Gender-Affirming Psychological Assessment with Youth and Families: A Mixed-Methods Examination

Abstract

This study aims to discover what parents of gender diverse youth have found helpful as participants in a comprehensive psychological assessment process, and why. Sixteen parents of youth ages 5–16 years who completed a psychological assessment at a pediatric transgender health specialty clinic responded to a survey about the helpfulness of various aspects of the assessment process, including aspects of the assessment considered to be best practice in general (i.e., "non-specific factors"), and those consistent with recent recommendations for gender-affirming care. Non-specific factors of the assessment process ranked as most helpful included steps taken by the clinician(s) to develop a strong working relationship with parents (e.g., demonstrating respect or authenticity). In terms of assessment related specifically to gender, parent-identified aspects that were most helpful included the parents perception that the clinician(s) had the child convince them of their gender identity, providing guidance on how to approach school officials about creating a gender-affirming school environment for the child, and encouraging the parent to explore their own views on gender diversity. The findings highlight the importance of the mental health professional in promoting parental acceptance of their child's gender identity, their pivotal role in helping families and youth secure social support, and may aid clinicians to revise and improve upon their psychological assessment process of gender dysphoria.

Keywords: gender-affirming care, assessment, transgender, youth, family, gender diverse

Implications for Impact Statement: This study provides information on how mental health professionals can promote parental acceptance of their child's gender identity by describing supportive interviewing and psychological assessment procedures for transgender youth and their families at the point of entry to gender-affirming medical care. Little is known

about how best to support transgender youth and their families as they contemplate social and medical transition. Improved knowledge among mental health providers will improve access to quality gender affirming care for transgender youth and their families.

Gender-Affirming Psychological Assessment with Youth and Families: A Mixed-Methods Examination

A growing body of research literature indicates that gender-affirming medical and psychosocial interventions have a positive impact on transgender youths' mental health. In particular, among transgender youth and adults, use of chosen names and pronouns (Russell et al., 2018), social transition (Olson et al., 2016), and usage of gender-affirming medical interventions such as pubertal suppression medication and gender-affirming hormones have been associated with improved quality of life and general well-being and lower rates of depression, anxiety, and suicidal ideation (Allen et al., 2019; de Vries et al., 2014; Turban et al., 2020). Among prepubescent socially transitioned children (i.e., children who adopted a gender presentation corresponding to their affirmed gender identity rather than their sex assigned at birth), there appears to be no substantial difference in anxiety and depressive symptoms relative to their peers (Olson et al., 2016). As young adults, transgender and gender diverse individuals benefit from gender-affirming social support within (Ryan et al., 2010) and outside the family (Allen et al., 2020). In response to these empirical findings, the American Academy of Pediatrics recommends access to comprehensive gender-affirming care and the prioritization of research that is dedicated to improving the quality of care provided to transgender youth (Rafferty, 2018).

Despite growing recognition of gender-affirming approaches as the standard of care for transgender individuals, research has documented many barriers that transgender people encounter as they navigate gender transition. These include barriers not only within their family but also at school (Kosciw et al., 2018), in their communities (Kosciw & Graytak, 2009) and within the health care system (Gridley et al., 2016; Wilkening, 2017). When they are ready to access gender affirming medical care, transgender youth report that they experience long wait

times (Inwards-Breland et al., 2019) and may have to travel some distance to access pediatric gender affirming clinics (Douhit, Dwolatzky, & Biswas, 2015). Some youth report feeling as if they have to prove they are "trans enough" to warrant gender-affirming care and that their providers often fail to use appropriate names and pronouns and seem unaware of standards of transgender health care (Gridley et al., 2016). Perhaps for this reason, some transgender individuals describe educating their health care provider themselves while others may avoid seeking services altogether due to fears of mistreatment (James et al., 2016). For transgender youth, one of the most common barriers to accessing gender-affirming care resides within their parents or caregivers, who may fear "false positives" (i.e., incorrectly assuming a persistent transgender identity; Marchiano, 2017) or that their child's gender identity is "a phase" or are akin to a "social contagion" (Littman, 2018). Some parents may be unaware of how best to support their child's emerging gender identity or question what gender affirming care involves.

