term for certain sexualities and gender identities, and is an initialism that stands for lesbian, gay, bisexual, and transgender (Rutherford et al., 2012).

Multicultural competence: A developmental process where mental health professionals acquire self-awareness, cultural knowledge, and skills to provide quality services to multiculturally diverse populations (Arredondo & Perez, 2003; Sue et al., 1992).

Multicultural competence: Defines the ability of a mental health professional to obtain awareness, knowledge, and skills to work with individuals of diverse backgrounds ethically and effectively (Sue, 2001).

Multicultural competency theory: A metaframework or approach that aims to provide services in a sensitive manner when working with culturally diverse, marginalized, or minority members of society (Sue et al., 1992).

Sex: Refers to a combination of physical characteristics and attributes of males

and females (Lindqvist et al., 2021; Tseng, 2008).

Sexual identity: Term used to describe one's sexual or romantic attraction to genders (Hidalgo et al., 2013).

Sexual orientation: Used to describe the types of individuals toward whom a person has emotional, physical, and/or romantic attraction (Fausto-Sterling, 2019; Perzanowski et al., 2020).

Standards of care (SOC): Refers to the clinical guidance and framework for health professionals who work with transgender and gender nonconforming individuals (WPATH, 2022).

Transgender and gender nonconforming (TGNC): Stands as initialism for transgender and gender nonconforming. Individuals who identify and express themselves in different forms regarding their gender identity, sexual orientation, and relational orientation are TGNC (Weiselberg et al., 2019).

Transgender: Used as an umbrella term that relates to all kinds of phenomena related to gender incongruence (Beek et al., 2016; Shulman et al., 2017). Also, *transgender* refers to individuals who express and experience misalignment with the sex they were assigned at birth and the gender roles expected from them to hold in society (Ehrensaft, 2016; Weiselberg et al., 2019).

Transition: The process that individuals go through where changes occur to their physical, social, and/or legal characteristics in accordance with their affirmed gender identity (Nokoff, 2022).

Trigender: Refers to individuals who shift between female, male, and a third

gender identity (Eagly et al., 2004).

World Professional Association of Transgender Health (*WPATH)*: The WPATH is a multidisciplinary organization whose mission is to make recommendations for the standards of care for TGNC individuals (WPATH, 2022).

Assumptions

Underlying assumptions impact the direction and nature of a study. In conducting this Delphi study, I assumed that five to 15 doctoral-level psychologists in the United States would be an appropriate sample size. I also assumed that all five to 15 experts would be honest when they answered the screening questions, and had training and understanding in multicultural competency and gender-affirmative models of care. I assumed that the experts were knowledgeable regarding the level of competency, minimal level of training, assessment methods, and best treatment practices to treat TGNC youth with gender dysphoria. Also, I assumed that the experts would be honest and accurate in representing their opinions. Further, I assumed that the instrument (questionnaires) to collect data would elicit reliable and valid responses from the expert advisory panel. There was also the assumption that the expert panelists would understand the instructions and questions they would review in each round.

Scope and Delimitations

This Delphi study gathered the opinions of 11 doctoral-level psychologists across the United States who were considered experts specialized in treating TGNC youth. Opinions were collected from these experts geographically spread regarding the necessary and sufficient specialized training to develop clinician competence when

working with TGNC youth as well as best practices for assessment and treatment methods for working with this client population.

Only psychologists who specialize in gender identity services and worked at an established organization or practice that currently imparts a multidisciplinary and affirmative approach to care for TGNC youth diagnosed with gender dysphoria were selected as part of the advisory expert panelist for the study. Experts who did not have at least 5 years of experience working with the population of interest were excluded from the study. In addition, experts from outside the United States were not included in the research. Research findings from this study have the potential to be transferable to psychologists across the United States, but findings may not be predictive or generalizable to other healthcare professionals (populations).

Limitations, Challenges, and Barriers

The primary limitation of this Delphi study was the relatively small sample size. Because the interviews were only conducted with 11 experts, the collected data regarding the experts' opinions, experiences, and perspectives was limited to this small sample. It is worth noting that the data collected for this study was based on expert opinions and may not reflect the views of other practicing clinicians in the United States working with TGNC youth or adults. Experts' opinions could be affected by the state rulings in which they are practicing. Results may not be broadly generalized; however, they may serve as groundwork for future studies. The goal of the study was to generate a list of recommendations and is limited in that regard. I did not collect detailed narratives of the experts' experiences in treatment, as the research design does not allow for this type of

data collection.

Including a representative selection of experts can be challenging; therefore, correctly defining the meaning of "expert" for this study as someone who possessed a doctoral-level, knowledge, skills, and expertise in the area(s) of interest was helpful to addressed expert identification and recruitment barriers. Established qualification criteria for inclusion were set in recruiting expert panelists to address the researcher's bias regarding selecting experts for this study.

Limited commitment on the part of the participants, as well as their dropping out of the study before it concluded, were also potential challenges, as experts were asked about the same topic multiple times. To address these possible issues, I ensured that the expert panelists understood the aim of the study and the flexibility of using SurveyMonkey to collect data. Objectives and instructions were clearly stated to increase experts' commitment to the study and the validity of their responses.

Significance

In the United States 1.6 million individuals identify as transgender (Herman et al., 2022) and 1.8 % of those individuals are youth (Nokoff, 2022; Turban et al., 2021). The prevalence of gender dysphoria in TGNC youth is approximately 0.5% to 1.3% of individuals in the United States (APA, 2015; Blackwell, 2012; Kaltiala-Heino et al., 2018; Zucker, 2017). Mental health clinicians are increasingly being called on to serve in multidisciplinary care teams to assist in these clients' mental health needs (Blackwell, 2012; Chen et al., 2018). The APA (2015) has recognized that there is a need for psychologists to provide quality services and advocate for TGNC individuals; however,

there is still a lack of information about competency and training for psychologists to treat this population as well as the assessment and treatment strategies that are used by experts who treat TGNC youth with gender dysphoria (Knight et al., 2014; Riggs & Due, 2015). Moreover, even with the APA (2003) emphasizing the importance of ingraining multiculturalism in all areas of clinical training and practice through the development of evidence-based practice guidelines, there is still limited to nonexistent evidence-based research regarding best practices and protocols to treat TGNC youth with gender dysphoria (Cochran & Robohm, 2015; Pantalone, 2015; Rutherford et al., 2012). Without standards of treatment clinicians will continue to cause harm and not meet TGNC youth's needs to achieve overall well-being.

The information obtained from this study to explore psychologists' perspectives on the required competency and training when treating TGNC youth with gender dysphoria is valuable, as it fills a gap in knowledge of best practices and protocols in the treatment of TGNC youth with gender dysphoria. The information obtained is valuable to current and future clinicians to raise awareness and understanding regarding what level of education, experience, and training is needed to develop skills and competency to work with this population's mental health needs. Further, the gained insight from specialized psychologists who are actively providing services to the population of interest will help future clinicians reexamine limited exposure and access to TGNC youth in training programs. This information may help psychologists advocate for the development of graduate program curriculums where best practices, specialized gender identity training models, and multicultural guidelines of care are imparted (Bidell, 2014; Cochran &

Robohm, 2015; Pantalone, 2015).

Summary

TGNC youth comprise a heterogeneous group seeking medical and mental health at a younger age, which cannot be overlooked (Janssen et al., 2019). TGNC youth present with more mental health needs compared with cisgender peers. Researchers indicated that anxiety, depression, isolation, suicidal ideations, and self-harm are among the mental health problems to affect this population (Stewart et al., 2023). Emotional and sexual abuse, autism, and bullying were also commonly reported being experienced in this population (Puckett, 2019). Although mental health professionals doubt their competency and training to treat TGNC youth (Block, 2023; Jessen et al., 2021; Ratts et al., 2018), master and doctoral-level clinicians continue to provide treatment, and understanding what is being done with this underserved population would help determine the existence and extent of a gap between the guidelines and actual clinical practice.

Mental health professionals across the United States have encountered anti-transgender laws that impact their ability to provide treatment to TGNC youth (Kraschel et al., 2022). While affirmative care seems to be the approach recommended by the Endocrine Society (Hembree et al., 2017), the American Academy of Pediatrics (Rafferty & Committee, 2018), the American Psychological Association (2015), and WPATH (2022), it is unclear how experts in the field have been trained and how they incorporate or modify existing guidelines, standards, and theories for affirming care to meet the needs of the population. This qualitative Delphi study gathered the perspectives of experts actively working with TGNC youth. Understanding what these experts consider to be

adequate training, the appropriate assessment tools, and the gold standard in treatment strategies, may aid in developing training models of care to adequately work with this underserved population.

Chapter 2 begins with an introduction to the research topic and provides information regarding search techniques used to find relevant literature for this study. The chapter will feature a literature review regarding the historical evolution of the current affirmative approach to the treatment of TGNC youth with gender dysphoria. The review will address the role of mental health professionals in the therapeutic process with TGNC youth and their families.

Chapter 2: Literature Review

Introduction

The purpose of this Delphi study was to explore the perspectives of psychologists who are experts in the area on required competency, training, assessments, and treatment practices when treating TGNC youth with gender dysphoria. In the last three decades, the field of psychology has undergone radical changes regarding its approach to diagnosing and treating LGBT clients. Despite the progress made within the field, there is also a need to gain more understanding and knowledge to address transgender and non-conforming individuals' needs. Researchers have provided valuable knowledge to develop trans-affirmative practice (Rutherford et al., 2012; Zucker, 2019), but most studies have been focused on clinicians with adult clients, and several researchers have noted that there is a lack of information regarding best practices for clinicians working with TGNC youth (e.g., Arora et al., 2016; Rutherford et al., 2012; Zucker, 2017). Without proper research, guidelines, and training for clinicians to provide optimal trans-affirmative practice, TGNC youth are left with few options for mental health treatment to help them cope with their everyday stressors and move forward with transition.

Researchers, scholars, and leaders in the mental healthcare field, such as the APA (2003), recommended developing and implementing multicultural guidelines and competencies to work in a pluralistic society (see also Boroughs et al., 2015*;* Chae et al., 2006; Chiu et al., 2013; Chou & Johnson, 2022; Clauss-Ehlers at al., 2019; Coyne et al., 2023; La Roche, 2021). The main objective of the development of multicultural guidelines and competencies is to reduce disparities in mental healthcare for culturally

diverse clients associated with a lack of training and competence in multiculturalism and multicultural competence (Clauss-Ehlers et al., 2019; Cochran & Robohm, 2015; Coyne et al., 2023; Gallardo et al., 2009; Holt et al., 2020; Hope & Chappell, 2015; Malpas et al., 2022). There is a lack of expert-driven research determining best practices in therapy with TGNC individuals, and the study addressed this gap by conducting a Delphi study with current specialists in the field.

This chapter will begin with a review of the history and current perspective of TGNC affirmative practice in psychology. In addition, I will provide explanations for gender identity development, theories, and the role of gender. I will also review the research that has been conducted on transgender identity and implications for practice that include gender dysphoria and gender identity disorder, transgender clients and gender related trauma, the role of psychologists with TGNC clients in the therapeutic process, the World Professional Association for Transgender Health Standards of Care, and barriers in competency and lack of training. Other topics addressed in the chapter will be competency and training in doctoral-level programs to treat TGNC clients, APA's guidelines for psychological practice with transgender and gender nonconforming people (APA, 2015) and the Standards of Accreditation for Health Service Psychology (APA, 2015). The chapter will conclude with an overview of the gender affirmative model of care, the multicultural counseling training competencies, and the multicultural competency theory as components in this study.

Literature Search Strategy

The research reviewed for this dissertation was obtained from diverse sources.

Resources used for the literature review were peer-reviewed journals published within the past 5 years. Older peer-reviewed journal articles containing relevant information for the study area were used. The primary research databases explored to access peer-reviewed articles, doctoral dissertations, and book chapters were EBSCO, ProQuest, PsycINFO, PsyArticles, SAGE Journals, LGBT LIFE, and Google Scholar. Information about transgender care, experiences, and guidelines for professional practice, competency, and training were obtained from online sites, including the American Psychological Association, the American Counseling Association (ACA), and the WPATH. The keywords used in the literature search included *Gender Dysphoria, transgender, gender non-conforming, LGBT, LGBT ally, gender identity, sexual identity, gender expression, sexual orientation, gender identity theories, gender variant/expansive, gender incongruence, TGNC youth, psychologists competency, psychologists training, treatment, intervention, therapy, standards of care, affirmative practice/therapy/training, affirmative model of care, multicultural competence, multiculturalism, multicultural theory, doctoral programs,* and *historical foundations.*

Conceptual Framework

This study utilized Sue et al.'s (1992) multicultural counseling competence theory to develop guidelines on the required competency training and best treatment practices to work with transgender non-conforming youth with gender dysphoria in a mental health setting. A panel of experts was consulted to develop these guidelines in a Delphi study using this framework as a guide. Sue (2001) explained that multicultural competence could be defined in a tripartite model as the ability of a mental health professional to

obtain awareness, knowledge, and skills to work with individuals of diverse backgrounds ethically and effectively.

From a multicultural theory perspective, multicultural competence entails the awareness and understanding of the world views, values, biases, and assumptions of patients who differ from mental health providers (Abreu et al., 2000; Sue & Sue, 2013; Sue et al., 1992). It also entails the ability to provide an appropriate array of services to diverse populations (Sue & Sue; 2013). Moreover, multicultural competence is the ability to acquire and possess culture-specific skills required to work with patients from specific populations (Sue & Sue, 2013). Finally, multicultural competence entails psychologists' ability to possess a mutual intergroup understanding and awareness to develop multicultural alliances with clients that could promote advocacy, social justice, and equal opportunities for ethnic, racial, and sexual minorities to whom services are provided (Sue et al., 1996; Sue, 2001; Sue et al., 2009; Sue & Sue, 2013; Vera & Speight, 2003).

Sue (2001) indicated that multicultural counseling competency theory includes a multidimensional model of cultural competence. The model described three primary dimensions of multicultural competence that are incorporated and serve as a reference point for the evaluation of competence (Sue, 2001). Dimension one pertains to acknowledging culture and racial specific group perspectives (Sue et al., 1998; Sue, 2001). Dimension two is composed of cultural competencies of awareness/ beliefs, knowledge, and skills (Sue, 2001; Sue et al., 2009). Dimension three assesses the foci of cultural competence of individual versus the organizational system of analysis (Sue, 2001, p.802).

Sue et al. (1996) asserted that mental health practitioners' multicultural competency and training should focus on an individual level of awareness/ beliefs, knowledge, and skills. Further, multicultural competence proceeds hierarchically along with the four main foci: individual, professional, organizational, and social justice to improve intervention strategies for culturally diverse clients (Sue et al., 1998). This framework was utilized in the current study, as it supports self-awareness and positive attitudes toward TGNC clients, knowledge of the TGNC population, and skills doctoral-level psychologists must acquire to provide specialized gender identity services.

It is important to note that the multicultural competency theory is in continuous development. Cultural competence is needed to define the skills, knowledge, abilities, and behaviors required to provide person-centered care and reduce health disparities. Culturally competent clinicians must engage in ongoing process of self-exploration and self-critique combined with a willingness to learn (Fouad et al., 2009; Lekas et al., 2020). Culture itself is not stagnant and assuming that individuals of certain groups share ideas, values and core beliefs that are unchanged results in stereotypes and stigma (Lekas et al., 2020, p.2). Hence, cultural humility in training is advised because it recognizes that clinicians cannot know everything and are willing to learn while being aware of their own embeddedness in culture (Lekas et al., 2020, p.2). Multicultural competency theory was used in this Delphi study both in the development of questions to ask the expert panel and in organizing their responses for each round of questions.

Multicultural Competency Theory in Clinical Care

The increase in the number of referrals of TGNC youth to specialty clinics

offering gender-affirming care to individuals from diverse ethnic, racial and demographic minority groups (Coyne et al., 2023;Oransky et al., 2019; Malpas et al., 2022; Pullen Sansfaçon et al., 2019) is one of several phenomena that have led graduate counseling and psychology programs to incorporate multicultural counseling competencies into their academic curricula (Hembree et al., 2017; Coyne et al., 2023; Pullen Sansfaçon et al., 2019; Worthington et al., 2007). Culturally competent mental health professionals must possess the ability to provide an appropriate array of services and best practices to a culturally diverse population (Acarturk et al., 2019; Arredondo & Perez, 2003; Constantine, 2001; Dillon et al., 2016; Hembree et al., 2017; Sue et al., 2009). Culturally competent mental health professionals must also have the awareness, knowledge, and skills to acknowledge the dominant culture's negative influence on attitudes toward mental health treatment in minority cultures (Arredondo & Perez, 2003; Martell & Williams, 2019; Oransky et al., 2019).

It is imperative for mental health professionals to examine their multicultural diversity knowledge and ideology before diagnosing and treating TGNC youth (Hays, 2016; Ratts et al., 2016; Whitman & Han, 2017). Competent multicultural therapists should understand social justice and practice advocacy skills for gender-diverse minority clients as a foundation for their work (Arredondo & Perez, 2003; Katz, 1985; Pedersen, 1991; Shipherd & Sloan, 2019; Speight et al., 1991; Toporek et al., 2006).

Unfortunately, not all mental health professionals practice an affirmative-care approach due to a lack of appropriate training and resources (Case & Meiers, 2014; Greenberg et al., 2021; Knight et al., 2014; Kuff et al., 2019; Olson et al., 2018; Puckett,

2019; Pullen Sansfaçon et al., 2019; Rafferty et al., 2018; Newhook et al., 2018; Thompson et al., 2016; Whitman & Han, 2017). Few studies have examined mental health professionals' experiences working with TGNC youth (Holt el al., 2020; Whitman & Han, 2017). In addition, the lack of longitudinal studies regarding treatment outcome has led to confusion in treatment options to avoid harm when treating TGNC youth (Kraschel et al., 2022; Santoro, 2022). The use of Keo-Meier and Ehrensaft's (2018) gender-affirmative model of care and Sue et al.'s (1992) multicultural counseling training competencies based on Sue et al.'s tripartite model both promote the development of a nonjudgmental approach to care and effective interventions for culturally diverse clients' specific needs (Chen et al., 2016; Keo-Meier & Ehrensaft, 2018; Sue et al., 1992; Sue et al., 1996).

Because TGNC youth are a diverse group with unique needs and struggles that must be addressed individually, the gender-affirmative model of care and Sue et al.'s (1992) multicultural counseling training competencies helped me develop the questions that were posed to the Delphi panel experts regarding the best practices and optimal training to meet the needs of TGNC youth. Also, the multicultural counseling training competencies based on Sue et al.'s tripartite model helped me organize and sort the data collected by themes related to the awareness, knowledge, and skills of experts within the field.

Literature Review

History and Current Perspective of TGNC Affirmative Practice in Psychology

Throughout history, mental health professionals have played a vital role in creating social change by supporting and challenging the validity of global issues that affect society as a whole (Brown, 2011; dickey & Singh, 2016; Hays, 2016; Pachankis, 2018). The APA has been known for its ongoing efforts to develop ethical practice guidelines for working with specific groups (Brown, 2011; dickey & Singh, 2016). However, this has not always been the case. During the first half of the 20th century, homosexuality was perceived as a mental illness and pathology by the psychiatric establishment in the United States (Brown, 2011; Drescher et al., 2012; Pachankis, 2018; Zilcha-Mano et al., 2015). Homosexuality was listed as a psychiatric disease in the first two versions of the DSM (APA, 1952, 1968). During that time, some researchers classified homosexuality, "transsexualism," and transgender identity issues under the same category and took a pathologizing stance toward gender non-conformity (Brown, 2011; Drescher; 2015; Pachankis, 2018; Shidlo et al., 2002; Zilcha-Mano et al., 2015).

Using scientific authority but lacking evidence-based foundations and guidelines, some mental health professionals who conceptualize TGNC individuals as diseased proposed conversion therapies to "treat" gender identity conflict (Barrett, 2014; Beek et al., 2016; Brown, 2011; Drescher, 2001; Shidlo et al., 2002; Zilcha-Mano et al., 2015). With little to no choice, TGNC youth are placed in adverse situations where they experience emotional and, at times, physical hardship as a result of conversion therapies (Barrett, 2014; Brown, 2011; Reay, 2014; Shidlo et al., 2002). The primary goal of

conversion therapies is to reorient patients to their gender assigned at birth (Barrett, 2014; Brown, 2011; dickey & Singh, 2016; Forstein, 2001; King, 2019; Shidlo et al., 2002).

Without advocates for gender minorities, individuals will continue to be denied the legal, social, and academic power to validate the existence of a broad spectrum of gender identity and gender expression (APA, 1952; King, 2019; Reay, 2014; Shidlo et al., 2002). As a result of the lack of empirically-based data on this topic, sexual and gender minority individuals are not always granted fair and equitable healthcare services (APA, 1952; King, 2019; Reay, 2014; Shidlo et al., 2002). Clinical encounters need to address the social-structural determinants and personal history that impact individuals' mental health such as discrimination, victimization, stigma, social exclusion, and minority stress. Without appropriate research it is unclear how to deliver such care (Hope & Chappell, 2015).

In the middle of the 20th century, the rapid change in the United States political and sociocultural landscape created an evolution in society and the mental health community (Brown, 2011; Cochran & Robohm, 2015; dickey et al., 2017). A new generation of mental health advocates emerged with theories and evidence-based practice approaches to treat ethnic, sexual, and gender minority individuals in an affirmative manner (Brown, 2011). Understanding and respecting the diversity of identities and experiences that each individual holds became the cornerstone for mental health professionals working with LGBT patients (Brow, 2011; Singh & dickey, 2017). During this time, mental health providers shifted from perspectives that pathologized and stigmatized homosexuality toward greater diversity awareness in determining and

defining what is and is not pathological (Barrett, 2014; Brow, 2011). The shift aimed to break away from conceptualizations of pathology that were formulated mainly by white males of European ancestry, reflecting the norms of their gender, ethnicity, political, religious, and social class (Barrett, 2014; Brow, 2011; Drescher, 2015).

Diagnostic Evolution of Gender Non-Conforming Individuals

In 1973, the APA decided to remove homosexuality from the DSM (Drescher, 2015; King, 2019; Shulman et al., 2017). In 1979, the WPATH (1979) first published the Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People. In 1980, the DSM-III was published and transsexualism, gender identity disorder of children and atypical gender identity disorder were included in the manual with different sets of criteria for different genders for some disorders (APA, 1980; Beek et al., 2016; Shulman et al., 2017). The DSM-IV (APA, 1994) later shifted the diagnosis of gender identity disorder to the category of sexual and gender identity disorders, and the diagnostic criteria became the same for men and women but with a different criteria set for children (APA, 1994; Beek et al., 2016; Shulman et al., 2017; Singh & dickey, 2017). The diagnoses focused on behavior rather than identity, changing the defining feature from anatomical sex to ways that incongruence plays out socially (Beek et al., 2016; Shulman et al., 2017; Singh & dickey, 2017). Toward the end of the 20th century, gender identity disorder was the umbrella term used in the international classification of diseases ICD-10 (WHO, 1993) and the DSM-IV (APA, 1994) to diagnose people who are TGNC (Beek et al., 2016; King, 2019; Shulman et al., 2017).

In 2013, the DSM-5 was published (APA, 2013), eliminating the diagnosis of

gender identity disorder, retaining the diagnosis of gender dysphoria, and including the new term *gender incongruence* (APA, 2015; Singh & dickey, 2017; Shulman et al., 2017). The main objective of changing diagnoses and terms in the DMS-5 was to reduce stigma and discrimination for TGNC individuals while securing access to care for those individuals who need it (Beek et al., 2016; Drescher et al., 2012; Shulman et al., 2017; Zucker et al., 2013). The goal of the diagnostic and terminology changes was to shift the focus from behavior to the distress some TGNC individuals experience (APA, 2013). Pathology was not determined by gender variance but rather in the distress experienced due to a lack of alignment between gender experience and societal assumptions or expectations regarding gender identity (APA, 2013). In 2018, the ICD-11 edition (WHO, 2018) changed terminology and also removed the reference to gender identity disorders from the mental health section to "gender incongruence" in a new section placed in Chapter 17 entitled "Conditions Related to Sexual Health" (WHO, 2018).

In 2022, the APA published the DSM-5-TR (APA, 2022), and one of the goals of this revision was to update the terminology in the gender dysphoria diagnoses. For example, the *desired gender* was changed to the *experienced gender* (APA, 2022, p. 512). *Cross-sex medical procedure* was updated to *gender-affirming medical procedure* (APA, 2022, p. 512). *Cross-sex hormone treatment* is now *gender-affirming hormone treatment* (APA, 2022, p. 512). *Natal male* was updated to *individual assigned male at birth* and *natal female* to *individual assigned female at birth* (APA, 2022, p. 512). These changes reflect more inclusive language to further depathologized the experience of gender non-conformity.

Treatment Guidelines for TGNC Youth

The ACA (2010) published the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC) competencies for counseling with transgender clients, which was written from a multicultural, feminist, and social justice perspective. The main goal of the ALGBTIC competencies was to guide mental health professionals when working with TGNC clients across several domains including human growth and development, social and cultural foundations, helping relationships, group work, professional orientation, career and lifestyle development, appraisal, and research (ACA, 2010; ALGBTIC, 2009). When patients' identities or behaviors do not align with the sex assigned at birth, mental health professionals use the term *gender incongruent*, and the term *transgender* is used as an umbrella term that relates to all kinds of phenomena related to gender incongruence (Beek et al., 2016; Drescher & Byne, 2013; Shulman et al., 2017).

In 2015, the APA developed the Guidelines for Psychological Practice with Transgender and Gender Nonconforming Clients (APA, 2015). The APA (2015) guidelines posit that conducting psychological assessments with TGNC individuals is essential, as it captures the effects that discrimination, marginalization, and social prejudice has had on patients' psychological well-being. Mental health providers are instructed to assess the influence of gender-related minority stress and resiliency as it may help diagnose gender-related conditions (APA, 2015; Coleman et al., 2012). There are no separate APA guidelines for the assessment and treatment of TGNC youth.

Despite the advance in the new affirmative framework under which many mental

health providers now practice, and the ongoing attempts by researchers to improve the quality of services for sexual and gender minorities, there continues to be limited evidence-based research regarding training and guidelines to treat TGNC youth with gender dysphoria (Budge et al., 2017; Chen et al., 2018; Edwards-Leeper et al., 2016; Lev, 2009; Lytle et al., 2014; Pachankis, 2018; Pantalone, 2015). The guidelines for cultural diversity in psychotherapy research with sexual and gender minorities are inadequate to address the needs of this vulnerable population. Researchers continue to lump TGNC individuals together in one group when, in fact, this is a diverse group composed of individuals with unique needs and struggles that must be addressed individually (King, 2019; Lytle et al., 2014; Pachankis, 2018; Pantalone, 2015). Guidelines for minors are especially important, as developmental considerations and ability to consent need to be taken into account.

Although several guidelines and treatment models have been published, there is a lack of information regarding if and/or how they promote training and education to provide optimal care to TGNC youth with gender dysphoria (Janssen et al., 2019; Jessen et al., 2021). To date, only two groups of researchers, Hidalgo et al. (2013) and Keo-Meier and Ehrensaft (2018), have developed and supported a gender-affirmative treatment model for TGNC children and adolescents. This gender-affirmative model is informed by the stories of transgender adults and is based on the premise that children should have the freedom to live in and express their authentic gender without experiencing restriction, criticism, or rejection (Hidalgo et al., 2013; Keo-Meier & Ehrensaft, 2018). The role of mental health professionals in the gender-affirmative model

is to facilitate social support for TGNC youth to discover and express their authentic gender (Hidalgo et al., 2013; Keo-Meier & Ehrensaft, 2018). Mental health professionals serve as translators who understand what TGNC youth are experiencing and expressing regarding their authentic gender through words, actions, feelings, thoughts, and relationships (Keo-Meier & Ehrensaft, 2018, p. 13).

Because gender expression and gender identity are considered human rights, the gender-affirmative model posits that gender expression and experience should be seen as fluid, not binary, and should never be pathologized (Hidalgo et al., 2013; Keo-Meier & Ehrensaft, 2018). Hence, the focus of the gender-affirmative model is to help children develop resilience, coping strategies, and wellness by incorporating a support network (Hidalgo et al., 2013; Keo-Meier & Ehrensaft, 2018). Mental health professionals aim to increase their capacity to be curious about celebrating human diversity by managing personal biases and countertransference in providing treatment (Hidalgo et al., 2013; Keo-Meier & Ehrensaft, 2018).

While the developmental impact of the gender-affirmative model approach has yet to be rigorously studied (Hidalgo et al., 2013), researchers suggest that the suppression of an individual's authentic gender endorses more negative mental health outcomes compared to those who are supported in experiencing and expressing their authentic gender (Kraschel et al., 2022). In addition, there is a lack of longitudinal research regarding the outcomes that follow TGNC youth in adulthood after gender-affirmative care (WPATH, 2022). WPATH (2022) noted that although minor adaptations, changes, or addendums to the guidelines may occur:

> Should new data become available that will significantly affect specific recommendations, a revision of the guidelines will be considered by a newly to be formed revision committee that will be recruited and established after the completion and publication of the guidelines (Methodology for the development of soc8 section).

Janssen et al. (2019) stated that TGNC youth with gender dysphoria comprise a heterogeneous group with diverse clinical needs that cannot be overlooked. Developing an understanding of what is being done with TGNC youth would be helpful in assessing the existence and extent of a gap between the guidelines and actual clinical practice in the field. Mental health professionals across the United States have encountered anti-transgender laws that impact their ability to provide mental health services to TGNC youth. For example, in 2022, Texas Governor Greg Abbot directed state officials to investigate healthcare professionals and parents who help TGNC youth receive gender-affirmative care, calling it "child abuse" (OAG Opinion No. KP-040, 2022, p.1). Providing treatment to TGNC youth has become a conflicting and controversial topic, and mental health professionals are left with not knowing what course of action to take (Turban et al., 2021). Research is urgently needed to address this gap and advocate for the needs of TGNC youth.

In addition, in 2021, more than 100 bills across 33 states in the United States aimed to prohibit gender-affirming care (Kraschel et al., 2022; Santoro, 2022). In Texas, the anti-transgender affirmative care state policies have left mental health professionals in an untenable position where their ethical obligations, the professional standards of care

and the new state policies do not align (Kraschel et al., 2022; Santoro, 2022). Professional standards of care have been legally overridden until changes are made to Texas policies or the policies are nullified by the court.

The diagnosis, classification, treatment, and best practices for disorders related to transgender identity and gender dysphoria with TGNC youth are areas that continue to be characterized by misconceptions and lack of knowledge that could hinder access to healthcare services (Hidalgo et al., 2013; Jessen et al., 2021; Keo-Meier & Ehrensaft, 2018; Turban et al., 2021). This research sought to address this gap by recruiting an expert panel to determine what the best practices and optimal training are in order to best meet the needs of TGNC youth. The expert panel recruited in the research have had the opportunity to review and apply the guidelines, and a Delphi approach was used to determine current best practices as well as what the required training should be to work with this population.

Sex, Gender Role, and Gender Identity Definitions

Before the 19th century, an individual's gender was exclusively determined by their assigned sex at birth (Beek et al., 2016; Fausto-Sterling, 2019; Levitt, 2019; Lurye et al., 2008). The use of this binary paradigm for sex-typing individuals as male or female would influence not only their gender identity but their gender roles, affecting the individual's expectations regarding their inner sense of self and what is expected from them as males or females within society (Beek et al., 2016; Budge, 2017). However, between the mid- 1920s and early 1990s, with the ongoing work of pioneer researchers in the field of gender identity development, the terms *gender* and *sex* were no longer

perceived as synonymous (Beek et al., 2016; Bem, 1981; Bem & Lenney 1976; Drescher, 2010, Lurye et al., 2008; Money, 2002; Starr & Zurbriggen, 2017; White et al., 2012). Several theories about gender identity development were subsequently established, and controversy and awareness that gender is not only determined by an individual's assigned sex at birth became a focus of researchers (dickey et al., 2017; Kreukels et al., 2014; White et al., 2000). Current conceptualizations of gender and gender identity include that they are determined by the individual's beliefs, expression, and internal sense of self of being male, female, or a blend of both or neither gender (dickey et al., 2017; Kreukels et al., 2014; White et al., 2000).

In the context of our developing understanding of these concepts, the focus of research concerning the complexity of gender and gender identity development in the transgender and gender non-conforming community has faced an urgent need to change and broaden (APA, 2015; Budge et al., 2017; Ehrensaft, 2016). The main reason for this is that mental health providers working with TGNC youth have observed a growing number of younger people identifying as transgender or non-binary (Budge et al., 2017; Ehrensaft, 2011; Ehrensaft, 2016; Lindqvist et al., 2021; Pullen Sansfaçon et al., 2019; Zucker, 2017). Edwards-Leeper (2017), Keo-Meier and Ehrensaft (2018), Lindqvist et al. (2021), and Mock (2014) all opined that gender should not be seen as a binary term that compartmentalizes individuals as either male or female based on their biological or natal sex or social cognitive gender schemas. Instead, these scholars suggested that an individual's gender should be seen as unique as their complex life experience because when variations in the connection between sex and gender occur, it could wrongfully be

regarded as a gender identity abnormality (Edwards-Leeper, 2017; Keo-Meier & Ehrensaft, 2018; Lindqvist et al., 2021; Mock, 2014).

Although biological sex is an essential component in gender identity development and self-concept, there are important distinctions between sex, gender and gender expression (Lindqvist et al., 2021; Tseng, 2008). The terms *sex* and *gender* are related but different components of an individual, and must never be used synonymously (Fausto-Sterling, 2019). Both terms are used to describe psychological and cultural characteristics associated with the individual's anatomy or appearance that differentiates males from females (Nicholson & Mcguinness, 2016). According to Lindqvist et al. (2021) and Tseng (2008), *sex* refers to a combination of physical characteristics of males and females, while *gender* refers to socially constructed roles, expressions, behaviors, and identities of males and females. Sex is assigned at birth based on distinct biological characteristics between males and females based upon physiological, anatomical, genetic, hormonal, and chromosomal properties (Diamond, 2002; Lindqvist et al., 2021; Tseng, 2008). Between 0.018% and 1.7 % of individuals are born intersex (Fausto-Sterling, 2000), which is variation in the sexual characteristics of individuals that include hormones, chromosomes, and genitals that do not allow for exclusively identify them as female or male (Eagly et al., 2004; Fausto-Sterling, 2012; Fausto-Sterling, 2019).

Gender refers to the cultural and social distinction between women and men based on traits and behaviors that are considered appropriate to masculine or feminine characteristics (Eagly et al., 2004; Fausto-Sterling, 2000; Westbrook & Saperstein, 2015). Because gender is mainly based on a social-cultural construct associated with the

individual's personality, behavior, or expression, conventionally assigned to males and females, individuals can use gender identity to determine where they fit into a group (Ernst, et al., 2020; Lindqvist et al., 2021; Martin & Ruble, 2010). Therefore, gender could also be seen as how individuals self-describe based on the sex-typing or the gender role they play in society connected to their feminine or masculine expression (Diamond, 2002; Fausto-Sterling, 2012; Martin & Ruble, 2010). *Gender expression*, in contrast, describes how individuals choose to show their gender to others when attempting to self-define their gender identity (APA, 2015; Hidalgo et al., 2013; Keo-Meier & Ehrensaft, 2018).

Terms that must be distinguished from each other when treating transgender youth are *gender identity,* which describes someone's gender and *sexual identity*, which refers to one's sexual or romantic attraction to gender (s) (Hidalgo et al., 2013). G*ender identity* is an individual's internal recognition of one's abstract self (Nicholson & Mcguinness, 2014). Gender identity refers to an individual's experience of their gender that involves feelings of belongingness to a sex category (Eagly et al., 2004; Fausto-Sterling, 2012; Martin & Ruble, 2010). However, gender identity is a social-cultural multidimensional construct as it has two gender roles which are masculine or feminine, where certain social behaviors and attitudes are expected never to deviate (Nicholson & Mcguinness, 2014). Hence, gender identity is a term used to describe the individual's personal experience regarding their gender that can align or differ from their birth sex (Levitt, 2019; Nicholson & Mcguinness, 2014).

Some terms and definitions will continue to evolve as we learn more about sex

and gender issues (Singh & dickey, 2016). Culturally competent mental health providers need to understand and be aware of existing terms and definitions to ensure sensitivity toward transgender and gender-nonconforming patients and their families (Beek et al., 2016; Budge et al., 2017; Chen et al., 2018). When addressing transgender nonconforming individuals, mental health providers should always ask patients how they identify and wish to be addressed (Keo-Meier & Ehrensaft, 2018). More importantly, mental health providers should be able to distinguish between sex, gender, gender identity, gender expression, sexual orientation, and the role of gender before providing services to this population (Keo-Meier & Ehrensaft, 2018).

Transgender and gender-nonconforming individuals identify and express their gender identity in many different ways (Drescher, 2015; Edwards-Leeper, 2017). Researchers are engaged in ongoing debate regarding the terminology used to describe the transgender population (Edwards-Leeper, 2017). Hence, mental health providers must possess theoretical and linguistic knowledge to differentiate terms because outdated views or discrepancies can create confusion, hindering diagnosis and treatment outcomes (Beek et al., 2016; Diamond, 2002; Lindqvist et al., 2021).

Gender expression may not always be consistent with social-cultural gender identity norms, behaviors, and characteristics associated with masculine or feminine identities (Levitt, 2019; Martin & Ruble, 2004). In most cases, being male or female comes naturally, and that is perceived as gender congruence or gender binary (Chen et al., 2018). *Cisgender* is a term from a Latin prefix meaning on the same side, therefore a cisgender individual is someone who experiences a congruency between their assigned

sex at birth and the gender to which they feel a sense of belonging (Chen et al., 2018; Eagly et al., 2004; Weiselberg et al., 2019). In contrast, the term *gender-expansive* refers to individuals who might feel comfortable with the sex assigned at birth, but does not conform to the roles or stereotypes that society expects from them (Chen et al., 2018; Eagly et al., 2004). *Transgender* refers to individuals who express and experience misalignment with the sex they were assigned at birth and the gender roles expected from them to hold in society (Ehrensaft, 2016; Weiselberg et al., 2019). When someone feels a sense of discomfort from incongruence between their assigned sex at birth and gender identity, this is often referred to as *Gender Dysphoria* (Beek et al., 2016; Drescher, 2015; Kreukels et al., 2014).

Gender non-binary refers to individuals for whom gender identity falls outside of or between the male or female category (Chen et al., 2018; Eagly et al., 2004; Ehrensaft, 2016). *Agender* refers to individuals who do not identify with or conform to any gender. *Gender fluid* refers to individuals who do not identify themselves with a fixed gender, and their identity changes depending on the situation (Eagly et al., 2004). *Bigender* refers to individuals who shift between male and female identity, and *trigender* refers to individuals who shift between female, male, and a third gender identity (Eagly et al., 2004). *Genderqueer* refers to individuals who feel their gender identity does not match the social norms and expectations associated with their assigned sex at birth (Drescher, 2015). Genderqueer individuals "defy all categories of culturally defined gender and prefer to self-identify as gender-free, gender-neutral, or completely outside gender" (Chen et al., 2018, p.75).

Terminology within the transgender and gender-nonconforming community will continue to evolve as research and society progress (Ehrensaft, 2016; Healy, 2017; Weiselberg et al., 2019). Because gender identity is a personal matter that reflects an individual's current thinking and feeling, it is best practice to allow individuals to self-identity instead of assuming their gender identity (Ehrensaft, 2016; Healy, 2017; Hines & Sanger, 2010). Thus, it is vital to know the difference between gender identity and gender expression (Levitt, 2019; Weiselberg et al., 2019).

Gender Identity Development Theories

Weiselberg et al. (2019) conveyed that gender identity development is a lifelong process with diverse milestones and challenges individuals face along the way. Gender and gender identity are topics that have undergone critical examination and exploration among scholars (Chrisler & McCreary, 2010; Keo-Meier & Ehrensaft, 2018; Stetson, 2022). Unfortunately, many mental health providers continue to hold outdated views of gender identity development, affecting diagnosis and treatment for transgender-nonconforming individuals (Levitt, 2019; Lindqvist et al., 2021; Lurye & Ruble, 2008; Martin & Ruble, 2010). It is important for clinicians to understand current research and take into account that gender identity is a compilation of nature, nurture, culture, and time that work together to allow an individual to self-express (Ehrensaft, 2016; Fausto-Sterling, 2019).

Diverse theories have emerged in an attempt to explain how an individual's gender identity as a part of their sense of self develops, is expressed and accepted. White et al. (2000) stated that defining one's identity is a complex task as biological,

psychological, and social or cultural factors should never be seen as separate components (p.26). Sex and gender will always be essential components of an individual's identity development because individuals are biological beings that interact and develop in a social world (White et al., 2000). For that reason, theories of gender development emphasize the importance of understanding the difference between sexual identity and gender identity development by thinking of sex as one's physical or biological identity and gender as the psychological identity based on one's sense of self (Chrisler & McCreary, 2010; Weiselberg et al., 2019; White et al., 2000).

Biological Theory

The biological theory of gender identity development posits that an individual's gender identity and role differences result from biological processes that are different in males and females (Keo-Meier & Ehrensaft, 2018; White et al., 2000; Wilton et al., 2019). Further, the biological approach emphasizes that an individual's biological sex and brain organization influence physical functioning, psychological functioning, and behavioral gender differences (Keo-Meier & Ehrensaft, 2018; Money, 1987; Slavin & Slaughter, 2019). The biological approach holds that in humans, gender is determined by two biological factors: chromosomes and sex hormones, which play essential roles in how peoples' brains develop and work (Berk, 2010; Kreukels et al., 2014; Keo-Meier & Ehrensaft, 2018). Hence, men and women will behave, feel, and think differently based on differences resulting from existing hormonal and chromosomal differences (Berk, 2010; Money, 1980, Money, 1987; Rimmele et al., 2019; White et al., 2000; Wilton et al., 2019).

Humans have 23 pairs of chromosomes: twenty-two matching pairs are called autosomes, and the 23rd pair consists of the sex chromosomes that mark the difference in males' and females' biology and behavior (Berk, 2010). Women have two X chromosomes (XX), whereas males have an X and a Y chromosome (XY; Berk, 2010). As individuals develop, women and men produce different sex hormones that could affect their body functions and stereotypical behaviors of either male or female gender roles (Berk, 2010; Dabbs et al., 1995). For example, testosterone is produced in higher volumes in men compared to women, affecting toughness, dominance, violence, and risk-taking behaviors (Dabbs et al., 1995). In contrast, women have higher levels of oxytocin, which is linked to increased sociability, attachment, and memory for face recognition (Rimmele et al., 2019).

Although the biological approach attributes gender identity and gender roles to biological processes, it also recognizes that other factors, such as cognitive processes, cultural differences, and sex stereotypes, contribute to the evolution of gender identity in individuals (Keo-Meier & Ehrensaft, 2018). Therefore, the biological approach also utilizes certain approaches of the evolutionary theory as it examines the influence that evolutionary history has played on sex differences in behavior across time, cultures, and lifespan (Buss & Kenrick, 1998; Kenrick & Luce, 2000).

Psychoanalytic Theory

Sigmund Freud's psychoanalytic theory of gender identity development posits that gender identity development occurs through different identification processes for boys and girls (Bussey & Bandura, 1999; Drescher, 2015). Within this framework, the

family, mainly the mother, plays a vital role in shaping gender identity (Bussey & Bandura, 1999). According to this theory, gender is deeply embedded in our personality structures in the early stages of development (Bussey & Bandura, 1999; Drescher, 2015; Flax, 2004; Van Haute & Westerink, 2016). Between the ages of 3 and 5, children begin to identify with same-sex parents (Berk, 2010; Bussey & Bandura, 1999). The identification process with the same-sex parent is presumed to help children resolve the internal conflict they are experiencing due to erotic attachment to the opposite-sex parent and the jealousy experienced toward the same-sex parent (Berk, 2010; Bussey & Bandura, 1999). Thus, identification with a same-sex parent will reduce anxiety originating from the fear of the same-sex parent retaliation, opening the path to gender role adoption and gender identity formation (Bussey & Bandura, 1999; Drescher, 2015; Flax, 2004; Van Haute & Westerink, 2016).

Social Cognitive Theory

Albert Bandura's social cognitive theory of gender development posits that children learn about gender roles by observing and imitating those around them (Bussey & Bandura, 1999). The social cognitive approach asserts that gender roles and differentiation of gender-typed behaviors are achieved through observation, practicing, and modeling (Berk, 2010; Bussey & Bandura, 1999; Schunk, 2012). This approach affirms that individuals' gender roles are promoted through rewards or punishments for behaviors that are gender-inappropriate or appropriate (Bussey & Bandura, 1999; Kennedy & Ku, 2017). However, gender constancy "is the product rather than an antecedent of the emulation of the same sex" (Bussey & Bandura, 1999, p. 688). Hence,

gender reinforcement is vital to promote gender identity identification to prevent children from straying too far from the social gender norms (Schunk, 2012).

Cognitive Development Theory

Lawrence Kohlberg's (1966) cognitive theory of gender identity development, which was based on the ideas of Jean Piaget's cognitive development theory, posits that gender identity constancy is developed in a sequence of three distinct stages ranging from the least to the highest level of gender understanding (Berk, 2010; Bussey & Bandura, 1999; Kohlberg, 1966; Kohlberg & Ullian, 1974). The first stage is gender labeling, around three years, which requires a child's ability to label themselves as a girl or boy (Bussey & Bandura, 1999). The second stage is gender stability, where the child recognizes that gender is stable over their lifespan (Bussey & Bandura, 1999; Martin & Ruble, 2004; Schwartz et al., 2011). The final stage is gender consistency, achieved around age 6 or 7, when the child can acknowledge that gender is permanent and invariant across situations and over time (Berk, 2010; Bussey & Bandura, 1999). The cognitive gender identity development approach states that gender identity is the organizer and regulator of children's gender learning (Bussey & Bandura, 1999; Martin & Ruble, 2004; Kohlberg & Ullian, 1974). It also asserts that sexual attitudes in children are not formed directly by either biological instincts or random cultural norms (Bussey & Bandura, 1999; Kohlberg & Ullian, 1974). Instead, sexual attitudes are shaped by children's cognitive organization of their social world along sex-role dimensions (Kohlberg, 1966).

Gender Schema Theory

Sandra Bem's 1981 gender schema theory "is an information process approach to gender typing that combines social learning and cognitive development features to explain how environmental pressures and children's cognitions work together to shape gender-role development" (Berk, 2010, p.277). Bem's approach was proposed to explain gender development, differentiation, and how gender schemas within cultures influence how children perceive the world, organize information, and maintain a sense of consistency and predictability (Bem, 1981; Berk, 2010; Bussey & Bandura, 1999). Gender schema theory asserts that gender is a social construct that influences how individuals process information, behave, and think (Bem, 1981). However, the approach indicates that an individual's sex assigned at birth will instinctively determine the gender schema they will follow throughout their lifespan (Bem, 1981; Brown, 2011; Keo-Meier & Ehrensaft, 2018). Also, individuals at the early stages of development learn about gender roles from the culture in which they live (Bussey & Bandura, 1999). Consequently, gender and social schemas influence children to adjust their behavior to align with the gender norms of their culture (Bem, 1981; Bussey & Bandura, 1999).