Psychological assessment of gender dysphoria is a point of entry to entry to gender-affirming care for parents and gender diverse youth that can serve to either promote or reduce caregivers' hesitations regarding gender-affirming care. Prior to the initiation of medical interventions such as pubertal suppression medications or gender-affirming hormones in children and adolescents, the clinical practice guidelines of the Endocrine Society (Hembree et al., 2017) and the World Professional Association of Transgender Health (WPATH; Coleman et al., 2012) state that a psychological assessment of gender dysphoria (GD)[1] should be done by a qualified

[1] The International Statistical Classification of Diseases and Related Health Problems (ICD-11) uses the language of "gender incongruence" instead of "gender dysphoria." This diagnosis was moved out of the "mental and behavioural disorders" chapter of the ICD-11 and into the new

mental health professional. According to WPATH practice guidelines (Coleman et al., 2012) mental health professionals conducting these assessments should assess for a history of gender nonconformity, the emergence or worsening of gender dysphoria at the onset of puberty, and coexisting medical or psychosocial problems that may interfere with assessment or treatment. Further, mental health professionals should obtain parental permission and support, informed consent, and ensure that they have adequate comprehension of the impact of medical interventions.

Because transgender youth often cannot legally consent to their own gender-affirming treatment, familial engagement during the initial interactions with the mental health system is critical. Poorly conducted psychodiagnostic interviews, particularly those that do not adequately address parents' concerns may perpetuate skepticism or fear about their child's gender identity, therefore delaying or preventing access to care. By enabling the youth to tell the story of their gender development and gender identity with the parent present, mental health professionals can aid the family in supporting the youth while also addressing parental questions and fears. Failure to respond to parents' doubts about their child's gender identity may contribute to their misconceptions, shame, and hesitation about offering support and understanding to their transgender child (Healy & Allen, 2019; Rafferty, 2018).

Unfortunately, parents of transgender youth have expressed concerns that mental health

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chapter "conditions related to sexual health." This is reflective of i) not all transgender or nonbinary people will necessarily experience a sense of "dysphoria" or desire medical interventions and ii) transgender and gender diverse identification is not inherently reflective of psychopathology.

professionals did not adequately explore the history of gender dysphoria or assess for co-occurring mental health conditions (Littman, 2018). Notably, parents travel their own pathway toward understanding and acceptance of their child's gender identity (Coolhart, 2018). They may feel a sense of loss for who they once thought was their "son" or "daughter" (Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016). Even after psychological assessment, some parents remain unsupportive of medical interventions and take issue with providers offering gender-affirming care (Rafferty, 2018). Failure to adequately engage families in the assessment process may result in the delayed ability to social transition and access to gender-affirming medications (for those youth seeking these interventions), which may ultimately harm youth if withheld (Allen et al., 2019; Radix & Silva, 2014).

The need for greater availability of competent, gender-affirming care is clear and there have been multiple calls for the prioritization of research dedicated to improving the quality of care provided to transgender youth (Allen et al., 2019; Chen, Edwards-Leeper, Stancin, & Tishelman, 2018; Gerritse et al., 2018; Rafferty, 2018). And, critically, caregivers' acceptance is associated with transgender youths' mental and physical health outcomes (Klein & Golub, 2016; Olson et al., 2016). Unfortunately, there has been limited research examining what parents of transgender youth actually find helpful or supportive during the psychological assessment process. In the absence of such research, frameworks identifying the "non-specific" factors of the psychological assessment and psychotherapy process may provide insights into strategies that clinicians can use to engage transgender youth and their parents. For example, it has been suggested that all psychotherapy outcomes are mediated by basic clinician actions such as the expression of warmth, encouragement, and acceptance (Wampold & Imel, 2015). Further, it has also been argued that clinicians can take steps to make the assessment process itself therapeutic

(Finn & Tonsager, 1997). Therefore, mental health professionals might be able to utilize these skills throughout the basic aspects of the assessment process (and when examining the youth's "gender history" and providing psycho-education on the topic of gender diversity) to promote youth and parent engagement and satisfaction.

In order to better understand the factors associated with engagement among parents of transgender youth, the present study surveyed the perspectives of transgender youths' parents regarding the psychological assessment process. Parents of gender diverse youth who had completed the psychological assessment process ranked the relative helpfulness of a list of nonspecific factors their clinician(s) engaged in during the visit. To further distinguish the unique contributions of gender-affirming care practices to parents' reactions to the assessment process, they also ranked a list of gender-specific assessment elements (e.g., assessment of GD, psychoeducation about gender) in terms of their relative perceived helpfulness.