The nature versus nature debate will likely continue to exist when it comes to the process of forming an understanding of how an individual's gender identity develops. However, while each theoretical approach to gender identity formation posits a different developmental process, most theorists seem to acknowledge that biological, cognitive, and social factors are equally valuable in gender identity formation. Understanding the transgender community as a subculture with unique needs and struggles is an ongoing

objective for mental health professionals. Clinicians must go beyond theory and "incorporate developmental and contextual antecedents of identity and consider how they can be acknowledged, addressed, and embraced to generate more effective models of professional engagement" (Clauss-Ehlers et al., 2019, p. 232).

Transgender Identity and Implication for Practice

Transgender individuals rely on mental health practitioners' gatekeeping to live their lives and receive the treatment and support they need. Mental health professionals, under the WPATH (2022) Standards of Care, are asked to diagnose gender dysphoria and determine if clients are mentally and emotionally prepared before they are ready for gender-affirming care (Shipherd & Sloan, 2019). Mental health professionals work closely with clients and their families at diverse stages of the client's treatment, providing gender-affirming evidence-based therapies (Chan et al., 2019; Shipherd & Sloan, 2019; Sing & dickey, 2017).

Clinicians can demonstrate cultural competence by recognizing the critical role of mental health professionals as social change agents to reduce stress for those who belong to a stigmatized minority group (Shipherd & Sloan, 2019). Advocating for an interdisciplinary transgender and gender-diverse affirming approach while recognizing the impact of pathologizing individuals will address the unique needs that have not been addressed in the applied clinical literature that guides practice (Chan et al., 2019; Shipherd & Sloan, 2019; Oransky et al., 2019). Establishing an environment where clients feel supported, safe, welcomed, and understood is paramount for optimal treatment outcomes (Chan et al., 2018; Istar, 2004; Oransky et al., 2019; Puckett, 2019).

Providing consultation and referral options to specialists knowledgeable about transgender health is advised with the ultimate goal of reducing mental health disparities.

Competency and Training in Doctoral Level Programs to Treat TGNC Clients

The APA's commitment to improving the qualifications and competencies of mental health providers by establishing high standards of ethics, conduct, education, and training to correct inequality of services to gender minority individuals is an ongoing process (APA, 2012; APA, 2015). *C*ompetence has become the cornerstone of clinical practice and doctoral training programs as it is "the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and community being served" (Epstein & Hundert, 2002, p. 227). However, there is an existing gap in research regarding best practices, assessment batteries, and protocols for the assessment and treatment of TGNC youth with gender dysphoria (Holt et al., 2020; Kaltiala et al., 2019). The emphasis of certain guidelines to treat gender dysphoria is outdated and may not reflect the current experiences that experts in the field have when treating TGNC youth. Mental health professionals' theoretical orientation may also influence in the way existing guidelines are perceived and implemented.

In the United States, there are over 414 APA- accredited doctoral programs, 647 accredited internship programs, and more than 175 accredited postdoctoral residency programs with the ethical responsibility to include a multicultural domain in their curriculum (APA, 2022). Programs that are accredited by the APA to train mental health professionals to be eligible for licensure as doctoral-level psychologists are expected to

prepare interns to serve a diversity of clients despite the setting (APA, 2015). However, despite advances in research and practice, less than 30% of psychologists in doctoral-level programs report familiarity, knowledge, and understanding of issues that TGNC individuals experience (APA, 2015). Professional disagreement exists regarding the types of assessments and treatment options for TGNC youth (Block, 2023; Janssen & Leibowitz, 2018; Stetson, 2022).

Murphy et al. (2002) indicated that 28% of psychologists reported that they had no formal clinical training to work with sexual minority clients. Among the psychologists who reported formal training, only 10% reported having one course or seminar that dealt with issues related to LGBT clients, and 14% of psychologists reported having direct exposure during their internship field experience (Murphy et al., 2002). Most of the training reportedly came from continuing education (46%), attending presentations (36%), books (32%), or articles. In some cases, participants reported that supervision helped (46%) even when some supervisors had no formal training and lacked the knowledge, experience, and skills to treat the population of interest (Murphy et al., 2002). A gap in knowledge, skills, and competence in this area of practice remains when individuals who identify as TGNC face several health disparities compared to those who identify as cisgender (Whitman & Han, 2017).

Current Training in Psychology Doctoral Level Programs

Stryker et al. (2022) stated that "the disproportionate burden of mental illness of TGNC individuals is not matched by proportional access to appropriate mental health care" (p. 68). Stryker et al. (2022) reported that in their study with 281 mental health

professionals, which aimed to explore the training experiences that had been available to experts who provide care to TGNC individuals, only 20.0% reported exposure to significant content in a graduate course and 25.2% during clinical training (Skyler et al., 2022). It was reported that (76.4%) of MHPs found training opportunities in professional conferences and (41.2%) through mentorship (Skyler et al., 2022).

Eliason and Hughes (2004) reported that between 35% and 50% of the clinicians they surveyed felt inadequate and unprepared to deal with topics such as internalized homophobia and the coming out process of clients. Sherry et al. (2005) indicated that less than a quarter of counseling and doctoral-level programs added sexual minority clients' issues and disparities into courses because topics were only covered in courses dedicated to sexuality or diversity. Further, Burkard et al. (2009) concluded that sexual minority issues are not covered in multicultural, diversity, or sexuality courses in most class discussions. Given these findings, Newell et al. (2010) and Stryker et al. (2022) concluded that integrating multicultural training across the curriculum and separate courses that relate to the needs and issues of LGBT and TGNC clients is essential to develop awareness, knowledge, and skills to provide adequate services. It is clear that one course or one chapter in a book is not sufficient training to fill the gap of both the didactic and experiential knowledge clinicians need to conduct assessments, interventions, consultations, or advocate for TGNC clients (Pieterse et al., 2009).

Doctoral-level psychologists practicing today find themselves unprepared to serve as allies that provide multicultural and gender-affirmative services that meet the needs of individuals to minimize the social, mental, and health inequalities they face (Knight et al.,

2014; Kraschel et al., 2022; Stryker et al., 2022). Existing literature on best practices to treat TGNC youth indicates that mental health providers are not prepared to serve the needs of the population of interest because not all graduate training programs integrate into their curriculum gender affirmative care practice, multicultural issues, and direct exposure to LGBT clients during the field experience (Grove, 2019; Keo-Meier & Ehrensaft, 2018; Knight et al., 2014; Kuff et al., 2019; Martell & Williams, 2019; Nowaskie, 2020; Oransky et al., 2019; Stryker et al., 2022).

Multicultural Counseling Training Competencies

The Civil Rights era of the 1950s and 1960s focused on social justice and brought about an evolution of multicultural counseling psychology (Arredondo & Perez, 2003). Several ethnic and racial-specific associations were created, such as the Association of Black Psychologists and the Association of Non-White Concerns, to address racism and discrimination in the field of psychology (Arredondo & Perez, 2003). Sue and Sue (2013) conveyed that "without awareness and knowledge of race, culture, and ethnicity, counselors and other helping professionals could unwittingly engage in cultural oppression" (p.24). Thus, the agreement that counseling psychology would be committed to the systematic study of multiculturalism, eradicating racism, and promoting social justice became the central force of multicultural counseling psychology (Sue & Sue, 2013, p.25). In 1992, after several years of research, the Executive Committee endorsed Sue, Arredondo, and McDavis' Multicultural Counseling Training Competencies and Standards (Arredondo & Perez, 2003). The competencies and standards proposed adopting a series of multicultural counseling competencies by accredited institutions

within their curriculum (Sue et al., 1992).

Most mental health providers do not have sufficient practical experience to be aware, knowledgeable, and skilled to work with multiculturally diverse minority populations (Sue et al., 1992). Cross-cultural skills could be developed or organized using a three characteristics times three dimensions matrix called the tripartite model of multicultural counseling competencies (Sue et al., 1992, p.481). The characteristics of a cross-culturally skilled practitioner include awareness of their assumptions, values, and biases, understanding the worldviews of culturally diverse clients, and developing appropriate intervention strategies or techniques. The three dimensions practitioners must navigate through are their beliefs and attitudes, knowledge, and skills.

In 2002, based on Sues et al.'s 1992 Multicultural Counseling Training Competencies and Standards, the APA Council of Representatives endorsed the adaptation of the Multicultural Education, Training, Research, Practice And Organization Development For Psychologists' guidelines (APA, 2003). The purpose of these guidelines was to address the inequities and injustices resulting from the bias and oppression that exists toward certain social minority groups (Sue et al., 1992; Sue & Sue, 2013). The guidelines reflect a revolutionary, changing multicultural society that calls upon knowledgeable and skilled mental health practitioners to provide quality services amid drastic societal change and disparity (APA, 2003).

The goals of the guidelines are to provide mental health professionals with the knowledge and skills to address multiculturalism and diversity in education, training, research, practice, and organizational change (APA, 2003, p. 377). Further, the guidelines

aim to present up-to-date empirical research, information, and terminology from psychology and related disciplines that support the value of the competencies (APA, 2003). They are designed to put forward "references to enhance ongoing education, training, research, practice, and organizational change methodologies; and paradigms that broaden the purview of psychology as a profession" (APA, 2003, p. 377).

The Guidelines on Multicultural Education, Training, Research, Practice, and Organization Development for Psychologists are suggestions or recommendations for mental health professionals (APA, 2003). The guidelines are not intended to be mandatory or accompanied by an enforcement mechanism, as they may not apply to every mental health professional or clinical situation (APA, 2003; Sue et al., 1992; Sue & Sue, 2013). The guidelines support mental health professionals' systematic development as they have an ethical obligation to provide culturally competent care to reduce mental health disparities to everyone they serve (APA, 2003).

The Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists reference the APA Ethics Code of Conduct and General Principles. Per the APA (2003), psychologists are called upon "to work with a variety of populations (Principle A), to respect others' rights (Principle D), to be concerned to not harm others (Principle E) and to contribute to social justice (Principle F; APA, 1992)" (p.379). Guidelines 1 and 2 encourage psychologists to commit to cultural awareness and knowledge of self and others regarding ethnic and racial differences and to become sensitive and responsive to the oppression and marginalization others have experienced (APA, 2003). Guidelines 3, 4, 5, and 6 address the application of

multiculturalism in education, training, research, practice, and organizational change (APA, 2003). How these guidelines might be applied in a practical manner in training programs is largely unknown. In addition, what constitutes adequate training to work with the TGNC youth population is unknown.

It is worth noting that since the development of the Guidelines on Multicultural Education, Training, Research, Practice and Organizational Change for Psychologists derived from Sue et al. (2003) work, there have been significant sociopolitical changes in United States society, research, and theory that affect psychologists' provision of mental health services to specific populations (Clauss-Ehlers et al., 2019). In 2017, the APA revised the existing guidelines and developed the Multicultural Guidelines: An Ecological Approach to Context, Identity and Intersectionality, which dissemination aims to aid mental health professionals in understanding and applying knowledge related to an individual's cultural identities and background (Clauss-Ehlers et al., 2019).

In the United States, there are more than 35 interdisciplinary clinics where psychologists provide gender-affirming services to TGNC youth. However, the ongoing lack of scholarly attention, paucity of research, and limited professional competence and training to treat TGNC youth with gender dysphoria are barriers that have contributed to perpetuating the marginalization of this vulnerable population (Hayes, 2016; Mizock & Lundquist, 2016). There is a gap in research regarding what adequate training consists of for psychologists in order to improve their competence in providing services to LGBT and TGNC youth. In order to address this gap, experts in the field were consulted regarding what they consider to be adequate training to treat this population.

Gender-Affirmative Model of Care a Path to Gender Affirmative Practice

As early as 1919, the Institute for Sexual Research opened its doors in Berlin, headed by Dr. Magnus Hirschfeld, a physician, and sexologist who advocated for the rights of homosexual individuals and coined the term *transvestite* (Leng, 2017; Shumer et al., 2016). The institute became known for the medical and counseling services offered to individuals with sexual disorders (Schillace, 2021). In particular, the institute offered treatment for gender transition, as Hirschfeld believed they were following their nature (Leng, 2017; Schillace, 2021).

Hirschfeld's early work also promoted the Scientific-Humanitarian Committee, established in 1897, which was recognized as the first homosexual organization (Leng, 2017; Schillace, 2021). The institute housed the World League for Sexual Reform, established by Hirschfeld in 1928, whose main objectives were to abolish Germany's anti-gay penal code, promote public sex education and contraception, and advocate for political and social reforms for sexual minorities' civil rights (Leng, 2017; Schillace, 2021). Some of Hirschfeld's revolutionary ideas paved the way for advocates such as Harry Benjamin, who became known for his 1966 book, *The Transsexual Phenomena*, forwarding the idea that some individuals could be born with characteristics that did not fit into heterosexual or binary categories (Shumer et al., 2016). Hirschfeld believed that "a third gender was naturally experienced and that human sexuality could be fluid" and proposed new terms such as *sexual intermediaries* for gender-nonconforming individuals (Schillace, 2021, p.74). *Situational* and *constitutional homosexuals* were proposed as umbrella terms to validate a spectrum of bisexual practices (Schillace, 2021, p.74). Also,

the term *transvestites* was proposed for individuals "who wished to wear the clothes of the opposite sex and those who from the point of view of their character should be considered as the opposite sex" (Schillace, 2021, p.74). The Institute for Sexual Research was raided by Nazis in 1933, and all of the accumulated research of the institute was destroyed (Fuller & Owen, 2022).

The late 20th and early 21st centuries marked a crucial time in the mental and medical health fields as practitioners began to analyze and theorize about transgender issues in a more profound manner, moving away from pathologizing individuals to an affirming model of care (Carroll et al., 2002; Drescher, 2015; Drescher et al., 2012; Oosterhuis, 2012). In 1979, the Harry Benjamin International Gender Dysphoria Association was renamed The World Professional Association for Transgender Health (Chen et al., 2016; WPATH, 2022). The following year, the first standards of care were published by WPATH for the health of transgender, transsexual, and gender-nonconforming individuals, with their 7th edition published in 2012 (Chen et al., 2016; Shumer et al., 2016). The WPATH (2022) revised 8th edition publication posed concerns and criticism regarding the guidelines and standards of care for the health of transgender and gender-diverse individuals lacking medical evidence, ethics, and child safeguarding. The 8th edition guidelines removed a minimum age limit when children should be given puberty blockers, hormones, or gender-affirming surgery.

In 2009, The Endocrine Society published clinical practice guidelines to treat transgender individuals supporting gender-affirming interventions (Shumer, 2016). In the same year, results from a survey conducted by the APA (2009) indicated that less than 30

percent of psychologists and graduate students were familiar with the disparities that transgender and gender-nonconforming individuals encounter. Hence, in 2015, the APA published 16 gender-affirmative practice guidelines for mental health professionals working with transgender and gender-nonconforming individuals (APA, 2015). The APA task force created the guidelines to fill the existing gap regarding best practices among psychologists to help them understand lifespan development, stigma, discrimination, and barriers to help diagnose and treat TGNC individuals (APA, 2015).

Research on gender-affirmative practices increased with the development of a theoretical basis for supporting gender identity and expression as existing in infinite varieties (Edwards-Leeper et al., 2016; Ehrensaft, 2011; Ehrensaft, 2018; Keo-Meier & Ehrensaft, 2018; Matsuno, 2019). According to researchers, TGNC individuals who receive gender-affirming care from a multidisciplinary team have an increased likelihood of achieving positive treatment outcomes and improving their quality of life (ACA, 2010; APA, 2015; Coleman et al., 2010; Chen et al., 2016; Chen et al., 2018; Edwards-Leeper et al., 2016; Ehrensaft, 2011; Ehrensaft, 2018; Keo-Meier & Ehrensaft, 2018; Matsuno, 2019). Researchers have also noted that TGNC individuals, particularly youth who receive gender-affirming support from their caretakers and parents, have better mental health outcomes than patients who do not have family support (Riggs & Due, 2015).

The success of the gender-affirmative practice over the last decade is due to an affirming philosophy that supports gender-diverse youth identity and gender expression (Kaltiala-Heino et al., 2018; Lev, 2004; Schillace, 2021). In gender-affirming practices, TGNC youth are supported and guided as they express themselves freely throughout their

transition process (Chen et al., 2016). This approach utilizes a comprehensive psychological and psychosocial assessment of patients and their families that promotes exploration of gender without presuming a fixed trajectory concerning gender identity (Chen et al., 2016; Chen et al., 2018; Janssen & Leibowitz, 2018; Kaltiala-Heino et al., 2018). TGNC individuals are valued and supported as gender variation is believed to be a natural form of human diversity and not a pathological matter (Breland et al., 2016; Janssen & Leibowitz, 2018).

A range of organizations have strongly supported the notion that for psychologists to be a part of a gender-affirmative interdisciplinary practice, they must possess expertise in diverse domains, including child and adolescent growth and development, in order to diagnose and make treatment decisions based on the needs of minors and their families (Kaltiala-Heino et al., 2018; Lev, 2004; Schillace; 2021). In addition, researchers in the field agree that as gender-affirmative practices are more widely accepted and used, research needs to be conducted for extended periods with large sample sizes to evaluate gender-affirmative practice approaches and outcomes with pubertal and prepubertal individuals (Gray et al., 2012; Kaltiala-Heino et al., 2018).

Multiculturalism as a Center Force

One of the most critical components of psychotherapy is the therapeutic alliance, a relationship between the client and the mental health professional built on trust, respect, and a mutual agreement on treatment goals (Zilcha-Mano et al., 2015). Mental health professionals guide and help culturally diverse clients establish goals and set tasks to effectively meet therapeutic outcomes and expectations based on the client's needs

(Greene, 2007; Zilcha-Mano et al., 2015). With continuous demographic changes, multiculturalism has become an important driving force for doctoral-level clinicians in the United States (Fowers & Davidov, 2006; Ridley & Shaw-Ridley, 2011; Vera & Speight, 2003; Worthington et al., 2007; Worthington & Dillon, 2011). Understanding diversity within cultures and cultural backgrounds is an essential competency for clinicians because it helps reduce biases and discriminatory attitudes when treating racial, ethnic, and sexual minority clients (Constantine, 2001; Constantine & Ladany, 2002; Constantine et al., 2002; Dillon et al., 2016; Green, 2007). Viewing the world through a multicultural lens provides a sense of sensitivity, empathy, and respect for the unique experiences and difficulties that clients undergo (Sue & Sue, 2013).

Multiculturalism and multicultural training approaches have become central forces in the mental health field to examine, understand, and address the needs of vulnerable populations with competency (Constantine, 2001; Constantine et al., 2002; Constantine & Ladany, 2002; Dillon et al., 2016). The APA (2003) Guidelines on Multicultural Education, Training, Research, Practice, and Organization Change for Psychologists were developed to influence the field of psychology as a whole and influence changes regarding its approach to diagnosing and treating lesbian, gay, bisexual, and transgender clients. The value for mental health professionals found within the multicultural training literature and existing guidelines have included specific techniques to effectively navigate the endless diversity of clients with confidence, ethics, and effectiveness (Constantine & Ladany, 2000; Greene, 2007; Ridley & Shaw-Ridley, 2011; Speight et al., 1991; Worthington & Dillon, 2011).

Multicultural Competency Theory and the Tripartite Model

Within the multicultural counseling theory perspective, competence is the ability of mental health providers to effectively and ethically work with culturally diverse clients to reduce mental health disparities (Dillon et al., 2016; Sue et al., 1992). Multicultural competence is a developmental process where mental health professionals acquire self-awareness, cultural knowledge, and skills to provide quality services to multiculturally diverse populations (Arredondo, 1999; Sue et al., 1992). The developmental process begins with mental health professionals' awareness of the cultural similarities and differences they possess compared with those to whom they provide services (Sue & Sue, 2008). This introspective examination provides an opportunity to reflect on one's own biases, privilege, or oppression, helping therapists take a more sensitive and inclusive perspective of the client's multicultural contexts, worldviews, experiences, and needs when providing services (Pederson et al., 2008).

Addressing the deficiencies in clinicians or psychology graduate training programs regarding multicultural competencies can be daunting. In the last two decades, several researchers have taken on the mission of addressing how psychology graduate programs can better prepare future clinicians to work within a multicultural, pluralistic society (Dunn et al., 2013; Gurung, 2009; Kite & Littleford, 2014; Mio et al., 2012; Prieto, 2009). Unfortunately, several minority groups, such as LGBT individuals with disabilities and transgender individuals, are underrepresented in this research (Greene, 2007). Therefore, to address the needs of marginalized and oppressed populations, multicultural counseling competencies use a tripartite model. The multidimensional

approach to developing multicultural competence highlights the need to incorporate valuable features of multicultural competence when providing services.

For example, *Dimension I: Group-Specific Worldviews* proposes the inclusion of individual differences associated with race, gender, sexual orientation, physical ability, age, and other significant reference groups (Sue & Sue, 2008, p.48). *Dimension II: Components of Cultural Competence* indicates that culturally competent mental health professionals "must be aware of their own biases and assumptions about human behavior, must acquire and know the particular groups they are working with and must be able to use culturally appropriate intervention strategies in working with different groups" (Sue & Sue, 2008, p.49). *Dimension III: Foci of Therapeutic Interventions* states that culturally competent mental health professionals must provide services and advocate for culturally effective and sensitive mental health services at individual, professional, organizational, and societal levels (Sue & Sue, 2008, p. 49).

Doctoral internships and training programs must conduct ongoing evaluations of their students' readiness, comfort level, and interest in inequality issues (Oransky et al., 2019). Addressing disparities in training is vital; in a study conducted by Hope and Chappell in 2015, they found that only 27% of clinical psychology graduate programs included LGBT faculty members (Hope & Chappell, 2015), and only 53% of clinical psychology graduate programs included LGBT graduate students (Hope & Chappell, 2015). The information gathered in this study may be useful for training programs to use in program development to best prepare psychologist trainees to provide the best care to their TGNC clients.

The Gender-Affirmative Model of Care Approach

Gender identity has been recognized as an individual's fundamental human right to develop, explore, and express (Ehrensaft, 2016; Janssen & Leibowitz., 2018; Lev, 2004; Temple Newhook et al., 2018). The primary therapeutic tenet of this approach is that an assigned gender should not determine a child's gender identity at birth; instead, the child's gender identity should be determined or expressed by the child (Ehrensaft, 2017). Further, the premises of the gender-affirmative model of care indicate that gender identity (a) exists in infinite varieties and is not pathological; (b) is fluid, not stable or binary throughout one's lifetime; (c) varies across cultures and contexts; (d) requires cultural sensitivity; (e) is a web where biological, cultural, social, and developmental factors interweave in time, and; (f) originates from cultural reactions to gender diversity rather than by internal psychological disturbance in the child (Ehrensaft, 2011; Ehrensaft, 2018; Edwards- Leeper et al., 2016; Hidalgo et al., 2013, Keo- Meier, C., & Ehrensaft, 2018; Matsuno, 2019).

The gender-affirmative model of care posits that "children should not be denied the opportunity to explore and embrace their identity, socially and medically, if they are simultaneously being treated for other presenting problems" (Koe-Meir & Ehrensaft, 2018, p.72). These guidelines also state that TGNC youth gender identities should never be pathologized as they are a natural part of human diversity and instead should be affirmed (Edwards-Leeper et al., 2016; Ehrensaft, 2011; Ehrensaft, 2016; Matsuno, 2019). Therefore, one of the main objectives of mental health professionals within the affirmative model of care approach is to listen to what a child is communicating about

their gender identity and expression by working with their parents or caregivers in deciding what the child is experiencing and articulating (Hidalgo et al., 2013).

When mental health professionals support the presenting gender of TGNC youth rather than attempt to alter it, this facilitates feelings of confidence, safety, and positivity (Kraschel et al., 2022; Vance et al., 2018). As a result, mental health professionals can then reach other vital objectives of serving as facilitators and advocates to help clients find their authentic gender self, alleviate gender stress and distress, secure social support, and help the client build gender resilience (Edwards-Leeper et al., 2016; Ehrensaft, 2011; Ehrensaft, 2017; Keo-Meier & Ehrensaft, 2018; Hidalgo et al., 2013; Matsuno, 2019).

Competent Gender Affirmative Care

Martell (2018) noted that researchers' perspectives regarding a topic will always influence their findings. In most cases, the assumptions researchers make when studying sexual minority individuals and reaching conclusions for treatment will be in some way affected by positionality (Martell, 2018). Some mental health practitioners have questioned the gender-affirmative model of care based on the lack of evidence-based findings that individuals can communicate a gender identity incongruence when they are young (Ehrensaft, 2017). Also, there is a lack of research regarding if or how individuals benefit from a gender identity social transition at an early stage of development (Ehrensaft, 2017; Kraschel et al., 2022). Overall, mental health providers who work with TGNC individuals must be cautious when offering services to this population if their level of competency is limited because the pillars of cultural competence of awareness, knowledge, and skills are used to treat this population (Matsuno, 2019; Sue, 2001). There

is little to no information available about what mental health providers see as necessary components of treatment or how they apply this model in their care of clients.

When using the gender-affirmative model of care, the primary contribution of a mental health care provider in a multidisciplinary collaborative care team is to provide acceptance, support, and understanding without making assumptions about gender identities or gender expressions (APA, 2015; Ducheny et al., 2017). Mental health providers must work as gender specialists, with basic knowledge and understanding of the variety of hormonal and medical interventions offered in transgender care (Ducheny et al., 2017; Ehrensaft, 2017; Olson et al., 2015). Mental health providers are encouraged to display expertise in assessing and treating gender dysphoria to reduce psychological issues before, during, and after gender-affirming medical care (Austin & Craig, 2015; Oransky et al., 2019).

Mental health professionals who work with the parents and extended family of TGNC youth must help them work through the stages described by Saeger (2006) of acceptance, discovery, turmoil, decision-making, and finding balance. According to Saeger, if families can reach the final stages of decision-making and finding balance, parents can support and advocate for their children to live as the gender they self-identify. For that reason, mental health professionals conduct psychological evaluations to understand children and their family's needs and to inform optimal treatment interventions that at all times will avoid harm (Hembree et al., 2009; Hill et al., 2010).

Researchers have indicated that TGNC youth who have access to gender-affirming models of care significantly improve their overall health outcomes (Acarturk et

al., 2019; Knight et al., 2014; Olson et al., 2018; Rafferty et al., 2018; Newhook et al., 2018; Thompson et al., 2016; Whitman & Han, 2017). One of the main reasons for the success of the gender-affirmative model of care is that TGNC individuals receive valuable insight and specific interventions tailored to their individual needs during their decision-making process (Chen et al., 2016; Pullen Sansfaçon et al., 2019). We continue to lack knowledge about how that model is applied by mental health providers and what training is required in order to competently apply the model to clients.

Working with Families and Building Alliances

The role of mental health professionals in the lives of TGNC youth and their families is an ongoing debate within the field (Kraschel et al., 2022). There is a need for mental health services that support guardians understanding gender variance and the need to affirm gender identity as children and adolescents experience (Hill et al., 2010; Kraschel et al., 2022; Olson et al., 2016; Riggs & Due, 2015; Sherer, 2016; Simons et al., 2013). However, the lack of evidence-based research regarding best therapeutic practices for working with transgender and gender-expansive children and their families has made it hard for mental health professionals to agree on a gender-affirmative approach to care (Janssen & Leibowitz, 2018; Kraschel et al., 2022; Sherer, 2016).

Researchers, for several decades, advised parents and mental health practitioners to take a highly cautious approach to gender non-conforming youth (Riggs & Due, 2015). This approach guided parents in facilitating their children to perform more in accordance with their assigned gender at birth. Consequently, TGNC youth and their families reported negative experiences with mental health professionals (Hill et al., 2010; Olson et

al., 2016; Riggs & Due, 2015; Sherer, 2016; Simons et al., 2013). For example, TGNC clients reported experiencing clinical encounters "with discrimination and prejudice such as offensive statements, dehumanizing treatment, and outright refusal of care" (Mozock & Lundquist, 2016, p. 148). Riggs and Due (2015) concluded that an alliance with clients and their families could reduce TGNC youths' anxiety, depression, and suicidal ideations. Also, assigning a formal diagnosis restored trust toward mental healthcare providers (Case & Meier, 2014; Simons et al., 2013). In order to effectively serve TGNC youth and their families, mental health providers must become experts in gender health and help clients access necessary services in the legal, medical, and mental health fields (Hidalgo et al., 2013; Keo-Meier & Ehrensaft, 2018).

One goal of psychologists who provide gender-affirmative treatment is to assist caregivers and parents in helping children develop self-esteem (Lev, 2019). Through advocacy and collaborative care, mental health professionals become allies and help TGNC clients through the range of obstacles and barriers they regularly encounter (Case & Meier, 2014; Janssen & Leibowitz, 2018; Lev, 2004). The APA Task Force on Gender Identity and Gender Variance, the World Professional Association for Transgender Health Standards of Care (WPATH, 2022), the Endocrine Society Guidelines (Hembree et al., 2017), and the American Counseling Association Competencies for Counseling with Transgender Clients (2010) all have made valuable recommendations for working with TGNC individuals and their families.

Although several standards of treatment exist and have a general consensus on gender-affirmative care, few studies have examined mental health professionals'

experiences working with TGNC youth and how they apply these standards (Holt el al., 2020; Whitman & Han, 2017). More information for mental health professionals who work with TGNC youth at earlier stages is needed to improve access to culturally responsive evidence-based care (Holt et al., 2020). Affirming care is not always offered to TGNC individuals despite published guidelines of care and continued negative experiences in psychotherapy that are well-documented (Holt et al., 2020).

Developing Resilience in TGNC Youth and Their Families

One of the goals of mental health professionals when working with TGNC youth is to help individuals, their families, and communities develop resilience, which is the ability for TGNC youth "to overcome or survive adversity and to grow and flourish because of the experience" (Keo-Meier & Ehrensaft, 2018, p.141). Researchers' findings on transgender youth, including those who meet the criteria for gender dysphoria, found that the support and acceptance received from peers, family, culture, and social context are vital components to creating resilience among TGNC youth (Gray et al., 2012; Hill et al., 2010; Riggs & Due, 2015). Researchers' findings show that families could support, accept, and advocate for children's transgender identity only when all family members are capable of passing through the initial reactions of confusion, ignorance, fear, guilt, or shame (Breland et al., 2016; Ehrensaft, 2012; Saeger, 2006).

Tishelman et al. (2015) conveyed that in some cases, families who have initial knowledge of their children's gender identity variance may not have the ability to respond with acceptance, love, and support as they may experience a feeling of loss of a child. In contrast, some families could experience resilience and overwhelming love for

their children but may experience a need to find a rapid solution to their children's transitioning needs without caution before making life-changing decisions (Case & Meier, 2014; Tishelman et al., 2015). Thus, it is crucial to assess how the parents have made sense of their child's gender development and how they responded to the child's gender identity variance (Zucker et al., 2012). Further, assessments should be conducted to measure how the child's cognitive level, psychosocial functioning, and school performance, as well as the role that the child's gender nonconformity, has played in family dynamics (Breland et al., 2016; Hidalgo et al., 2013). Family support will always serve as a protective factor for TGNC youth resilience to improve mental health disparities linked with the challenges of living and developing in a cisnormative and transphobic society (Simons et al., 2013). Given the complex nature of family work, it is clear that treatment standards for working with TGNC adults cannot be applied to TGNC youth without significant adaption, and little is known about how mental health professionals adapt their clinical work to fit this client population.

Despite the contribution of the multicultural counseling training competencies and the tripartite model in professional organizations and graduate training programs within the mental health fields, there is also not enough research that examines the success and validity of master and doctoral-level mental health professionals (Worthington et al., 2007; Worthington & Dillon, 2011). There is a paucity of studies that have examined mental health professionals' experiences working with TGNC youth in regard to both training and application (Holt et al., 2020; Whitman & Han, 2017).

Clinicians are constantly facing ethical dilemmas as there is a lack of evidence-

based studies confirming the benefits in TGNC youth who start treatment at earlier stages, as most studies focus on adult experiences (Kraschel et al., 2022; Santoro, 2022). There is also no empirical literature on effective treatment for transgender youth who meet the criteria for social anxiety disorder and gender dysphoria at a young age (Busa et al., 2018). Existing guidelines to treat gender dysphoria should be carefully considered as they remain vague and unclear regarding treatment and best practices to treat TGNC youth. Gender-affirmative treatment cannot be seen as a one-size-fits-all model of care for TGNC youth because every individual may not seek to transition or may not meet the criteria for gender dysphoria. Understanding what mental health professionals need in actual practice and what is being done with TGNC youth based on the usefulness of existing guidelines remains unclear.

This research was urgently needed to meet the gaps described in this chapter. The findings will be of value in understanding how to work within a system and with families, as providing treatment to TGNC youth has become a conflicting and controversial topic due to anti-transgender laws being passed across the United States. (Turban et al., 2021). The research also provides valuable information from experts who work with TGNC youth regarding efficacious and culturally sensitive treatment, guidelines, and best practices based on their current knowledge, skills, and experiences. Findings from this study may be used to guide mental health professionals in what action to take, impacting their ability to provide mental health services to TGNC youth caused by outdated, inhumane, harmful treatments such as conversion therapy (Turban et al., 2021).

Summary

Despite the evolution of the physical and mental health treatment of transgender nonconforming clients, there continues to be limited research regarding the best gender-affirming evidence-based therapies to treat this population. There is a gap in the knowledge, skills, and multicultural competence of mental health professionals to address and reduce the health disparities of TGNC youth and their families. The limited competence and training of mental health professionals to treat transgender and gender nonconforming (TGNC) youth with gender dysphoria has perpetuated the marginalization of this vulnerable population. Although all graduate psychology programs offer at least one course on multicultural competency, students are largely not provided with sufficient knowledge, experience, and exposure to provide optimal care effectively. Efforts to improve clinical skills and preparedness to understand and address the mental health needs of TGNC youth with gender dysphoria might be achieved by increasing formal education and contact hours with the population of interest (Nowaskie, 2020).

Chapter 3: Research Method

Introduction

The purpose of this qualitative Delphi study was to develop a consensus regarding training standards of care with a panel of psychologists who are experts in required competency, training, assessment methods, and best treatment practices when treating TGNC youth. I aimed to address the gap in the literature regarding the need for information about the necessary and sufficient specialized training to develop clinician competence when working with the population of interest, as well as the need for information about assessment methods and best treatment practices in working with this population. The opinions of expert psychologists specializing in treating TGNC youth were gathered to develop consensus opinions on these two issues.

The focus of this chapter is to provide a detailed description of the research methods used to collect data for this study. An explanation of the rationale for using a qualitative Delphi methodology will be provided. I will also explain the researcher's role, describe how participants were selected, list the research questions, and explain the method of data collection and analysis. Additionally, I will discuss trustworthiness issues, credibility, dependability, and ethical procedures related to the study. Finally, there is an overall summary of the main points of Chapter 3.

Research Design and Rationale

Competency refers to "a professional being qualified, capable, and able to understand and do certain things appropriately and effectively" (Rodolfa et al., 2005, p. 348). Elucidation of competencies when treating TGNC individuals is imperative as it

could influence the development of curriculum, training, and practice, meeting the needs of underrepresented minority groups. Currently, there is limited research and data available on this specific topic. A qualitative Delphi method was used to address the literature gap of what specialized training is needed in psychology graduate programs to develop clinician competence when working with TGNC youth with gender dysphoria. Further, the existing gap in research regarding a consensus expert opinion on the best practices and protocols for the assessment and treatment of TGNC youth with gender dysphoria was addressed (Holt et al., 2002; Kaltiala et al., 2020).

The Delphi method was developed in the late 1950s during the Cold War by Dalkey and Helmer (1963), who used it to forecast the outcomes of nuclear weapon usage in war. The Delphi design seeks opinions from experts on a particular topic to acquire group knowledge, guide decision-making, or understand a phenomenon in greater depth to forecast future needs (Dalkey & Helmer, 1963). The Delphi method provides a foundation for future research through consensus development. Sekayi and Kennedy (2017) highlighted that the "anonymous collection of narrative group opinion coupled with the tightly structured nature of the process and quantitatively described results renders the approach difficult to situate in a methodological category" (p. 2755). Hence, the Delphi approach has been described as a qualitative, quantitative, and mixed-methods approach (Sekayi & Kennedy, 2017).

Qualitative research is used to understand a phenomenon in a real-world setting without manipulating the investigated phenomenon (Ravitch & Carl, 2016). The Delphi method is used in healthcare settings, governmental agencies, and education as a reliable

means of determining consensus when there is a lack of research on a topic or conflicting information is found (Linstone & Turoff, 2002). A qualitative Delphi method is characterized as a decision-making and forecasting method "for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem" (Linstone & Turoff, 2002, p. 3).

The Delphi design is an iterative process that uses a systematic progression of repeated rounds of input and feedback to reach an expert group consensus (Sekayi & Kennedy, 2017). The classical or conventional method used in this study entails assembling a panel of experts on a topic who can be geographically remote. Members of the expert panel did not know who the other members were, which is a strategy that addresses the obstacles that can occur in face-to-face group thinking where certain group members dominate the decision-making process, resulting in group conformity (Linstone & Turoff, 2002; Nasa et al., 2021). The panel of experts provides their opinions and ratings in a series of rounds that involve responding to a question or questions. After each round, the panel of experts receives feedback on the group response, which usually takes the form of points of agreement on a Likert-type scale (Sekayi & Kennedy, 2017). Feedback continues until consensus is reached, which in a Delphi method is defined in advance and "ranges from 55% to 100 % agreement, with 70% considered the standard" (Avella, 2016, p. 307). Controlled feedback may continue until each round's return discrepancies decrease, reaching saturation (Sekayi & Kennedy, 2017). Reliability and validity of the study occur when there is a clear literature foundation from which to establish a survey and when the knowledge obtained comes from a group of experts as

they produce the answers to the items that will be rated (Niederberger & Renn, 2023).

The Delphi has been used to identify expert competencies to treat LGB clients (Godfrey et al., 2006), to develop WPATH's standards of care for the health of transgender and gender-diverse people (Coleman et al., 2022), and to obtain experts opinion regarding key competencies in clinical practice (von Treuer & Reynolds, 2017). The method is valuable and practical and can also ensure confidentiality (Linstone & Turoff, 2002). With this method, expert opinions are sought regarding a problem that is difficult to quantify (Niederberger & Renn, 2023). Opinions are generated and combined, and feedback can be provided by experts via e-mail, Google Docs, or other document-sharing technology (Avella, 2016; Sekayi & Kennedy, 2017). After two to four rounds of questions, clearly defined opinions are ranked in order of importance (Sekayi & Kennedy, 2017). The consensus among a knowledgeable group of experts is obtained without the need for face-to-face interactions, avoiding the pressure for conformity within a group where feedback is critical for the objective judgment of experts (Niederberger & Renn, 2023).

A classical Delphi method was used in this study as a systematic process through which experts reached a consensus in an area where there is a lack of research. The advisory panel of experts reached a consensus through a systematic process, and data were collected on what expert clinicians believe are the required competencies, training, assessment methods, and best treatment practices when treating TGNC youth. Moreover, the data collected provided information to potentially help develop curricula for doctoral-level programs to meet the needs of TGNC youth as well as treatment guidelines for

working with this population.

An advantage of the Delphi method is the flexibility to gather a group of experts to share existing knowledge and pinpoint areas of agreement and disagreement that would have been impossible due to time or geography. The Delphi method is also cost-effective as questionnaires can be distributed via web services or, if needed, over the phone. Thus, to explore the central phenomenon or concept in the study, which is the development of treatment guidelines for the competency and training required when treating TGNC youth with gender dysphoria, the research questions that guided this study were:

- RQ 1: According to an advisory panel of experts, what is the level of competency required to treat TGNC youth with gender dysphoria?
- RQ 2: According to an advisory panel of experts, what is the minimal level of training required to treat TGNC youth with gender dysphoria?
- RQ 3: According to an advisory panel of experts, what assessment methods are required to treat TGNC youth with gender dysphoria?
- RQ 4: According to an advisory panel of experts, what are the best treatment practices (interventions, protocols, or guidelines) to treat TGNC youth with gender dysphoria?

Role of the Researcher

My interest in this dissertation topic originated from an ongoing need to build on my experience, skills, knowledge, and competency to work with TGNC individuals, particularly clients at earlier stages in life. As a mental health professional who has

advocated for equal access to mental health services in Texas during the last 2 years, I have witnessed occasions where TGNC children and adolescents could not receive the mental health services they required for diverse reasons. In a state where there are increasing legal obstacles to receiving gender-affirming care, it has been challenging to meet the needs of TGNC youth and their families. This experience has motivated me to continue to advocate for this vulnerable population and promote rigorous training for clinicians to develop expertise in gender-affirming care through up-to-date evidence and research findings.

In this qualitative Delphi study, there were several roles that I fulfilled as the researcher that included the planning, coordination, and facilitation of the study, as opposed to being the primary instrument in traditional qualitative studies (Avella, 2016; Habibi et al., 2014). My tasks included recruiting the advisory panel of experts, planning and organizing the research, collecting data, analyzing results, and writing up and disseminating the findings.

Qualitative research is interpretative; the researcher's role as inquirer requires ethical strategies to identify biases, values, and personal background that may influence the interpretations formed during the research process (Creswell, 2014). Maintaining the rigor and credibility of various aspects of the research was my priority in keeping a reflexive journal, as described by Brady (2015). Monitoring any potential to interpret too quickly was essential (Creswell, 2014) to my role, and this was done by consulting with my dissertation committee chair, who was familiar with the Delphi design. Remaining aware and clear about my assumptions and biases on the topic was vital through the

process of reflexivity (Ravitch & Carl, 201; Rubin & Rubin, 2012). Recognizing that my role was not of the contributor but instead, a facilitator helped me remain focused on how the research questions were formulated, who was invited to participate in the research, how expert panelists were selected, how the study was explained to the panel of experts without biasing potential participants, how expert panelists continued to be motivated, and how the data was objectively analyzed and shared (see Linstone & Turoff, 2002; Rubin & Rubin, 2012).

As the planner, I screened potential panelists prior to enrollment in the study. The selected "experts" were individuals with whom I had no prior personal or professional relationships and who provided an opinion based on their knowledge and expertise of a topic from the position of the group to which they belong (see Linstone & Turoff, 2002; Ravitch & Carl, 2016). According to Hasson et al. (2000), a facilitator's role is to ensure that participants remain committed to a study where participants are questioned about the same topic several times. Therefore, as the facilitator, I strived to ensure that experts remained motivated and engaged throughout the research process by sending e-mail reminders or phone calls to enhance response rates. Furthermore, Ravitch and Carl (2016) stated that ensuring that expert participants remain informed and clear throughout the study about what they are asked to do, how much time they are expected to contribute to each round, and how the information they provide will be used plays an essential role in the research process. Hence, as the coordinator, I developed questionnaires to solicit and receive honest expert opinions in a series of rounds. Once I collected the opinions of experts, I objectively analyzed data, consolidated opinions, and provided summarized

results to the panel of experts in each round until a consensus was reached (Linstone & Turoff, 2002).

Methodology

The Delphi design was chosen to address the research questions. Other qualitative research designs, such as case studies, grounded theory, ethnography, and phenomenology, were inappropriate for the study because they did not align with the research purpose. The case study design was rejected because I was not interested in developing an in-depth analysis of a case involving events, programs, processes, or individuals using various data collection procedures over a sustained period (Creswell, 2014). Grounded theory was inappropriate because I was not interested in generating theories from the collected data. The ethnographic design was unsuitable because I was not interested in understanding and observing a phenomenon over a prolonged period in a natural setting. Finally, the phenomenological design was considered, but I found it inappropriate because it focuses on participants' experiences or essence and would not aid in developing a consensus of expert opinions based on knowledge and skills about the topic of interest (Creswell, 2014).

Participant Selection Logic

The Delphi method involves choosing a panel of experts on a topic to provide their opinions and ratings through multiple structured rounds for a broader purpose (Linstone & Turoff, 2002; Nasa et al., 2021). In a qualitative Delphi study, the size of the expert panel varies based on the topic of research, time, money, and the nature of diverse viewpoints of heterogeneous or homogeneous expert specialties (Nasa et al., 2021;

Niederberger & Renn, 2023). Although Delphi studies have been conducted with as few as six to twelve expert panelists (Hogarth, 1978), some researchers recommended expert panels to be between ten to fifty participants when the group is homogenous (Nasa et al., 2021).

The advisory panel of experts participating in this study was purposefully recruited using expert criterion sampling. Purposive criterion sampling is considered a non-probability sampling technique (Creswell, 2014) that best suits a Delphi study because it is not concerned with having a generalizable sample but instead seeks knowledgeable individuals who meet inclusion criteria with specific expertise on a topic and who are referred to as "expert" panelists (Linstone & Turoff, 2002; Ravitch & Carl, 2016).

In order to participate in the study, expert panelists must have been licensed doctorate-level psychologists who specialize in gender identity services with TGNC youth within the United States. They all worked at an established organization or practice that currently imparts a multidisciplinary and affirmative approach to care for TGNC youth diagnosed with Gender Dysphoria. They also had a minimum of 5 years of experience working with the population of interest.

The recruitment process entailed sending e-mail invitations to the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, and the American Psychological Association Division 44 (Appendix A). I also reached out to multidisciplinary centers across the U.S. that specialize in care for TGNC youth. I placed notices about the research on social media sites that focused on TGNC healthcare and

LinkedIn (Appendix B). E-mail addresses and phone numbers of organizations that provided support for the population of interest were obtained from the Internet, and snowball sampling was also used. The purpose of the study and criteria for participation were explained in the e-mail invitation to ensure that the mental health professionals met the inclusion criteria to participate in the research. Organizations were contacted to request their representatives help to distribute and forward research invitations to their members through flyers or emails (Appendix C).

I invited the first 11 potential participants who met the inclusion criteria to participate in the study. Delbeq et al. (1975) explained that smaller samples yield satisfactory results for saturation compared to large samples, which increases the complexity and difficulty of data collection, reaching consensus, data analysis, and results verification. Data saturation can be obtained when the data collected no longer provides new insights or reveals new information (Creswell, 2014).

Once the organizations sent out notices to their members and potential expert panelists contacted me stating their interest in participating in the study, I e-mailed volunteers a link to start the initial contact via Teams or Zoom meetings. During the meeting, I informed the participants in detail of what they were asked and required to do, how much time they would be expected to participate and contribute to the study, and how the information they rendered would be used. Also, I administered the screening questionnaire. If the potential participant qualified and wanted to participate in the study, informed consent was sent via e-mail immediately so that they could read and agree to participate in the study by replying to the e-mail with the words, “I consent.” Once digital

consent was obtained, I proceeded to collect the demographic by sending the demographics questionnaire with the first round of the survey/questionnaire through e-mail (Appendix D) and asked panel members to return the forms within fourteen days.

It is worth noting that McKenna's (1994) study found that conducting face-to-face interviews in the first round helped increase the level of motivation of the expert panelist in subsequent rounds. If the advisory panel experts had any questions before or after the demographic meeting, I provided my Walden e-mail address for clarification during or after the recruitment process.

Instrumentation

The questionnaire for round one was developed for this Delphi study based on an extensive literature review and existing gaps in research in order to address the research questions. Traditional Delphi studies utilize a series of data collection and data analysis rounds to reach a consensus (Sekayi & Kennedy, 2017). In the first round, an e-mail with a link to access the open-ended questionnaire via SurveyMonkey, a cloud-based survey tool, was sent to the advisory expert panelist to brainstorm the topic of interest (Appendix D). Two consecutive rounds of questionnaires (Appendix E and Appendix F) in a Likert-type scale were developed, given the analysis of the first round, and e-mailed again to the panelists.

The data collected (experts' opinions) were not interpreted statistically; instead, they were organized and tallied into themes to be presented in the subsequent rounds of questionnaire. After each round, the advisory expert panelist had the opportunity to review the previous round results and to reconsider their answers based on the added

information. The rounds continued until an 80% consensus was reached.

It is worth noting that data was collected and stored through SurveyMonkey, which is a cloud-based survey tool that protects data through encryption, SSO, and other features that helped me remain compliant with the Health Insurance Portability and Accountability Act and the General Data Protection Regulation. The collected responses were identified by code numbers that were kept separately from the advisory expert panelist names to protect the confidentiality of experts.

Procedures for Recruitment, Participation, and Data Collection

The Delphi method is an iterative data collection and analysis process to reach expert consensus over the course of several rounds (Linstone & Turoff, 2022). Subject matter experts' opinions are collected using quantitative, qualitative, or mixed methods methodology and then interpreted statistically or organized and tallied into concepts or themes (Brady, 2015). The Delphi method's flexible nature allows three to five rounds to be conducted. In essence, as cited by McKenna (1994), "the Delphi technique is a multistage approach, with each stage building on the results of the previous one" (p. 1221). Collected responses are identified by code numbers (e.g., P1, P2, etc.) and are kept separately from the expert panelists' names to protect the confidentiality of participants.

In this study, the data collection and data analysis process of each round entailed asking the advisory expert panelists to render their opinions on the topic of study via e-mail. The questionnaire for each round was developed based on the analysis of the findings from previous rounds. Findings of each round were summarized and shared with the expert panelists in a new questionnaire form to review and rank in order to narrow

down responses until an 80% consensus was reached. Results from the final round were distributed to the advisory panel of experts as a summary via e-mail and served as the last debriefing.

Round 1

Once the advisory expert panel had been selected, the first round of open-ended questionnaires related to the research topic was distributed to the experts via e-mail with a link to SurveyMonkey. The list of questions is provided in Appendix D. Experts had fourteen days to open the link and complete the questionnaire, and e-mail reminders were sent on day six and day twelve to experts who had not completed the questionnaire. I then collected and analyzed the data from the first round. Next, I developed the second questionnaire based on the findings of the first round and distributed it to the advisory panelists via e-mail with a link to SurveyMonkey (Appendix E).

Round 2

The data collected from the round one questionnaire was organized by themes or concepts and summarized by using content analysis. A separate list of items derived from each research question in round one for the second round was created. An e-mail with a link to the second-round questionnaire in Survey Monkey was sent. Experts had fourteen days to open the link and complete the questionnaire, as they did for round one, with e-mail reminders sent on day six and day twelve to experts who had not completed the questionnaire. Items from the round one questionnaire were presented in list format for experts to rank on a 5-point Likert-type scale ranging from 5 (Strongly Agree) to 1 (Strongly Disagree) regarding how important they thought or agreed that item was in

regard to the competency, training, assessment methods, and best treatment practices when treating TGNC youth with gender dysphoria. In this round, experts also were given an opportunity to make comments about items, edit items, or add new items that they believed were missing.

Round 3

The third questionnaire based on round two results was also distributed to the advisory panelists via e-mail, and they again ranked the items listed by level of agreement, including each item in the list of standards for the required competency, training, assessment methods, and best treatment practices when treating TGNC youth with gender dysphoria (Appendix F). The link was open for fourteen days, with reminders to complete the questions sent on day six and day twelve. I collected and analyzed round three responses to determine if a consensus had been reached. If not, a fourth-round would have been conducted, which would have been similar to round three.

When consensus had been reached, the advisory panel of experts were contacted via e-mail with the research findings. The expert panelists were able to comment on the research findings as in previous rounds within fourteen days.

Debriefing

In this Delphi study, the advisory panel of experts debriefing occurred throughout the iterative process. The expert panelists were given information about the research results from each round in a new questionnaire and so received ongoing feedback on the findings. In the final round, when consensus was reached, the advisory panel of experts was contacted via e-mail with the research findings and were invited to comment on the

results. A follow-up session was offered via Zoom or Teams meeting to thank participants for their time and participation. If participants had comments, concerns, or questions regarding the study's findings, this virtual face-to-face session served as a platform to address them. To compensate for their time and commitment at the end of the study, the panel of experts received monetary compensation via e-mail, such as an Amazon $10.00 gift card or a Starbucks $10.00 gift card (experts were given an option to choose).

Data Analysis Plan

Data analysis in this Delphi was conducted iteratively throughout the study, as the data collected in prior rounds was analyzed to develop the questionnaires for subsequent rounds. The collected data was stored and accessed for analysis via SurveyMonkey, a cloud-based survey tool, where all questionnaires were developed and distributed to expert participants.

Data collected during round one was qualitative with open-ended responses, but data collected for round two and subsequent rounds utilized a 5-point Likert-type- scale. The advisory panel of experts' responses were analyzed using thematic and content analysis to identify themes, concepts, and categories that allowed me to move from the experts' specific ideas to explanatory ones.

Although the Delphi methodology is qualitative, descriptive statistics can be helpful in organizing, analyzing, and describing the characteristics or facts of collected data in a meaningful manner through a chart, table, or graph (Salkind, 2011). Inferential statistics, on the other hand, was not suitable because it is used to make predictions based

on probability of an entire population (Salkind, 2011). SPSS was used to examine the rankings and Likert-type-scale data was analyzed as interval data using measures of central tendency (e.g., median, mean, and mode) and level of dispersion (standard deviation, and percentages to reach an 80% consensus). Holey et al. (2007) suggested that "a combination of the simple descriptive statistics be used to reduce subjectivity and ensure maximum validity of results in Delphi methodology for improved evidence of consensual decision-making" (p.10).

Issues of Trustworthiness

Research validity, as Ravitch and Carl (2016) conveyed, is an active methodological and complicated process that entails quality and rigor in the way researchers can "affirm that their findings are faithful to participant's experiences" (p.186). Qualitative researchers follow standards and ethics of good practice that are trustworthy when interpreting and reporting qualitative data (Fossey et al., 2002). Integrity in the research process and the research results lead to trustworthiness (Shenton, 2004), which entails establishing (a) credibility, which refers to the confidence in the truth of the findings, (b) transferability, in which findings show to have applicability in other contexts, (c) dependability which shows that the findings are consistent and replicable, and (d) confirmability, in which findings show neutrality as the researcher's bias did not influence results (Lincoln & Guba, 1985).

Credibility

Credibility or internal validity is an essential criterion that required me to ensure that this study measures or tests what is intended **(**Ravitch & Carl, 2016). The interview

questions were developed to reflect the research questions, and follow-up general questions (is there anything that wasn't asked above?) are included to make sure that all of the experts' opinions on the topic were solicited. Per Lincoln and Guba (1985), "If the investigator is to be able to support that his or her reconstructions are recognizable to audience members as adequate representations of their own (and multiple) realities, it is essential that they be given the opportunity to react to them" (p.314). After each round, expert panelists had the opportunity to verify and validate the accuracy of the interpretation of data analysis and findings from the previous round by agreeing, clarifying, correcting, commenting, or adding information if necessary.

Transferability

Transferability or external validity in qualitative research is an essential criterion where researchers provide readers with a complete and detailed description of their experiences during data collection so that readers can make the transferability judgments themselves (Ravitch & Carl, 2016). A thick description of the phenomenon under study was provided to demonstrate that the findings from this study can be applied or transferred to another context, situation, time, and population. Rich data for this study occurred when emerging themes, concepts, or categories were plentiful, leading to recurring meaning, 80% consensus, and saturation.

The participants that were selected for this study through purposive criterion sampling were a panel of experts that met inclusion criteria with specific knowledge and expertise on the phenomenon of study. Subject matter experts' opinions were collected and analyzed using the Delphi iterative process to reach expert consensus throughout

several rounds that took approximately nine weeks in total.

Dependability

Dependability in qualitative research refers to the stability and reliability of the research data over time (Ravitch & Carl, 2016). To establish the dependability and consistency of findings in this study, I maintained an audit trail or research journal with a thick description of the research design and methodology. I included the date and the time that the notes were recorded. All information was kept in a secure computer file that I only had access to, with a password known only to me. An external audit was also conducted by a researcher who was not involved in my study to evaluate the data collection process, data analysis, and results. The external audit confirmed the accuracy and validity of the results, interpretations, and conclusions supported by the collected data (Ravitch & Carl, 2016).

Confirmability

Confirmability in this Delphi study was achieved by the level of objectivity or neutrality to which the research results were based on the expert panelists' perspectives and experiences instead of on my bias, motivation, or interest as the researcher (Lincoln & Guba, 1985). The researcher reflexivity process throughout the research was used to help me reflect upon my positionality and biases. A research journal or reflexive journal served as a methodological log to document and reflect upon decisions made, questions, thoughts, and ethical concerns that emerged throughout the research process.

Ethical Procedures

Ethics in qualitative research requires the researcher to be clear and transparent

with participants regarding the goals of the research, the expectations that the researcher has of the participants, the role of the researcher, the timeline of the study, and what the research process entails (Ravitch & Carl, 2016, p.363). When participants agree to share their opinions, experiences, and behavioral patterns openly, researchers need to ensure that they are treated with respect throughout the research process, as it is the researcher's ethical obligation to avoid harm (Rubin & Rubin, 2012).

This Delphi study had minimal risks for the advisory expert panelists. Reviews of the Delphi method highlight that confidentiality and privacy characterize this technique from other consensus methods. Before recruiting the advisory expert panel to participate in this Delphi study, I gained approval from Walden's Institutional Review Board. Once I obtained the IRB's approval, I began the recruitment process.

I e-mailed selected advisory expert panelists a link to an informed consent form and asked them to reply to the e-mail with the words "I consent" to participate in the study. Consent is a process, and the panelists were asked to contribute throughout all of the rounds, but they also were informed that they could withdraw from the study at any time without repercussion.

Expert panelists were given a copy of the research agreement and were reminded that their participation was voluntary and that information would be kept confidential. Experts were also reminded that they could withdraw from the study at any point in the research. I protected all of the collected data by keeping the names and identifying information of the panelists out of the database and on a key that only I could access. Also, the links to the questionnaires throughout the study were copied blindly. The

research data downloaded from SurveyMonkey was kept on a computer that I only accessed and was password protected. Expert participants had access to the research study results and were able to discuss concerns or questions with me during, before, and after the research had been completed. All data will be deleted five years after publication.

Summary

Chapter 3 focused on describing in detail the research design and rationale. The methodology for the present study, which included the participant selection, procedures for recruitment, data collection, and data analysis method, was described. I listed the research questions and explained the methods that were used to screen participants and collect data. The researcher's role, trustworthiness issues, and ethical procedures were also explained.

Chapter 4: Results

Introduction

The purpose of this qualitative Delphi study was to explore the perspectives of psychologists who were experts in required competency, training, assessments, and treatment practices when treating TGNC youth with gender dysphoria. Opinions of 11 doctoral-level psychologists across the United States considered experts in treating TGNC youth were gathered. The findings of this study may be valuable to current and future mental health professionals in improving their clinical competency to provide mental health services to TGNC youth with gender dysphoria. The results of this study may also help mental health professionals advocate for further research as well as the development of graduate program curriculums where best practices, specialized gender identity training models, and multicultural guidelines of care are imparted (Bidell, 2014; Cochran & Robohm, 2015; Pantalone, 2015). The research questions that guided this study were:

- RQ 1: According to an advisory panel of experts, what is the level of competency required to treat TGNC youth with gender dysphoria?
- RQ 2: According to an advisory panel of experts, what is the minimal level of training required to treat TGNC youth with gender dysphoria?
- RQ 3: According to an advisory panel of experts, what assessment methods are required to treat TGNC youth with gender dysphoria?
- RQ 4: According to an advisory panel of experts, what are the best treatment practices (interventions, protocols or guidelines) to treat TGNC youth with

gender dysphoria?

This chapter will begin with a detailed description of the setting and the advisory panel of experts' demographics. A description of data collection procedures and the result of the data analysis will follow. I will discuss changes/adjustments made to the recruitment process and the number of participants from the plan presented in Chapter 3. I will discuss the results of the research, as well as the evidence regarding the trustworthiness of the research. I will conclude with a chapter summary.

Setting

I initiated the recruitment process after receiving approval from Walden University's Institution Review Board (02-09-24-0669512) to conduct the study. Data collection was mainly conducted through asynchronous interactions via e-mail and through the cloud-based hosting service SurveyMonkey. All the experts also participated in the screening interview through the videoconference application Zoom.

Demographics

Participants' recruitment spanned 5 months. All of the eleven experts were licensed doctorate-level psychologists who specialized in gender identity services with TGNC youth in the United States and were from seven different states. Five experts held a PhD, and six held a PsyD. Four experts reported that they were members of the Psychology Interjurisdictional Compact (PSYPACT), an interstate compact designed to facilitate psychologists' practice of telepsychology with clients across state boundaries and multiple states. These four experts provide services to the following states: Alabama, Arizona, Arkansas, Commonwealth of the Northern Mariana Islands, Connecticut,

Colorado, Delaware, District of Columbia, Georgia, Florida, Idaho, Illinois, Indiana, Kansas, Kentucky, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, Wyoming.

All 11 experts worked at an established organization or practice that imparted a multidisciplinary and affirmative approach to care for TGNC youth diagnosed with gender dysphoria. They all met the inclusion criterion of at least 5 years of experience working with the population of interest. Three experts noted that they had over 20 years of experience working with TGNC youth, and five had experience in developing competency-based curricula and mentoring in psychology graduate programs. Five experts were also published authors of books and articles on the topic of interest.

The 11 expert participants were all White females, and one expert was transgender. Experts' ages ranged from early thirties to late sixties. The theoretical orientation of experts when treating TGNC youth ranged from gender-affirming model of care-interdisciplinary approach, cognitive behavioral therapy, feminist therapy, trauma-informed care, psychodynamics, dialectical behavioral therapy, acceptance and commitment therapy, humanistic therapy, and existential therapy. Nine experts were active members of a mental health association at a national, local, or state level.

Data Collection

Changes to Recruitment Process

The recruitment process initially entailed sending over 140 email invitations to

associations/organizations and multidisciplinary centers across the United States that specialized in care for TGNC youth. Organizations and associations were contacted across the United States to request their representatives distribute and forward research invitations to their members through flyers or e-mails. I also placed notices about the research on social media sites that focus on TGNC healthcare and LinkedIn. E-mail addresses and phone numbers of organizations that provide support for the population of interest were obtained from the Internet, and snowball sampling was also used.

After 5 months, no potential experts had responded to the recruitment materials. This was likely due to the current political atmosphere in the United States regarding transgender laws and treatment bans, which resulted in potential panelists being highly guarded and unwilling to trust my intentions or the stated aim of the research. I also received responses indicating that members' identities needed to be protected, as their safety could be compromised, and they could not forward the study information. After receiving approval from my dissertation committee and the Walden IRB, I changed the number of expert panelists to a range of five to 15 and changed my recruitment strategy to contact the authors of published studies on the topic of interest. Authors were asked to forward the recruitment flyer with the study information to colleagues or coworkers who may be interested in participating (Appendix G). After a week, potential experts started to respond to the new recruitment strategy with a high interest in participating in the study or passing the information on to colleagues. It took 2 months for this strategy to yield to the 11 advisory panels of experts in this study.

Data Collection

Data collection and analysis for all three rounds spanned approximately 9 weeks. In each round, the expert panelists were asked to render their opinions on the topic of study via e-mail through SurveyMonkey, as stated in Chapter 3. The Round 1 questionnaire was open-ended, as discussed in Chapter 3, and questionnaires for the two following rounds were developed based on the findings of previous rounds. The cutoff of 80% level of agreement of these items was based on the top two ratings of 4 (*Agree*) and 5 (*Strongly Agree*) with a median of 4 or higher.

Round 1

In the first round, data collection entailed sending the expert panelists an e-mail with a link to an open-ended questionnaire with four questions to brainstorm the topic of interest (Appendix D). I collected and analyzed the data from the first round through SurveyMonkey by downloading the data to a Word document. The responses to the four items were organized into themes and categories using theme and content analysis. I then used the information to develop the questionnaire for round two.

Rounds 2 and 3

The data for Round 2 were collected using items from the first round presented in a 46-question format. Experts ranked each item on a 5-point Likert-type scale ranging from 5 (*Strongly Agree*) to 1 (*Strongly Disagree*; Appendix E). The experts also were asked to make comments about items, edit items, or add new items that they believed were missing in each section. There were no cases of significant discrepancy where one or more experts differed from the items that emerged in Round 1 (agreed, disagreed, or

had a neutral opinion) in Round 2 and Round 3 of this study. Experts provided a more detailed description of their choice answers in the missing items and comments sections, but no new themes emerged that required further clarification. However, an additional item asking for comments regarding specific training resources was added in Round 2, asking experts to name individual training tools, including books, podcasts, websites, and other training resources.

The level of consensus in items for Round 2 was measured and determined, with items being ranked 4 and 5 by experts. Those items were considered to have reached a consensus and were not included in the round three questionnaires (Appendix F). The cutoff of 80% level of agreement of these items was based on the top two ratings of 4 (*Agree*) and 5 (*Strongly Agree*) with a median of 4 or higher. Thirty items met consensus, and 16 items did not. The 16 items were then included in the third questionnaire round, along with the 33 new items that emerged from comments that were added by experts in round two.

For the third round, data were collected with 49 items in a 5-point Likert-Scale format based on the findings of the second round. In this round, no new themes emerged. Experts indicated 80% consensus on all 49 items. No new themes emerged, and experts provided a more detailed description of their choice answers in this round. When consensus was reached, results were distributed to the advisory panel of experts as a summary via e-mail, which served as the last debriefing. Experts were invited to comment on the results and if they had comments, concerns, or questions regarding the study's findings. Nine experts replied to the e-mail summary stating their support and

agreement with the study findings; the remaining two did not respond to the e-mail.

Data Analysis

Data analysis in this qualitative Delphi study was conducted iteratively throughout the study, as the data collected in prior rounds were analyzed to develop the questionnaires for subsequent rounds. The cloud-based hosting service SurveyMonkey was helpful as it had a statistical feature that automatically calculated the percentage of survey results for round two and round three. Likert-type-scale data were analyzed as interval data using measures of central tendency (e.g., median) and level of dispersion (standard deviation and percentages to reach an 80% consensus). The number of experts who selected a specific answer to each Likert-type scale question was divided by the total number of experts who answered the question, then multiplied by 100 to express the result as a percentage. Further, the statistical feature in SurveyMonkey displayed the proportion of expert panelists who chose each answer option within a question and displayed the data in charts and graphs as a percentage in the analysis section of the round questionnaire, allowing me to see if consensus was reached on items or if they needed to be incorporated in the subsequent round questionnaire.

I kept a digital research journal to keep track of valuable information throughout the study. I tracked the recruitment of experts and the dates on which milestones were achieved. Throughout the study, I protected experts' confidentiality by collecting responses and assigning identifier code numbers (e.g., P1, P2, etc.). I recorded when e-mails and follow-up requests were sent, responses were received, and thank-you e-mails were sent to experts.

Evidence of Trustworthiness

One of the goals of this qualitative Delphi research was to yield meaningful, reliable, valuable, and transferable results through knowledge grounded in the experience of experts in the topic of interest across the United States. Standards and ethics of good practice were followed in a three-round iterative process that could be trustworthy when interpreting and reporting the data. Integrity in the research process, transparency of the conduct of the study, and bias-free interpretation for consensus building among the experts are vital to achieving trustworthiness in the research results (Shenton, 2004). Demonstrating that the findings of this research study were credible, transferable, dependable, and confirmable was a priority for influencing future research and advancing cumulative knowledge for improving the provision of mental health services to TGNC youth.

Credibility

Credibility or internal validity in this research entailed measuring and testing what was intended by using questionnaires that reflected the research questions and through follow up general questions on multiple rounds. The data were validated through member checking and debriefing in all three rounds to reach a consensus. After each round, expert panelists had the opportunity and sufficient time to verify and validate the accuracy of the interpretation of the data analysis from the previous round by agreeing, clarifying, correcting, commenting, or adding information if necessary.

Transferability

To assist the reader in assessing transferability or external validity in this

research, a complete and detailed description of the research setting, expert participants' inclusion criteria, relevant background information, method, and procedures used to collect, analyze, and interpret the data were provided. Also, a thick description of the phenomenon under study was described to demonstrate that the findings from this study can be applied or transferred to another context, situation, time, and population (see Ravitch & Carl, 2016).

Dependability

As noted in Chapter 3, I maintained transparent and comprehensive documentation throughout the research process through an audit trail or research journal with a detailed step-by-step description of the research design and methodology to establish the dependability and consistency of findings. Dates and times were recorded in the journal notes, as well as the data collection procedures, data analysis techniques, and interpretation methods that were utilized in this research. External audits were conducted by a peer reviewer and my dissertation committee chair to evaluate and confirm the accuracy and validity of the results, interpretations, and conclusions (see Ravitch & Carl, 2016). It is worth mentioning that in the first round open-ended questions were utilized to elicit spontaneous and bias-free answers based on the knowledge and expertise that would serve as the main themes for consecutive rounds.

Confirmability

Confirmability was ensured by maintaining objectivity and neutrality, as results were based on the data and not my bias, motivation, or interest as the researcher (see Lincoln & Guba, 1985). Researcher reflexivity was maintained through a journal that

served as a methodological log to document and reflect upon the research process, including decisions, questions, and thoughts. The journal was beneficial in putting aside prior expectations and maintaining objectivity throughout the research process.

Results

In the first round, expert panelists were sent an e-mail with a link to an open-ended questionnaire with four questions to brainstorm the topic of interest (Appendix D). The responses to the four items were organized into themes and categories using theme and content analysis. After this initial round, 15 themes emerged for the first research question, with the most mentioned concepts/categories involving Knowledge/Understanding, Skills, Awareness, Experience, and Attitudes. Four themes emerged for the second research question, with the most commonly mentioned concepts/categories involving WPATH training/certification, Master's or Doctoral-level training, License for independent practice, and Internship and Clinical supervision. Three themes emerged for the third research question, with the most commonly mentioned concepts/categories including clinical interviews, risk assessments, and gender behavioral health evaluation. Finally, four themes emerged for the fourth research question, with the most commonly mentioned concepts/categories including WPATH Standards of Care and therapy interventions. For the missing items and comments sections, one theme emerged, with the most commonly mentioned concepts/categories being a need for training and supervision. For the additional comments section regarding training resources, 15 items emerged, with the most commonly mentioned categories being books, podcasts, websites, and training topics.

There were no cases of significant discrepancy where one or more experts differed from the items that emerged in Round 1 (agreed, disagreed, or had a neutral opinion) in Round 2 and Round 3 of this study. Therefore, no areas of inquiry were dropped. Experts provided a more detailed description of their choice answers in the missing items and comments sections, but no new themes emerged that required further clarification.

Research Question 1

RQ1- According to an advisory panel of experts, what is the level of competency required to treat TGNC youth with gender dysphoria?

When asked about identifying what is the minimal level of competency required to treat TGNC youth with gender dysphoria, consensus was reached in regard to competency entailing a clinician's ability to understand TGNC youth's gender development and identities, as well as their social gender transition and physical transition to an affirmed gender. Similarly, experts agreed that to adequately address the unique mental health needs of TGNC youth without supervision, culturally competent clinicians must develop, acquire, and possess several skills in diverse areas that include but are not limited to standards and guidelines of care for TGNC individuals. Table 1 presents the five areas of competency that the experts agreed were required to treat this population: knowledge, attitudes, experience, skills, and awareness.

Table 1

Minimal Level of Competence Required to Treat TGNC Youth with Gender Dysphoria

Level of Competency Required: Knowledge and Understanding	
Accepted Items	Example Quotes
Knowledge/ understanding of the WPATH's Standards of Care, and history of the SOC and the Gender Affirmative	"Knowledge of the WPATH's Standards of Care, and history of the SOC gender diversity to develop an understanding that gender diversity is not a pathology" " Knowledge of the Gender Affirmative Model regarding what it is and what is not"
Knowledge/ understanding of the DSM-5-TR and ICD-10 regarding gender dysphoria and gender incongruence	"Knowledge/ understanding of the DSM-5-TR , ICD-10" "Knowledge of the DSM-5-TR and the ICD-10 definitions of gender dysphoria and gender incongruence are important"
Knowledge/understanding of the APA's guidelines for Psychological Practice with Transgender and Gender Nonconforming People	"Knowledge/ understanding of the APA's guidelines for Psychological Practice with Transgender and Gender Nonconforming People because the majority of clients will seek medical and psychological support for interventions such as puberty blockers, hormone therapy, surgery, voice training, hair removal or growth products".
Knowledge/ understanding of state guidelines regarding treatment for TGNC youth	" Clinicians should have knowledge of APA guiles and practices and state guidelines regarding treatment for TGNC youth because every state has its own rules and regulations we must all follow and implement
Knowledge/ understanding of child development	" Knowledge and understanding of child development to work from a developmental perspective at various stages of transition"
	" I believe it is important to have knowledge with regards to gender and sexuality from a non-heteronormative position"
Knowledge/understanding from lived-experience within the trans community and trans authors	"It would be helpful and beneficial to have knowledge and understanding from lived-experience within the trans community and trans authors, I have seen too many providers who take an academic stance and learn from cis writers about trans experience rather than trans people themselves". "Clinicians do not need to have personal lived experience, but learning from those who have is beneficial" "I absolutely read from trans authors and attend their presentation/trainings"
Knowledge/understanding of TGNC youth mental health issues, struggles, and disparities	"Clinicians should have a baseline level of knowledge about medical interventions and transition for clients who are seeking it, as it reduces clients need to educate their providers and also allows providers to educate clients with accurate information". " Practitioners should have the knowledge of TGNC youth mental health issues" "Given the significance overlap between these communities, I think it is vital that providers have a broader understanding of neurodivergence in order to best serve the trans community"

Level of Competency Required: Skills	
Agreed Upon Items	Example Quotes
Capability of working with Family Therapy and Family systems with a parent-child relationship focus	"Capability of working within complex family systems with a parent-child relationship focus and skills to work from a developmental perspective"
Ability to work from a developmental perspective	" Clinician should have the ability to work with the needs of TGNC youth taking into account their needs based on their developmental stage and gender identity at that level" "Ability to understand that gender identity is complex and the process changes "
Ability to create inclusive spaces for the patient and their families	" Clinicians need to be able to create intentionally inclusive spaces, engage in continuous self-reflection" " Ability to create an inclusive space where youth feel affirmed and respected regarding their gender identity and correct noun usage"
Ability to self-reflect	"Ability to self-reflect on existing biases as much as possibly" " Ability to engage in continuous self-reflection to address privilege, and maintain competency to practice advocacy"
Ability to seek consultation and supervision with other licensed providers	"Clinicians should have the ability to seek consultation with other license providers, and skilled for continuing education in this area and openness to learn"
Ability to conduct collaborative biopsychosocial assessments that lend to a Gender Health Evaluation (i.e., helping and supporting clients with letters of support for medical interventions)	" Clinicians should be able to conduct collaborative biopsychological assessment that lend to a Gender health Evaluation"
Ability to confirm the presence or absence of gender dysphoria (i.e., documenting how discrimination and prejudice due to the client's gender identity impact their mental health and well-being	"Practitioners should be able to diagnosed gender dysphoria" " Clinicians should have the ability to see if client has gender dysphoria or does not have gender dysphoria"
Ability to recognize that gender dysphoria is not an experience all trans youth report	" Clinicians should be able to recognize that not all trans youth report experiencing gender dysphoria "
Ability to recognize that dysphoria may not be the language that trans youth use to describe their experiences	" Clinicians should recognize that dysphoria may not be the language that trans youth use to describe their experiences in treatment"
Ability to acknowledge mistakes and take responsibility when a mistaken misgendering has occurred.	"Clinicians must acknowledge that mistakes and must take responsibility when a mistaken misgendering has occurred"

Level of Competency Required: Awareness	
Agreed Upon Items	Example Quotes
Cultural awareness (i.e., sensitivity to diversity and similarities	" Cultural awareness of sensitivity to diversity and similarities"
Familiarized with language usage and pronouns	"Awareness and familiarizing with language and pronoun to show clients acceptance by honoring their pronouns and names" " Awareness to avoiding the usage of wrong pronouns leading to misgendering clients and rejecting who they are" "General understanding and awareness of queer language, while recognizing that language within the community has heuristic value and is individually defined"
Awareness/understanding of current diagnostic criteria regarding gender dysphoria	"Being up to date and aware of current diagnostic criteria regarding gender dysphoria is important" " Providers need to have awareness and understanding of the current diagnostic criteria regarding gender dysphoria"
Awareness of available interventions for TGNC youth with gender dysphoria	" Clinicians must have awareness of all available interventions for TGNC youth with gender dysphoria"
Awareness of diversity of resources (medical, providers, support groups, books, websites)	" It's important to be aware of all the type of resources that can be used and recommended" " Awareness of resources builds competency and trust with patients"
Awareness that an individual does not need to be diagnosed with Gender Dysphoria to be transgender	" I think it's important to have awareness that an individual does not need to be diagnosed with Gender Dysphoria to be transgender" " Awareness that not all TGNC clients are diagnosed with Gender Dysphoria to be transgender"
Awareness that TGNC youth seek social and medical transition due to other factors that are separate from gender dysphoria (i.e., lack of support from family, discrimination, victimization, etc.)	" Awareness that dysphoria is a small portion of the challenge trans clients facing and exploring in session, lack of support from family, discrimination, etc. are often the primary issue that come up related to seeking social or medical transition"
Awareness that pathologizing transgender individuals may be harmful (i.e., human rights may be violated)	"Be mindful and aware that pathologizing transgender individuals may be harmful" "Pathologizing transgender individuals causes is a violation of human rights and causes harm"

Level of Competency Required: Experience	
Agreed Upon Items	Example Quotes
Continuing education and training in TGNC care at various stages of transition	" Experience working with multiple clients from the population at various stages of transition (and effective results/client satisfaction).Continuing education in this area"
Continuing consultation and supervision with other licensed providers	"Engagement/consultation with other professionals from the community who work with TGNC youth" "Consultation with other licensed providers, Continuing education in this area"
Training in multicultural competence	" Maintain competency of practice advocacy is an essential component of this work" "Training in multicultural competence at all stages in our professional journey"
Certified by the world professional association for transgender health	"Certified by the world professional association for transgender health"
Certification by the WPATH when feasible	Certified by the world professional association for transgender health when feasible as the process is expensive"
Working toward certification by the WPATH when feasible to be allowed to practice as a specialist in this area	" WPATH certified clinicians should be allowed to practice as a specialist in this area" " When feasible seek WPATH certification to work as a specialist in this area"
Membership with organizations or associations who advocate for TGNC individuals (i.e., WPATH)	" Seek membership with organizations or associations who advocate for TGNC individuals" " Memberships with associations are useful for further training and resources"
Clinicians' commitment to continue specialized training after academic training has ended	"Academic, continuing education and a focus on working with TGNC individuals"
Level of Competency Required: Attitudes	
Agreed Upon Items	Example Quotes
Empathy towards diversity	"Display empathy and openness to learn from patient"
Advocacy for TGNC individuals and their families	"Advocating against negative attitudes due to the client's gender identity lead to discrimination and prejudice impacting their mental health and well-being"
Openness to continue to learn from patients	"Openness to continue to learn from patients experiences and challenges at all times"
Openness to continue to learn and work with patients' families	"Openness to learn from the patient and work with families"
Recognition of one's privilege and how it intersect with clients	" Refrain from asking inappropriate and irrelevant questions about their transgender experience" "Recognition of one's privilege and how it intersect with clients"
Openness to normalizing talking about gender identity with clients even when we identify as cisgender to provide a safer setting for non-binary clients	" Openness to unpack one's own gender, even if the provider is cisgender"

Knowledge and Understanding

Regarding knowledge, experts agreed that to treat TGNC youth with gender dysphoria, clinicians should have the knowledge and understanding of the WPATH's Standards of Care, and the history of the SOC, and the gender affirmative model, which is an interdisciplinary approach to working with TGNC children and their families. Experts also agreed that having knowledge of the DSM-5-TR and ICD-10 regarding gender dysphoria and gender incongruence was fundamental because although not all clients meet the criteria for a gender dysphoria diagnosis, "the majority will seek medical and psychological support for interventions such as puberty blockers, hormone therapy, surgery, voice training, hair removal or growth products." One expert indicated that "clinicians should have a baseline level of knowledge about medical interventions and transition for clients who are seeking it, as it reduces clients' need to educate their providers and also allows providers to educate clients with accurate information."

Knowledge and understanding of the APA's guidelines for Psychological Practice with Transgender and Gender Nonconforming People and state guidelines regarding treatment for TGNC youth was another point of agreement among experts. Experts noted that because clients will seek support for interventions, clinicians have a responsibility to stay up to date regarding APA policy statements and legislation on gender-affirmative care. Furthermore, the experts agreed that an understanding of gender and sexuality from a non-heteronormative position and knowledge of TGNC youth mental health issues, struggles, and disparities promotes competency in clinicians as they impart treatment to improve the well-being of transgender, gender diverse and nonbinary youth.

It is worth noting that although experts agreed that knowledge from lived experience within the trans community is beneficial when providing treatment, several clarified that "clinicians do not need to have personal lived experience, but learning from those who have is beneficial." However, as one expert noted, many providers take an academic stance and learn from cis writers about the trans experience rather than trans people themselves; experts agreed that being an active part of the community, reading trans authors, and attending their presentations and training is helpful and advised.

Skills

Regarding developed and acquired skills, experts agreed that in order to treat TGNC youth with gender dysphoria, clinicians should have the capability of working with family therapy and family systems with a parent-child relationship focus. Also, they agreed that clinicians should possess the ability to work from a developmental perspective by recognizing that gender identity is complex and that understanding of gender may change over time. One expert indicated that "the treatment for TGNC youth varies significantly across the age range, and it is important to be able to provide accurate psychoeducation on this topic". Overall, the consensus was that having the ability to create inclusive spaces for the patient and their families, to self-reflect on biases, and to seek consultation and supervision with other licensed providers when needed will lead to better provision of services for this vulnerable population.

Similarly, experts agreed that the ability to conduct collaborative biopsychosocial assessments as a comprehensive gender health evaluation is essential to diagnose gender dysphoria and provide support for patients and families during transition. Furthermore,

the ability to recognize that dysphoria is not an experience all trans youth report is vital. However, because gender dysphoria may not be the language that trans youth use to describe their experiences, the diagnosis of gender dysphoria should be conducted with caution as it is used to treat stress, anxiety, and depression that TGNC youth might experience. For that reason, the experts agreed that competent clinicians should have the ability to acknowledge mistakes and take responsibility when mistaken misgendering has occurred, as it potentially can impact clients' mental health and well-being.

Awareness

Regarding awareness, the consensus was that in order to provide the best care for clients, clinicians should have "cultural awareness as it promotes sensitivity to diversity and similarities." Experts also agreed that clinicians should have a general understanding and awareness of "queer language while recognizing that language within the community has heuristic value and is individually defined." Hence, awareness and familiarization with language and pronouns are essential "as it shows clients acceptance by honoring their pronouns and names and avoiding the usage of wrong pronouns leading to misgendering clients and rejecting who they are."

Similarly, there was agreement that awareness of diagnostic criteria regarding gender dysphoria, awareness of available interventions for TGNC youth with gender dysphoria, and awareness of the diversity of resources (medical, providers, support groups, books, and websites) was important to provide treatment and build trust with clients. In particular, awareness that an individual does not need to be diagnosed with gender dysphoria to be transgender is essential because "pathologizing transgender

individuals may be harmful as their human rights may be violated." Awareness that TGNC youth seek social and medical transition due to factors other than gender dysphoria, such as lack of support from family, discrimination, and victimization, helps clinicians focus on the primary issues clients need to address in treatment.

Experience

Regarding the level of experience required to treat TGNC youth with gender dysphoria, experts agreed that competent mental health professionals should seek continuing education and training in TGNC care at various stages of transition to meet the unique needs and challenges clients encounter at each of those stages. It was noted that continuing consultation and supervision with other licensed providers and training in multicultural competence were fundamental areas that must be acquired and developed. Although the experts agreed that being certified by WPATH and having membership with organizations or associations that advocate for TGNC individuals was beneficial, they also concurred that certification is expensive and takes time (at least two years) to complete, representing a barrier to mental health access for clients and an unnecessary expense for providers. The consensus was that working toward certification by WPATH or holding a membership is desirable when feasible but should not be required to treat TGNC youth. It was noted that experience is more important than certification or organizational membership because there are mixed opinions about WPATH and other organizations focused on the care and treatment of TGNC youth.

Attitudes

In regard to attitudes, the panel agreed that clinicians must display empathy

towards diversity and genuine interest in advocacy for TGNC individuals and their families. Clinicians should demonstrate openness to learning from patients and their families. Further, they should display positive attitudes toward TGNC and gender-diverse clients by refraining from asking inappropriate or irrelevant questions about their experience but instead asking about their main concerns and goals. Similarly, experts agreed that to prevent negative attitudes and discomfort with nonbinary individuals, clinicians should be open to the recognition of one's privilege and how it intersects with clients. One expert noted that "negative attitudes due to the client's gender identity lead to discrimination and prejudice impacting their mental health and well-being." Therefore, openness to normalizing talking about gender identity with clients, even when we identify as cisgender, provides a safer setting for non-binary clients.

Research Question 2

RQ2- According to an advisory panel of experts, what is the minimal level of training required to treat TGNC youth with gender dysphoria?

When asked about what is the minimal level of training required to treat TGNC youth with gender dysphoria, the consensus was that a doctoral degree or a minimum master's degree with a license for independent practice should be sufficient to treat TGNC youth with gender dysphoria. The panel agreed that the ideal level of training required should be a 2-year internship with direct experience with TGNC youth and licensed providers/supervisors with at least 5 years of experience working with the population of interest (Table 2). They also agreed that the level of training depends on the quality of training mental health professionals received in their training sites and from

available supervisors with experience treating TGNC youth in or after their academic training. Overall, the panel opined that setting requirements for the level of training to treat TGNC youth is important but unrealistic due to the current reality of graduate programs, which lack specialized internships and post-doctoral training opportunities. One expert stated that "very few people will be able to undergo a specialized internship or post-doc in TGNC youth, which means no practitioners could meet the requirements to work with this population." (Table 2). Several experts expressed their concern regarding the need for more mental health professionals who can work with TGNC youth and that setting requirements would be reasonable but would mean losing a lot of clinicians who do not currently meet training criteria.

Similarly, several experts agreed that mental health professionals' lived experiences, such as providers who are gender expansive, provide the tools needed to support a TGNC client. One expert stated that gender-expansive clinicians "are more likely to have lived experience and community-based experiences that increase their ability to navigate these conversations as they have likely been exposed to conversations within the trans community, not just therapist's ideas about what is like to be trans." Nevertheless, it is worth noting that the panel also agreed that trained clinicians do not need to be gender expansive or have lived experience to provide quality treatment for TGNC youth. They stated that cisgender clinicians can become informed and trained to treat the mental health needs of any population, including TGNC youth. For that reason, ongoing informal or non-academic training and formal training that comes from transgender individuals is valuable. One expert indicated, "Aside from face-to-face direct

experience with this population, a clinician needs to attend trainings with WPATH and other experts within the community." Experts agreed that although WPATH training and certification (i.e., Global Education Institute (GEI) Certified Training Courses: Best Practices in Transgender Medical and Mental Health Care) are not required, some WPATH training would be beneficial. The majority of experts agreed that a thorough understanding of the WPATH standards of care and the laws around transgender health discrimination is beneficial to better assist with the mental health needs of TGNC clients. Furthermore, experts agreed that a clinician's commitment to continue specialized training after general training has ended should be a requirement (Table 2)**.**

Table 2

Minimal Level of Training Required to Treat TGNC Youth with Gender Dysphoria

Level of training Required	Agreed Upon Items	Example Quote
Masters or Doctoral Level Training	Minimum of a master's degree	" I think someone who is just starting a masters degree in counseling/psychology could offer this support very successfully if they are within the community or knowledgeable in some of these areas and would likely be better at this than someone with a PhD who has not been exposed to trans communities and stories" " It depends on the quality of training but masters or doctoral level in psychology would be ideal and WPATH certification" " Master level, specific supervision in TGNC youth or internship""" Masters level with two years of experience"
WPATH training/certification	WPATH Training and Certification are not required, but an understanding of WPATH standard is beneficial. Training that entails 2 years of supervised experience with TGNC youth. Lived experience could be helpful but not required Commitment to continue specialized education after academic training has ended	" 2 years under direct supervision with expert who has at least 5 years of experience and/or WPATH Education with GEI Training Program" " Some WPATH training would be important" "WPATH training would be important but costly, it could create financial barriers for prospective providers" " Through understanding of WPATH standards of care" " Working toward WPATH certification should also allow for one to practice as a specialist in this area as its comprehensive program often is not made available until after licensure, and providers may have additional training and resources" "Commitment to continue specialized education after academic training has ended"
License for Independent practice	Licensed practitioner	"Being fully licensed in one's jurisdiction with a minimum of a master's degree. " Licensure sets minimum standard" " They should hold a valid mental health professional license in their state"
Internship and Clinical Supervision	Internship with licensed providers/supervisors and with direct experience with TGNC youth	" Licensure for independent practice in their field and two years of supervised clinical experience" "Ideally 2-3 years of supervised experience/training and ongoing consultation with other license providers" "Specific supervision in TGNC youth or internship"

Research Question 3

RQ3- According to an advisory panel of experts, what assessment methods are required to treat TGNC youth with gender dysphoria?

When asked about what assessment methods should be required to treat TGNC youth with gender dysphoria, consensus was reached that a clinical interview with patients and family is the most reliable and optimal form of assessment and treatment planning. One type of clinical interview proposed and agreed upon by several experts was the collaborative bio-psychological clinical interview. One expert indicated that the interview is optimal for the treatment of TGNC youth because it "considers the whole person as they move through their developmental phase in various domains (i.e., gender, milestones, academic attainment/functioning, social, sexual identity development, as well as aspects with the family and societal context)." Consensus was also reached regarding the use of risk assessment for suicide, suicide assessment scales, and the Gender Minority Stress and Resilience Scale (Testa, 2015); when a screening indicates that a client is suicidal, it is useful to follow up with an assessment that can aid clinicians in understanding how minority stress and resilience are experienced by TGNC youth. It was understandably noted that any assessment instruments used should depend on the person's age, presenting problem, and the purpose of treatment (Table 3).

Furthermore, the panel opined that although TGNC youth experience stressors that may impact their mental health, uniform assessments should not be used with all TGNC clients if they are not needed. Nevertheless, the experts agreed that behavioral health evaluations conducted to support and affirm the patient's self-exploration rather

than questioning their experience are practical assessment methods to evaluate and plan treatment for TGNC youth. Similarly, experts agreed that when assessment methods are used in complex cases such as dysphoria, clinicians should use a culturally sensitive lens in how to interpret the data (Table 3).

Table 3

Assessment Methods Required to Treat TGNC Youth with Gender Dysphoria

Assessment Methods Required	Agreed Upon Items	Example Quote
Clinical interviews	Clinical interviews (i.e., collaborative biopsychosocial interview)	"Collaborative biopsychological interviews are optimal because they consider the whole person as they move through their developmental phase in various domains" "We primarily use clinical interview as a way to best identify areas to focus on and go from there, I am unaware of specific assessments for this population that are in wide distribution" "Clinical interview with patient and family, supplemented with any necessary screening tools" "One of the most effective approaches is a clinical interview which allows the TNGC individual to tell their story"
Risk assessments	Risk assessments for suicidal patients Use of suicide assessment scale The Gender Minority Stress and Resilience Scale (Testa, 2015)	"Assessment instruments would depend on the person's age, presenting problem, and the purpose of treatment. If a client is suicidal, knowledge of a risk assessment is very important here" " If a screening gives indication that there is suicidality, then it would be good to follow up with an assessment" " Uniform assessments are not needed for all unless it is necessary" "GMSR-A, helps increase understanding of minority stress and resilience experienced by TGNC youth"
Gender behavioral health evaluation	Gender behavioral health evaluation through a multicultural sensitive lens	"Supports the intervention of psychoeducation, psychotherapeutic interventions and treatment recommendations for social and medical transitions. When measures are used in complex cases such as dysphoria, one should use a culturally sensitive lens in how to interpret the data"

Research Question 4

RQ4-According to an advisory panel of experts, what are the best treatment practices (interventions, protocols or guidelines) to treat TGNC youth with gender dysphoria?

When asked about what the best treatment practices are required to treat TGNC youth with gender dysphoria, consensus was reached that the best treatment approach is based on the client's needs and that best treatment practices for TGNC youth vary significantly across the age range. Several experts indicated that because interventions with TGNC youth can also include medical and surgical procedures at certain ages, it is essential for mental health professionals to accurately provide psychoeducation on this topic to clients and their families. Given this, the panel agreed that WPATH Standards of Care (SOC 8) and gender affirming-care and the APA guidelines and standards for the care of transgender and gender nonconforming people were also helpful tools when working with clients and their families. In addition, the experts expressed that the most common therapeutic interventions they used were family systems therapy, feminist therapy, acceptance and commitment therapy, cognitive behavioral therapy, dialectical behavior therapy, and group therapy. One expert stated that given the overlap of neurodivergent clients who are also Trans, "it is vital that clinicians have a proper understanding of neurodivergence in order to best serve the Trans community." It is worth noting that several experts expressed a need for training and supervision in this topic as there is a lack of training in graduate programs (Table 4).

Table 4

Best Treatment Practices Required to Treat TGNC Youth with Gender Dysphoria

Best Treatment Practices Required	Agreed Upon Items	Example Quote
WPATH Standards of Care	WPATH Standards of Care (SOC 8) AND APA guidelines and standards for care of transgender and gender nonconforming people	" The Gender Affirming Model: An Interdisciplinary Approach is a great start"
		"Team approach with Gender clinics"
		"Follow the WPATH Standards of Care and treat the whole family"
		"Affirming care, parent involvement and support, intersectional, working with identity trauma (s), medical interventions, assessing for specific stressors"
		" APA guidelines , and all practices outlined in the WPATH standards of care"
Therapy interventions	Family systems therapy	"The best treatment approach is based on the client's needs, I would hesitate to dictate any one of them. However, a feminist approach is an overall philosophy that helps with equity and inclusion"
	Feminist therapy	
	Acceptance and commitment therapy	
	Cognitive behavioral therapy	"Integrated client centered approach as one moves varies presenting treatment problems and co-occurring conditions"
	Dialectical behavior therapy	
	Group Therapy	
	Therapeutic approach based on client's needs	"CBT and if warranted, trauma informed cared"
		" Family system therapy and group therapy"
		"I have used books as resources to help adapt ACT interventions to better serve this population, I have used CBT and DBT"
		" A group therapy setting tends to make a significant impact on the wellbeing of clients and leads to major improvement in self-acceptance"

Summary

Consensus among an advisory panel of experts was reached regarding what expert clinicians believe are the required competencies, training, assessment methods, and best treatment practices when treating TGNC youth. Experts agreed that clinicians must develop and acquire specific attitudes, experience, skills, knowledge, and awareness in diverse areas to treat TGNC youth adequately. Similarly, experts agreed that the minimal level of training to treat TGNC youth with gender dysphoria should entail a licensed practitioner with a minimum of a master's degree and 2 years of experience. Regarding assessment methods, experts agreed that although there are several valuable assessment tools, a clinical interview is the optimal choice. Experts shared similar thoughts that the best treatment practice with TGNC youth is a client-centered approach where interventions are set to meet the client's needs. However, consensus was also reached that WPATH Standards of Care (SOC, 8)/ gender affirming-care and the APA guidelines and standards for the care of transgender and gender nonconforming people were also helpful tools. Experts also agreed that there is a need for training and supervision on this topic as clinicians lack training and psychoeducation in graduate programs. In Chapter 5, I discuss the interpretation of the research findings and the study's limitations. In addition, I provide recommendations for future research, describe implications for social change, and end the chapter with final thoughts.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

In the past decade, there has been both significant progress and regression regarding TGNC individuals' rights to seek and receive medical and mental health treatment (Boe et al., 2024). Despite the efforts of TGNC individual advocates, the creation of numerous anti-transgender laws across the United States has increased, intending to ban affirmative care for every TGNC individual regardless of age (Barbee et al., 2022). Mental health professionals have been placed in a position where their ability to provide gender-affirming care to TGNC youth has been limited (Holt et al., 2020).

There are no clear guidelines for the effective training of mental health professionals regarding gender-affirming cultural competencies (Stryker et al., 2022). TGNC individuals continue to experience health disparities due to a lack of training and inadequate mental health care services (Stryker et al., 2022; Whitman & Han, 2017). There is also a lack of research regarding what competence training in graduate programs regarding TGNC issues should look like (Whitman & Han, 2017) as well as how existing guidelines to treat TGNC youth have been applied by mental health professionals (Puckett et al., 2023). TGNC individuals often hesitate to seek medical or psychological services due to fear of discrimination and marginalization (Boe et al., 2024; Heiden-Rootes et al., 2022). They also report that the barriers to accessing care cause damage to their mental health (Puckett et al., 2023). Both the development of standards for training as well as an understanding of how current standards of care are being implemented are needed in order to advocate for the TGNC population and their care.

The purpose of this Delphi study was to explore the perspectives of psychologists who were experts in required competency, training, assessments, and treatment practices when treating TGNC youth with gender dysphoria. I aimed to address the existing gap in the literature regarding what are the best practices to develop clinician competence as well as what assessment methods and treatment approaches are recommended for working with this vulnerable population. The findings of this study may be valuable to mental health professionals in assessing their clinical competency to provide mental health services to TGNC youth with gender dysphoria. The results may also assist clinicians in advocating for research as well as the development of graduate program curriculums where best practices, gender identity training models, and multicultural guidelines of care are imparted (Bidell, 2014; Cochran & Robohm, 2015; Pantalone, 2015).

According to the experts, competence entails a clinician's ability to understand TGNC youth's gender development and identities, as well as their social gender transition and physical transition, in an empathetic and nonjudgmental manner. Furthermore, experts concurred that clinicians must develop and acquire specific attitudes, experience, skills, knowledge, and awareness in diverse areas that include but are not limited to standards and guidelines of care for TGNC youth. They concurred that the minimal level of training should be a master's degree and 2 years of experience with a lifetime commitment to continue specialized training. Experts regarded clinical interviews with patients and their families as the most helpful assessment method and a client-centered approach where interventions are set to meet the client's needs as the best

treatment practice. Finally, they expressed that the strengths and barriers to treating TGNC youth could be addressed by focusing on training and supervision on this topic, as clinicians generally lack specialized training on transgender issues in graduate programs.

Interpretation of the Findings

Sue et al.'s (1992) multicultural competency theory was used as a guide in this Delphi study both in developing questions to ask the expert panel and organizing their responses for each round of questions. Recommendations on the required competency training and best treatment practices to work with TGNC youth in a mental health setting were developed through consensus. Further, this study's conceptual framework is rooted in Keo-Meier and Ehrensaft's (2018) gender-affirmative model of care and Sue et al.'s multicultural counseling training competencies as they guide the development of clinicians' competencies and skills when providing specialized gender identity services to TGNC individuals. Both models of care were supported in this study to have significant value as they are based on specific guidelines that promote the training and ongoing education of mental health professionals working with TGNC individuals.

Keo-Meier and Ehrensaft's (2018) gender-affirmative model supports the development of clinicians' nonjudgmental approach to care that helps TGNC youth feel safe by promoting the exploration of gender identity without presumptions (Chen et al., 2016). In alignment with this model, experts agreed that competence entails a clinician's ability to understand TGNC youth's gender development and identities, as well as their social gender transition and physical transition to an affirmed gender in an empathetic manner. Sue et al.'s (1992) multicultural counseling training competencies were also

supported by the experts in their recommendations regarding the training of multiculturally aware and skilled therapists (see also Sue et al., 1996). To adequately address the unique mental health needs of TGNC youth without supervision, experts agreed that clinicians must develop and acquire specific attitudes, experience, skills, knowledge, and awareness in diverse areas that include but are not limited to standards and guidelines of care for TGNC youth.

The results of this qualitative Delphi study indicated that although there are existing standards of care for treating TGNC individuals, there is a need for sufficient specialized training to develop clinician competence, as well as for information about how standards are applied in working with TGNC youth. The findings represent the perspectives of 11 experts who provide services to TGNC youth in the United States and may be influenced by current transgender laws and treatment bans in each state where experts provide services. Due to the unique perspective and context where each expert practices, consensus for all experts on every item was not feasible. However, the experts' responses were generally consistent with each other, and consensus was obtained.

Findings Concerning Competency, Training and Education to Work with TGNC Youth

The findings confirmed that competence has become the foundation of clinical practice and doctoral training programs as the United States continues to become multiculturally diverse (Hope & Chappell, 2020). Consistent with the peer-reviewed literature (i.e., Boe et al., 2024; Heiden-Rootes et al., 2022), the results supported the idea that the minimal level of competency required to treat this population entails the ability to

understand the development and identities of these individuals as well as their social and physical transition. Sufficient training and experience are necessary to reduce insensitivity, misgendering, deadnaming, discrimination, and exclusion. Additionally, the results supported those of Portz and Burns (2020) and McGeorge et al. (2021), who noted that competent mental health professionals must address cisgenderism and deconstruct cissexism in therapy.

The findings support evidence from previous observations by Boe et al. (2024) and Bettergarcia et al. (2021) that mental health professionals with exposure and direct contact with TGNC individuals (i.e., through professionally supervised training or personal life opportunities) demonstrate fewer negative assumptions and a higher level of cultural competence to provide affirming care. Despite a significant amount of research on cultural competence in general, there is a paucity of resources (i.e., training, supervisors, TGD affirmative training in graduate programs, and exposure to TGNC and TGD clients) for clinicians to address the mistrust the mental health field has engendered with TGNC clients (Hope & Chappell, 2020; Whitman & Han, 2017), and in particular those diagnosed with gender dysphoria (Whitman & Han, 2017). One notable finding of the current study that supports the work of other researchers (Arredondo & Perez, 2003; Martell & Williams, 2019; Oransky et al., 2019) was that culturally competent mental health professionals must acknowledge the dominant culture's negative influence on attitudes toward mental health treatment in minority cultures. Mental health professionals must go beyond familiarity with existing standards of care by employing cultural humility to address competency issues relevant to TGNC clients' concerns (Portz &

Burns, 2020).

Additionally, clinicians must build on several competency areas, such as awareness, knowledge, attitudes, and skills, to treat TGNC youth at various stages of transition compassionately. My findings concur with Boe et al.'s (2024) observations that the field of clinical psychology has yet to determine appropriate training standards to address the multicultural competencies required to treat TGNC youth. There are no guidelines for affirmative training associated with clinical cultural competency to treat TGNC youth (Stryker et al., 2022). This is an area mental health professionals need to address or self-assess when working with TGNC youth with gender dysphoria. Nonetheless, my findings are consistent with the direction of Lekas et al. (2020) in that supervised internships, self-directed reading, and personal reflection are strategies clinicians can use to develop competency when working with TGNC individuals.

Establishing an environment where clients and their families feel supported, safe, welcomed, and understood was found to be paramount for optimal treatment outcomes, which supported previous research (Chan et al., 2018; Istar, 2004; Oransky et al., 2019; Puckett, 2019). Furthermore, providing consultation and referral options to specialists in transgender health was found to be important. This is consistent with Stetson's (2022) assertion that consultation is a necessity when clinicians face unfamiliar situations regarding TGNC issues with the goal of reducing mental health disparities and harm.

Although the mental health field is working toward becoming more inclusive and aware of the health barriers and disparities TGNC individuals face, several challenges remain regarding knowledge, awareness, skills, attitudes, and experience in this area of

study. Although being certified by WPATH and having membership with organizations that advocate for TGNC individuals was found to be beneficial, the experts agreed that experience and openness to learning were more important in treating this population. The experts expressed mixed opinions about WPATH and other organizations' approaches to the care and treatment of TGNC youth. Ideally, working toward certification by WPATH or holding a membership was deemed desirable when feasible; however, they agreed that it should not be required to treat TGNC youth. Certification was seen as an unnecessary expense for practicing clinicians and a barrier to mental health access for clients. My results concurred with Hembree et al. (2017) in the finding that mental health professionals must work from a developmental perspective and demonstrate openness to learn from patients during their transition. Clinicians must become familiar with the terminology when working with TGNC individuals, as well as use correct pronouns and names, as this demonstrates respect for clients, which is crucial to the creation of trust, understanding, and empathy (Portz & Burns, 2020; Stetson, 2022; Stewart et al., 2021).

Moreover, my findings support the idea that competence formation is a lifelong process where clinicians must go beyond the primary resources that serve as the basis for therapists to treat TGNC individuals (i.e., DSM-5-TR, WPATH Standards of Care, Gender Affirming-Care Model, and the APA guidelines). Experts concurred that mental health professionals must work toward establishing alliances with clients that entail affirming gender identity.

In addition, it is important to recognize that GD and being transgender or gender-nonconforming are not the same thing. Individuals who are diagnosed with GD are

considered a part of the TGNC community, but not all TGNC individuals are diagnosed with GD (Stetson, 2022). Thus, competent clinicians are required to assess, diagnose, and assist TGNC individuals who meet GD's diagnostic criteria and to discuss varying degrees of transition. It is worth noting that experts agreed that clinicians must understand that not all individuals who are diagnosed with GD will seek surgical interventions. Being knowledgeable regarding a range of gender-affirmative services helps clinicians work with multidisciplinary teams, clients, and their families to determine the appropriate gender-affirming interventions that meet clients' unique needs (Coleman et al., 2012; Stetson, 2022). Further, experts concurred that while listening to clients and centering their stories, it is important to demonstrate a compassionate attitude to help clients disclose experiences of stigma and rejection they may have faced from friends, family, and healthcare professionals.

My findings were consistent with Bettergarcia et al. (2021) and Stryker et al. (2022), who observed that it is difficult to assess the educational preparedness of mental health professionals to provide affirming care because so few will be exposed to information focused on TGNC youth in their postgraduate education. Hence, it is important not to set stringent training requirements for clinicians to work with TGNC youth and their families, as many providers need to seek training and specialization after their academic training has been finalized to be qualified to provide such care. Most experts reported seeking training due to personal and professional ties to the LGBTQ+ community and a desire to overcome the lack of LGBTQ+ content in their formal education. Some examples of post-doctoral training opportunities the experts listed were

conferences, working with the population of interest, taking workshops, reading books, earning certifications, and conducting self-guided research of evidence-based studies.

Other researchers like Whitman and Han (2017) and Skyler et al. (2022) argued that mental health professionals who aim to work with TGNC individuals should seek to develop competencies that include at least an internship with direct clinical experience with TGNC youth. Further, Coleman et al. (2012) indicated that the recommended minimum credentials for mental health professionals to work with TGNC individuals with GD should entail a master's or doctoral-level degree in a related mental health field, competence in using the DSM-5-TR, and supervised training in counseling or psychotherapy. The expert panelists in this research did not recommend anything as specific as those authors; however, they did agree that a doctoral degree or a minimum master's degree with a license for independent practice should be required to treat TGNC youth with GD. Although the experts did not doubt their current level of competency and training to treat TGNC youth, some expressed concern that the mental health professionals providing services to this population are mostly social workers, counselors, and nurse practitioners with a lack of advanced training. This is consistent with WPATH's proposed domains of experiential and training qualifications (Coleman et al., 2012; Coleman et al., 2022).

Overall, the experts agreed that setting training requirements for clinicians to work with TGNC youth would severely limit the number of clinicians available to work with this population. However, setting training requirements could also ensure that graduate programs modify curricula to offer foundational knowledge and training

opportunities in providing TGNC affirmative care (Puckett et al., 2023). TGNC and TGD individuals experience mental health disparities and higher distress in comparison to cisgender peers (Puckett et al., 2023). Integrating multicultural training across the curriculum and providing courses that relate to the needs and issues of LGBT and TGNC clients, as Newell et al. (2010) and Stryker et al. (2022) concluded, could be beneficial to develop awareness, knowledge, and skills to provide adequate services.

Findings Concerning the Assessment and Treatment of TGNC Youth

My findings are consistent with multiple researchers (Coleman et al., 2012; Shulman et al., 2017; Singh & dickey, 2017) that culturally appropriate, evidence-based, standardized assessments should be utilized to avoid harm. The expert consensus supported Shulman et al.'s (2017) recommendations that accurate, evidence-based assessments of gender dysphoria, TGNC minority stress, positive aspects of a TGNC identity, and psychosocial aspects of medical transition are among the areas that must be assessed when providing gender-affirmative care.

Further, my findings support the recommendations from the APA (2015) and WPATH (2022) guidelines that the clinical interview with clients and families is the most reliable and optimal form of assessment and treatment planning. As Sommers-Flanagan (2014) stated, all clinical interviews allow clinicians to gather relevant information that sets the foundations for developing a therapeutic alliance, case formulation, and treatment intervention considerations. One type of clinical interview mentioned by the panel of experts was the collaborative bio-psychological clinical interview, also known as a biopsychosocial assessment, which considers the whole person as they progress through

their developmental phase in various domains.

The panel also provided recommendations regarding specific assessment instruments for the assessment of TGNC youth. Suicide assessment scales and the Gender Minority Stress and Resilience Scale (Testa, 2015) were mentioned to be of value for clinicians understanding of how minority stress and resilience are experienced by TGNC youth, which is in alignment with the noted elevated risk of mental health disorders and suicidal ideation in this population (Stewart et al., 2021). Accurate evidence-based assessments of gender dysphoria (i.e., the Utrecht Gender Dysphoria Scale) were recommended, which echoed Shulman et al. (2017). Experts also noted that clinicians should assess the positive aspects of TGNC identity as well as psychosocial aspects of medical transition and avoid cisnormativity when interpreting scores of assessment instruments that have been normed on cisgender individuals. The expert panel concurred that clinicians should refrain from using assessments meant for this community with those who do not identify as TGNC.

Consistent with the literature review (i.e., de Vries & Cohen-Kettenis, 2012: Turban et al., 2021), my findings highlight that mental health professionals cannot predict who will persist or desist in their TGNC identity. Although children who experience gender dysphoria with higher intensity are more likely to persist in their TGNC identification, clinicians should understand that gender identity fluctuates as individuals mature (Levine & Abbruzzese, 2023). Behavioral health evaluations need to be conducted with the aim of supporting and affirming clients' self-exploration rather than questioning their experience.

Similarly, when conducting an assessment with TGNC youth, clinicians should use a culturally sensitive lens. It was noted in the panel's comments that the use of assessment instruments should depend on the person's age, presenting problem, and the purpose of treatment to refrain from pathologizing TGNC youth. This finding supported Keo-Meier and Ehrensaft's (2018) gender-affirming care model, which recognizes that the assessment and treatment of TGNC youth with gender dysphoria is highly complex, requiring clinicians to work within a multidisciplinary team to assess the decision-making capability of the youth. In addition, the experts concurred that an evaluation to assess the family's ability to endure stress, give support, and deal with the complexities of the youth's situation is beneficial for optimal outcomes (Hembree et al., 2017).

Although there is limited evidence-based research regarding the application of best practices and protocols for psychologists to treat TGNC youth, this population requires care as it grows and continues to experience mental and healthcare disparities (Arora et al., 2016; Block, 2023). The rates of TGNC individuals attending therapy have grown, in part likely due to anti-transgender laws (Lee et al., 2024; Puckett et al., 2023), which makes this research and continued study in the field important and relevant. My findings agree with those of Keo-Meier and Ehrensaft (2018) that the best treatment practices when working with TGNC youth involve cultural competence and a client-centered approach to affirming gender identity. A client-centered approach encourages TGNC youth to become self-aware and understand their authentic selves through positive regard and empathic understanding (Kensit, 2000). This approach is ideal to reduce distress and help clients feel empowered (Kensit, 2000).

The findings of this study are consistent with those of Butler et al. (2018) and Chen et al. (2016) in that best treatment practices entail collaboration with a multidisciplinary team. The treatment approach should depend on the client and their family's unique needs. It will vary depending on age and transition phases in the clients' social, psychological, medical, and legal realms of being. In agreement with Stetson's (2022) findings, the panel agreed that clinicians should carefully consider suggesting any interventions (i.e., puberty-suppressing medications, gender-affirming hormone treatment, and possibly gender-affirming surgical interventions), as GD in childhood does not always persist into adolescence or adulthood. Further, clinicians should be mindful that current existing guidelines may change and do not necessarily reflect the needs of individual children or best practices to treat TGNC prepubertal clients and their families.

My findings also indicated that because interventions with TGNC youth can include medical and surgical procedures, it is essential for mental health professionals to accurately provide psychoeducation to clients and their families. Given this, the experts agreed that WPATH Standards of Care (SOC 8), the Gender Affirming-Care Model, and the APA guidelines for the care of transgender and gender nonconforming people were helpful tools when working with TGNC youth with GD and their families.

There is limited longitudinal research on the developmental trajectories of socially transitioned youth (de Vries & Cohen-Kettenis, 2012). The panel of experts in this study recognized this reality, recommending that treatment be based on the level of distress experienced by the client. My findings align with Stetson (2022), who states that mental health clinicians can support and guide TGNC youth and their families by providing

guidance on the timing of social transitioning. Clinicians can also provide education and clarification regarding reversible and irreversible interventions, make referrals to culturally sensitive medical providers, and connect them with local community resources and support groups.

One interesting finding in this study was that although expert panelists concurred with multiple researchers (ACA, 2010; APA, 2015; Coleman et al., 2010; Chen et al., 2016; Chen et al., 2018; Edwards-Leeper et al., 2016; Ehrensaft, 2011; Ehrensaft, 2018; Keo-Meier & Ehrensaft, 2018; Matsuno, 2019) that TGNC youth who receive gender-affirming care from a multidisciplinary team have an increased likelihood of achieving positive treatment outcomes, there is still a paucity of research regarding TGNC youth who detransition (Turban et al., 2021). Thus, most of the advisory panel of experts agreed with de Vries and Cohen-Kettenis's (2012) recommendations that watchful waiting and carefully observing how GD develops in the first stages of puberty may be beneficial. With equal importance, the expert panel noted that it is necessary to settle the debate among researchers regarding the age at which youth are considered mature enough to consent to medical transition to avoid harm when providing gender-affirming care.

According to the expert panel, family systems therapy, feminist therapy, acceptance and commitment therapy, cognitive behavioral therapy, dialectical behavior therapy, and group therapy are all intervention approaches that are appropriate for use with this population. As the experts noted, a clinician's theoretical orientation potentially influences the type of interventions and techniques used when working with TGNC youth because their framework provides the foundations for treatment planning. Consistent with

Puckett et al. (2023), it was noted that the ability to make adaptations to therapy approaches based on a client's needs was beneficial as it helps clinicians understand the client's "identity, minority stress, resilience, coping mechanisms, and other unique experiences" (p. 271). Cognitive behavioral therapy (CBT) is the theoretical orientation recommended by most experts within a gender-affirmative approach, as it can be modified to ensure that the treatment is efficacious and culturally sensitive (Busa et al., 2018).

Limitations of the Study

The primary limitation of this qualitative Delphi study was the small sample size of experts who participated. The panel size was smaller than initially planned due to the current political atmosphere in the United States regarding transgender laws and treatment bans, which resulted in potential panelists being highly guarded and wary of participation. Finding a representative selection of participants who met the inclusion criteria was challenging. Further, because the qualitative data in this study represents the unique perspective, opinions, experience, and context where each expert practices, findings cannot be broadly generalized, nor do they necessarily reflect the views of other practicing clinicians in the United States working with TGNC youth or adults. They may, however, serve as groundwork for future studies. It is worth noting that the study's goal was to generate a list of recommendations and is limited in scope. The participant panel demonstrated full commitment to this research, gearing valuable results; however, the limitations that are inherent to all Delphi studies must be considered, such as a methodological uncertainty and a lack of clear guidelines (i.e., definition of expertise,

how many panel members to recruit, definitions of consensus, and the use of different forms of statistical analysis).

Recommendations

The findings of this study were consistent with those discussed in the literature review, which showed a need for more formal training, standardized treatment, and research on the safety and medical outcomes of TGNC youth. Future exploration and research are needed to develop efficacious and culturally sensitive treatments, guidelines, and best practices to serve as a framework for mental health professionals who work with TGNC youth (with or without GD) and their families. Further research would also be beneficial regarding the characteristics of graduate training programs that support the development of clinical competencies when treating youth diagnosed with GD (Boe et al., 2024).

Longitudinal research on GD and the developmental trajectory of socially transitioned youth is particularly recommended, as currently, long-term outcomes are unpredictable (de Vries & Cohen-Kettenis, 2012). Another area that requires further research is predicting which TGNC youth are more likely to detransition to help mental health professionals do not harm (Turban et al., 2021). One limitation of the study was that it was conducted with doctoral-level psychologists; thus, research that compares recommendations from experts from various mental health backgrounds could be beneficial. Replicating this study using a larger panel of experts to determine if the themes that emerged from this study will be replicated is advisable. Similarly, following through with what experts have suggested as the minimal level of competency, training,

assessments, and best treatment practices when treating TGNC youth with gender dysphoria and assessing the effectiveness of these recommendations would be advised.

Implications

Over the last decade, the commitment of several mental healthcare organizations (i.e., the APA and WPATH) has been to work diligently to be more inclusive and aware of the mental health disparities of transgender and gender non-conforming individuals as this population remains vulnerable and is evolving. Despite attempts by mental health professionals to improve the quality of services for sexual and gender minorities (Edwards-Leeper et al., 2016; Hembree et al., 2017; Malpas et al., 2022; Stewart et al., 2021), the guidelines for cultural diversity in psychotherapy research with sexual and gender minorities are inadequate to address the needs of this vulnerable population. Although there are published standards, there is little to no information regarding actual clinical practice with TGNC youth. Researchers continue to lump TGNC individuals together in one group when, in fact, this is a diverse group composed of individuals with unique needs and struggles that must be addressed individually.

My findings supported the assertions of researchers who have stated that doctoral-level psychologists are largely unprepared to serve as allies that provide multicultural and gender-affirmative services to TGNC youth (Knight et al., 2014; Kraschel et al., 2022; Puckett et al., 2023; Stryker et al., 2022). Graduate training programs have failed to integrate gender affirmative care practice and exposure to LGBTQ+ clients during the field experience of their curriculum (Grove, 2019; Keo- Meier & Ehrensaft, 2018; Knight et al., 2014; Kuff et al., 2019; Martell & Williams, 2019; Nowaskie, 2020; Oransky et al.,

2019; Stryker et al., 2022). Hence, this study is significant because of the contribution of its findings regarding best practices and protocols for the assessment and treatment of TGNC youth with GD.

Individuals and their families may benefit from the findings of this study by using the recommended standards when searching for gender-affirming care that will meet their needs. Ideally, clients and their families would no longer feel the burden of taking on the role of educators of their cisgender clinicians. Given the current atmosphere of stigmatization, victimization, and marginalization experienced by TGNC youth in healthcare settings, the findings provide clinicians with a place to start regarding how to achieve the best standards of training and treatment practice to work with this population. Clinicians may benefit by examining their biases, assumptions, and training to optimize their ability to assess and treat TGNC youth. Similarly, these findings help clinicians obtain awareness of developments in their political atmosphere as well as the research that potentially impacts their services. Also, findings may help clinicians working in institutions or organizations expand their roles to advocate for TGNC youth to have access to gender-affirming care in safe and welcoming healthcare settings.

Graduate-level training focusing on the needs of TGNC youth with GD and their families is largely unavailable despite the clear need for gender-affirmative care. The gained insight from the present study may help future clinicians, organizations, and institutions understand what standards of education are needed to develop graduate program curriculums where best care practices for TGNC individuals are imparted. Further, my findings can help organizations ensure that their clinicians meet the standards

of training required to be competent to work with the population of interest. The standards identified in this study may serve as a foundational framework to examine graduate and post-graduate programs and change them if needed to address TGNC topics across curricula adequately. Students will benefit from such institutional curriculum changes by gaining experience, skills, knowledge, and exposure to strengthen their clinical competency in treating TGNC individuals. Finally, findings from this study could help institutions and organizations support diversity, promote social justice, and reduce oppression and marginalization by creating TGNC-inclusive spaces for educators, students, and staff members.

Unfortunately, the current social and political landscape in the United States, with the creation and passing of laws restricting the rights of transgender and non-binary individuals to access affirming medical and psychosocial care, displays a lack of understanding that affirming care is lifesaving in many cases (Lee et al., 2024). Hence, society may benefit from this research finding on a broader level helping mental health professionals advocate at all levels to develop policies that support and protect the right to access gender-affirming care. Findings may also aid policymakers in supporting and funding further research regarding the required level of competency, training, assessment, and treatment practices for psychologists who treat TGNC youth with GD.

Conclusion

Although several national organizations, including the APA and WPATH, have called attention to the importance of training clinicians who work with TGNC individuals, mental health professionals have limited training and experience in TGNC-

affirmative care. My findings showed that there is a need for more formal training, which supports the finding that mental health professionals tend to doubt their competency and training in treating TGNC youth (Block, 2023; Jessen et al., 2021; Ratts et al., 2018). Further, the findings from this research validate that the emphasis on specific guidelines to treat TGNC individuals may not reflect the current experiences that experts in the field have when treating TGNC youth, particularly those diagnosed with GD.

Despite increased attention in the last decade regarding the experiences, challenges, and struggles of TGNC youth, TGNC individuals continue to encounter obstacles that affect their mental health and well-being as access to treatment is limited or denied. As agents of social change, we must take a stand and advocate for the psychology field and the clients to whom we provide services. Through evidence-based research such as this study, we can make a difference and reduce disparities in mental healthcare for TGNC clients associated with a lack of specialized training and competence to assess and treat TGNC clients. As advocates and agents of social change, we must not forget that competency is a lifetime process. A balance between foundational and functional competencies must be achieved through reflection and self-awareness of one's skills, biases, and limitations.

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Appendix A: Representatives of Organizations/Associations Assistance Email

Good afternoon/morning,

I am a Ph.D. student in the clinical psychology program at Walden University, and I am writing to invite members of your organization to participate in a study regarding clinical psychology training and treatment standards for TGNC youth with Gender Dysphoria.

I am recruiting volunteers who are licensed, doctorate-level psychologists in the United States who impart a multidisciplinary and affirmative approach to care for TGNC youth with Gender Dysphoria, and who have at least five years of experience working with the population. This study is for my doctoral dissertation in Clinical Psychology at Walden University, and the goal is to examine what experts in the field consider to be important in both training and treatment standards for psychologists working with TGNC youth.

I am writing to request assistance in forwarding the study information to members of your organization or other professionals you may know who may be interested in participating. If you would like to know more about the research or/and are able to pass this information to colleagues who may be interested in participating, please respond to this email and I will send you more information.

If you have any questions or concerns, please contact me at
xxxxxx.xxxxxxx@xxxxxxxx

Sincerely,

Amydth Chumacero

Appendix B: Social Media Flyer for Recruitment

Invitation for a Delphi Advisory Panel of Experts

I am a Ph.D. candidate at Walden University conducting research on psychologists' competency and training regarding treatment of transgender and non-conforming (TGNC) youth with Gender Dysphoria.

I am inviting you to participate in a study as an expert on the topic of the treatment of TGNC youth. The goal is to develop a consensus of experts on the required competency, training, assessment methods, and best treatment practices for psychologists who treat TGNC youth. This research is being conducted in partial fulfillment for a doctorate in Clinical Psychology.

If you agree to participate:

We will have one 20 to 30 minute Zoom or Teams interview to discuss the study and collect basic screening information.
You will be asked to participate in three to four rounds of questionnaires via-email that will require about 20 minutes to complete.

All information will be kept confidential: you will not know who the other panelists are, they will not know who you are, and no identifying information will be released.

Qualifications to participate:

Licensed, doctorate level psychologists in the United States who works at an established organization or practice that currently imparts a multidisciplinary and affirmative approach to care for TGNC youth diagnosed with Gender Dysphoria
At least five years of experience working with the population of interest

If you are interested in participating, please contact: xxxxxx.xxxxxxx@xxxxxxxx

Appendix C: Advisory Panel of Expert Letter of Invitation

Dear Expert,

I am a Ph.D. candidate at Walden University conducting research on psychologists' competency and training regarding treatment of transgender and non-conforming (TGNC) youth with Gender Dysphoria. This research is being conducted in partial fulfillment for a doctorate in Clinical Psychology.

I am inviting you to participate in a study as an expert on the topic of the treatment of TGNC youth. Your contribution will be of great value to current and future psychologists to gain knowledge of the required competency, training, assessment methods, and best treatment practices when treating TGNC youth with Gender Dysphoria.

Your participation will include one 20- to 30-minute Zoom or Teams interview to discuss the study and collect basic screening information. You will be asked to participate in three or four rounds of questionnaires via email that will require up to 20 minutes to complete. The findings of each round will be collected and shared with the panel in a new questionnaire to review and narrow down responses until a consensus is reached.

To participate in this research study, you must be a licensed, doctoral level psychologist in the United States working at an established organization or practice currently that imparts a multidisciplinary and affirmative approach to care for TGNC youth diagnosed with Gender Dysphoria. And you must have at least five years of experience working with the population of interest.

All information will be kept confidential. You will not know the names of the other panelists and they will not know who you are. No identifying information will be released. This study has been approved by the Walden University Institutional Review Board (IRB). The IRB is a university committee established by Federal law responsible for protecting research participants' rights and welfare. If you have concerns or questions about your rights as a research participant, you may contact the IRB Administrator at or irb@mail.waldenu.edu.

If you are interested in participating, please contact: xxxxx.xxxxxx@xxxxxxxx

Kind Regards,

Amydth Chumacero

Appendix D: Round 1 Delphi Questionnaire Instrument

Dear Expert:

Thank you for your participation in this advisory panel. Your contribution in this first round is vital. The findings will assist in the development of an expert consensus in the development of guidelines for training, competency, assessment methods, and best treatment practices for mental health professionals who treat TGNC youth with Gender Dysphoria.

Please complete the initial questionnaire for round one and the demographic questionnaire via SurveyMonkey. Also, at the bottom of each questionnaire, remember to add your Expert ID.

There will be two to three subsequent rounds to narrow down the recommendations. This survey/questionnaire will be open for fourteen days, so please respond as soon as you can within that time.

The information you provide will be kept confidential. Once a consensus is reached, you will receive the results.

Thank you for your time and contribution.

Kind Regards,

Amydth Chumacero

cc: Dr. Lisa Scharff

Advisory Panel of Experts Demographic Questionnaire

Please complete the demographic questionnaire before you begin to answer round one questionnaire:

1. What is your gender?
2. How would you classify your race/ethnicity?
3. Have you published books or articles on the research topic?
4. Are you an active member of a mental health association at a national, local, and/or state level?
5. What theoretical orientation do you use to treat TGNC youth?
6. In what state are you licensed to practice?

Round 1 Questionnaire

Please answer the following questions. Additional comments are voluntary.

1. Based on your expertise, please list at least three (i.e., attitude, experience, skills, knowledge, and awareness) things that you think are required as a minimum for a clinician to be competent to treat TGNC youth (ages 3 to 17) with Gender Dysphoria without supervision?

2. Based on your expertise what, is the minimal level of training required to treat TGNC youth with Gender Dysphoria without supervision?

3. Based on your expertise, what are the best assessment methods (i.e., questionnaires, standardized interviews, rating scales) to use with TGNC youth with Gender Dysphoria?

4. Based on your expertise what, are the best treatment practices (i.e., interventions, theoretical orientation, protocols, or guidelines) to treat TGNC youth with Gender Dysphoria?

Additional Comments: Is there anything that you think is important to know that wasn't asked about above?

Appendix E: Round 2 Delphi Questionnaire

Dear Expert:

Thank you for your responses to the first round of the study regarding the expert perspectives in the area of required competency, training, assessment methods, and best treatment practices when treating TGNC youth. Your participation is vital to the study. I realize you are busy, and I appreciate your continued participation in this research.

Below is a link to SurveyMonkey with a list of responses from the first questionnaire. For round two, please rank the themes provided in the first round using a 5-point Likert scale. Leave a comment on any item if you wish to, and note if you think anything was left off the list that is important to add. Also, at the bottom of the questionnaire, remember to add your Expert ID.

This survey/questionnaire will be open for fourteen days, so please respond as soon as you can within that time.

We will continue to use this data collection and analysis method to reach a consensus among the expert panelists. Your responses are vital to the completion of the study; thank you for the time you have devoted to this research. Please check your emails for round three!

Thank you for your time and contribution.

Kind Regards,

Amydth Chumacero

cc: Dr. Lisa Scharff

Round 2 Delphi Questionnaire

Below is a list of responses from the first questionnaire. For round two, please rank the themes provided in the first round using a 5- point Likert scale:

(1) Strongly Disagree (2) Disagree (3) Neither Agree nor Disagree (4) Agree (5) Strongly Agree)

Leave a comment on any item if you wish to, and note if you think anything was left off the list that is important to add.

Q1. Based on the advisory panel of experts' expertise, would you agree that for clinicians to be competent to treat TGNC youth (ages 3 to 17) with gender dysphoria without supervision, they are required to hold a minimum of?

Knowledge/Understanding

- Knowledge and understanding of the WPATH's Standards of Care, and history of the SOC and the Gender Affirmative Model
- Knowledge and understanding of the DSM-5-TR and ICD-10 regarding gender dysphoria and gender incongruence
- Knowledge and understanding of the APA's guidelines for Psychological Practice with Transgender and Gender Nonconforming People
- Knowledge and understanding of state guidelines regarding treatment for TGNC youth
- Knowledge and understanding of child development
- Knowledge and understanding of gender and sexuality from a non-heteronormative position

(1) Strongly Disagree (2) Disagree (3) Neither Agree nor Disagree (4) Agree (5) Strongly Agree

Comments or missing items regarding knowledge or understanding that aren't listed above:

Skills

- Capability of working with Family Therapy and Family systems with a parent-child relationship focus
- Ability to work from a developmental perspective
- Ability to create inclusive spaces for the patient and their families
- Ability to self-reflect
- Ability to seek consultation and supervision with other licensed providers

(1) Strongly Disagree (2) Disagree (3) Neither Agree nor Disagree (4) Agree (5) Strongly Agree

Comments or missing items regarding specific skills that aren't listed above:

Awareness

- Cultural awareness (i.e., sensitivity to diversity and similarities)
- Familiarized with language usage and pronouns
- Awareness/understanding of current diagnostic criteria regarding gender dysphoria
- Awareness of available interventions for TGNC youth with gender dysphoria
- Awareness of diversity of resources (i.e., medical, providers, support groups, books, websites)

(1) Strongly Disagree (2) Disagree (3) Neither Agree nor Disagree (4) Agree (5) Strongly Agree

Comments or missing item regarding specific awareness that isn't listed above:

Experience

- Continuing education and training in TGNC care at various stages of transition
- Continuing consultation and supervision with other licensed providers
- Training in multicultural competence
- Certified by the World Professional Association for Transgender Health

(1) Strongly Disagree (2) Disagree (3) Neither Agree nor Disagree (4) Agree (5) Strongly Agree

Comments or missing item regarding specific experience that isn't listed above:

Attitudes

- Empathy towards diversity
- Advocacy for TGNC individuals and their families
- Openness to continue to learn from patients
- Openness to continue to learn and work with patients' families

(1) Strongly Disagree (2) Disagree (3) Neither Agree nor Disagree (4) Agree (5) Strongly Agree

Comments or missing items regarding specific attitudes that aren't listed above:

Q2. Based on the advisory panel of experts' expertise, would you agree that the minimal level of training required to treat TGNC youth with gender dysphoria without supervision should entail:

- Licensed practitioner with a minimum of a master's degree
- Licensed practitioner with a minimum of a doctorate
- Internship with licensed providers with direct experience with TGNC youth
- Clinical supervised training with other licensed providers that work with TGNC youth
- Training that entails 2 years of supervised experience with TGNC youth
- Training that entails 3 years of supervised experience with TGNC youth
- Training that entails 4 years of supervised experience with TGNC youth
- Training that entails 5 years of supervised experience with TGNC youth
- WPATH Training and Certification (i.e., Global Education Institute (GEI) Certified Training Courses: Best Practices in Transgender Medical and Mental Health Care)

(1) Strongly Disagree (2) Disagree (3) Neither Agree nor Disagree (4) Agree (5) Strongly Agree

Comments or missing item regarding specific training that isn't listed above:

Q3. Based on the advisory panel of expert expertise, would you agree that the best assessment methods (i.e., questionnaires, standardized interviews, rating scales) to use with TGNC youth with gender dysphoria are:

- Clinical interviews with patients and family
- Risk assessment for suicide
- Use of suicide assessment scale
- Gender Minority Stress and Resilience Scale (Testa, 2015)
- Gender and Behavioral Health Evaluation

(1) Strongly Disagree (2) Disagree (3) Neither Agree nor Disagree (4) Agree (5) Strongly Agree

Comments or missing items regarding specific assessment methods that aren't listed above:

Q4. Based on the advisory panel of experts' expertise, would you agree that the best treatment practices (i.e., interventions, theoretical orientation, protocols, or guidelines) to treat TGNC youth with gender dysphoria are:

- WPATH Standards of Care (SOC 8)
- APA guidelines and standards for care of transgender and gender nonconforming people
- Family systems therapy
- Feminist therapy
- Acceptance and commitment therapy
- Cognitive behavioral therapy
- Dialectical behavior therapy

- Group Therapy

(1) Strongly Disagree (2) Disagree (3) Neither Agree nor Disagree (4) Agree (5) Strongly Agree

Comments or missing items regarding specific best treatment practices that aren't listed above:

Additional Comments: ***Are there any specific books, websites, training, or resources that clinicians should be required to read about in order to treat TGNC youth?***

Appendix F: Round 3 Delphi Questionnaire

Dear Expert:

Thank you for your responses to round two of the study regarding the perspectives of psychologists who are experts in the area of required competency, training, assessment methods, and best treatment practices when treating TGNC youth.

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Below is a link to SurveyMonkey with a list of new themes that emerged from the second round and a list of existing themes that did not reach consensus. For round three, rank the items that are listed using a 5- point Likert scale. Leave a comment on any item if you wish to, and note if you think anything was left off the list that is important to add. Also, at the bottom of the questionnaire, remember to add your Expert ID:

The survey/questionnaire will be open for fourteen days, after which the link will expire.

Please check your emails for the next round if it is needed, or the findings if a consensus has been reached. Your responses are critical to the completion of the study, and I appreciate your time and contribution to the study.

Kind Regards,

Amydth Chumacero

cc: Dr. Lisa Scharff

Round 3 Delphi Questionnaire

For round three, you will have an opportunity to provide feedback to reach a consensus regarding the perspectives of psychologists who are experts in the area of required competency, training, assessment methods, and best treatment practices when treating TGNC youth.

Please rank the new themes that emerged in round two and the themes that **did not** reached consensus using a 5- point Likert scale:

(1) Strongly Disagree (2) Disagree (3) Neither Agree nor Disagree (4) Agree (5) Strongly Agree)

Leave a comment on any item if you wish to, and note if you think anything was left off the list that is important to add.

Q1. Based on the advisory panel of experts' expertise, would you agree that for clinicians to be competent to treat TGNC youth (ages 3 to 17) with gender dysphoria without supervision, they are required to hold a minimum of?

Knowledge/Understanding

- Knowledge and understanding from lived-experience within the trans community and trans authors
- Knowledge of TGNC youth mental health issues, struggles, and disparities

Comments or missing items regarding knowledge or understanding that aren't listed above:

Skills

- Ability to conduct collaborative biopsychosocial assessments that lend to a Gender Health Evaluation (i.e., helping and supporting clients with letters of support for medical interventions)
- Ability to confirm the presence or absence of gender dysphoria (i.e., documenting how discrimination and prejudice due to the client's gender identity impact their mental health and well-being)

- Ability to recognize that dysphoria is not an experience all trans youth report
- Ability to recognize that dysphoria may not be the language that trans youth use to describe their experiences
- Ability to acknowledge mistakes and take responsibility when a mistaken misgendering has occurred.

Comments or missing items regarding specific skills that aren't listed above:

Awareness

- Awareness that an individual does not need to be diagnosed with Gender Dysphoria to be transgender
- Awareness that TGNC youth seek social and medical transition due to other factors that are separate from gender dysphoria (i.e., lack of support from family, discrimination, victimization, etc.)
- Awareness that pathologizing transgender individuals may be harmful (i.e., human rights may be violated)

Comments or missing item regarding specific awareness that isn't listed above:

Experience

- Certification by the WPATH when feasible
- Working toward certification by the WPATH when feasible to be allowed to practice as a specialist in this area
- Membership with organizations or associations who advocate for TGNC individuals (i.e., WPATH)
- Clinicians' commitment to continue specialized training after academic training has ended

Comments or missing item regarding specific experience that isn't listed above

Attitudes

- Recognition of one's privilege and how it intersect with clients
- Openness to normalizing talking about gender identity with clients even when we identify as cisgender to provide a safer setting for non-binary clients

Comments or missing items regarding specific attitudes that aren't listed above:

Q2. Based on the advisory panel of experts' expertise, would you agree that the minimal level of training required to treat TGNC youth with gender dysphoria without supervision should entail:

- Internship with licensed providers/supervisors and with direct experience with TGNC youth
- Training that entails 2 years of supervised experience with TGNC youth
- Training that entails 3 years of supervised experience with TGNC youth
- Training that entails 4 years of supervised experience with TGNC youth
- Training that entails 5 years of supervised experience with TGNC youth
- WPATH Training (i.e., Global Education Institute (GEI) Certified Training Courses: Best Practices in Transgender Medical and Mental Health Care)
- WPATH Certification (i.e., Global Education Institute (GEI) Certified Training Courses: Best Practices in Transgender Medical and Mental Health Care)

Comments or missing item regarding specific training that isn't listed above:

Q3. Based on the advisory panel of expert expertise, would you agree that the best assessment methods (i.e., questionnaires, standardized interviews, rating scales) to use with TGNC youth with gender dysphoria are:

- Use of suicide assessment scale
- Gender Minority Stress and Resilience Scale (Testa, 2015)
- Formal Gender and Behavioral Health Evaluation (with the objective to support and affirm the patient's self-exploration rather than to question their experience)

Comments or missing items regarding specific assessment methods that aren't listed above:

Q4. Based on the advisory panel of experts' expertise, would you agree that the best treatment practices (i.e., interventions, theoretical orientation, protocols, or guidelines) to treat TGNC youth with gender dysphoria are:

- Family systems therapy
- Feminist therapy
- Group Therapy
- Acceptance and commitment therapy
- Cognitive behavioral therapy
- Dialectical behavior therapy
- Group Therapy
- Therapeutic approach based on client's needs

Comments or missing items regarding specific best treatment practices that aren't listed above:

Q5. Based on the advisory panel of experts' expertise, would you agree that clinicians should be required to read about the following resources or topics in order to treat TGNC youth?

- WPATH SOC guidelines regarding the treatment of TGNC youth
- APA Guidelines regarding the treatment of TGNC youth
- Topic regarding families in transition
- Topic regarding transgender children and youth
- Topic regarding transgender medicine
- Topic regarding gender assessment training for letter writing
- Topic regarding Autism spectrum disorder
- Topic regarding eating disorders
- Topic regarding neurodevelopmental disorders

- Supporting Transgender Autistic Youth and Adults: A Guide for Professionals and Families (By Finn V. Gratton)
- A Clinician's Guide to Gender-Affirming Care: Working with Transgender and Gender Nonconforming Clients (By Sand C. Chang, Anneliese A. Singh, and lore m.dickey).
- Trans Bodies, Trans Selves: A Resource by and for Transgender Communities 2nd Edition (By Laura Erickson-Schroth)
- The Queer and Transgender Resilience Workbook: Skills for Navigating Sexual Orientation and Gender Expression (New Harbinger Self-Help Workbook) (By Anneliese A. Singh)
- Affirmed: An Inclusive Guide to Medical and Surgical Transition (By Sidhbh Gallagher)

Comments or missing items regarding specific best treatment practices that aren't listed above:

Appendix G: Letter to Authors of Publications

Hello (Authors name),

I hope this email finds you well. I am Amydth Chumacero, a Ph.D. student in the clinical psychology program at Walden University. I am reaching out because I am conducting my dissertation research on the area of transgender healthcare in minors, and I read (title of article) with interest.

My dissertation is titled Psychologists' Competency and Training Regarding Treating TGNC Youth with Gender Dysphoria. The study aims to develop a consensus regarding clinical psychology training and treatment standards of care in the treatment of TGNC youth with Gender Dysphoria.

I am trying to recruit volunteers who are licensed, doctorate-level psychologists in the United States who work at an established organization or practice that currently imparts a multidisciplinary and affirmative approach to care for TGNC youth diagnosed with Gender Dysphoria, and who have at least five years of experience working with the population of interest.

Because the inclusion criteria for my study are specific, I am writing to request assistance in forwarding the recruitment flyer with the study information to colleagues or coworkers who may be interested in participating. I am happy to address any questions you may have about the research, and would greatly appreciate any recommendations you may have regarding potential recruitment for the study.

Thank you very much for your time.

Kind Regards,

Amydth Chumacero