Method

Participants

Parents of 103 youth who completed a psychological assessment with their child (from late 2014 to early 2019) at an outpatient psychology clinic within a large pediatric transgender health specialty clinic in a US Midwestern metropolitan city were solicited to complete an online survey about their experiences of the assessment. Invitations to participate in the survey were sent via email. Sixteen parents ages 33 to 56 years (M = 42.94, SD = 5.71) completed the survey. Parents were predominantly female (93.8%, n = 15) and all (100.0%, n = 16) identified as non-Hispanic White. Parent-reported annual household income ranged from less than $25,000 (12.5%, n = 2) to greater than $100,000 (37.5%, n = 6). The gender diverse youth presenting for clinical care ranged in age from 5 to 16 years (M = 11.50, SD = 3.41) at the time of the

assessment. Ten (62.5%) of the youth were assigned female at birth and were described by their parents as identifying as males. Six (37.5%) of the youth were assigned male at birth and described by their parents as identifying as female. At the time of the assessment, nine (56%) of the youth had already socially transitioned in the home, while six (31%) had also socially transitioned in their school environment. Of the patients seen in our clinic overall, the patient population is predominantly assigned female at birth (approximately 69%) and White (approximately 87% White, 6% multiracial, 4% Hispanic, 2% Black, and 1% Asian/Pacific islander).

Measures

Two surveys were developed by the authors to determine what general assessment practices and gender-specific aspects of the assessment process youth and parents perceived to be most clinically helpful. An initial pool of survey items was developed for this study based on a review of the literatures in the areas of nonspecific factors of psychotherapy, therapeutic assessment, and evaluations with transgender youth (see Supplemental Material Item A for a list of the items and the sources from which the items were derived). Items were developed to capture clinician actions or clinician-client relationship variables (client feeling respected, strong alliance) that had been linked to outcomes or recommended as best practices in the assessment process. Experts with experience in therapeutic assessment and transgender care subsequently reviewed the items, eliminated items judged to be unnecessary, and modified the content of the remaining items to be developmentally and culturally sensitive to the population served by the clinic. Finally, readability analysis indicated that all survey materials were at or below a 13-year-old reading level.

The two surveys evaluating clinician nonspecific factors and gender-affirming practices

of the assessment process were administered in a q-sort format (see Table 2 and 3 for item content). Compared to questionnaire formats where each item is *rated* according to a measurement scale (e.g., *strongly disagree* [1] to *strongly agree* [5]), q-sorts involve *ranking* items relative to one another according to a measurement scale. Typically, q-sorts are administered with a fixed item distribution, meaning that a pre-specified number of items are sorted into the numerically-valued categories along the measurement scale. For example, a nine-item q-sort of personality traits might have an individual sort items into a flat distribution of three adjectives into those that *applies the least* (1)*, applies somewhat* (2), and *applies the most* (3). The combination of rank ordering of items and a fixed item distribution provides several advantages, including increasing raters' attention to the item content and reducing response biases such as a tendency to respond using only one portion of the rating scale (e.g., extreme or conservative response styles).

This methodology ensures that respondents provide both positive feedback and constructive criticism. The q-sort was identified as an exceptional tool for collecting meaningful feedback from the small sample in the current study. Q-sorts have been used previously to study various aspects of the psychological assessment process (Dodd et al., 2018; Dodd et al., 2019). Q-sort methodology has also been argued by many to be an inherently mixed-method technique that allows for a focus on participants' subjectivity, while allowing for the quantitative analysis of what typically is studied qualitatively (Barker, 2008; Creswell, 2010).

Procedure

Initially, the study was designed so that both parent and youths' perspectives would have been gathered via the survey. However, due to the response rate on part of parents, we were unable to secure parental permission to contact youth and had an insufficient sample of youth to

analyze. In addition to the questions about demographic factors, the survey included items asking participants about the assessment recommendations they received and whether they followed through with them, and two sets of questions (i.e., the two q-sorts) that asked them to rank order both aspects of the assessment process that were taken from the nonspecific factors and gender-affirming care literature from *most* and *least* helpful. Finally, participants were provided open-ended questions asking them to elaborate upon their rankings and to describe how the assessment process influenced their decisions to follow through with the recommendations they received after the assessment (see Table 1). The purpose of seeking this sort of brief qualitative data was to provide some further context to interpret the results of the q-sort and are therefore provided in the discussion section. After completing the survey, participants were given the option to have $15 donated to a charity of their choosing. The institutional review board (IRB) of the University of Missouri–Kansas City ceded IRB review and continuing oversight duties to the Children's Mercy Hospital IRB, which approved the study.

The procedures of the gender clinic that participants in the study were assessed at have been described in more detail elsewhere (Allen, 2019; Allen et al., 2019). The goal of the psychological assessment is to determine whether the youth meets DSM-5 criteria for gender dysphoria. The psychological assessment consists of a medical records review, youth and parent interviews, and administration of a variety of measures designed to evaluate gender dysphoria, adaptive and behavioral functioning, and high-risk behaviors such as suicide, sexual activity and disordered eating. Depending on whether the child was referred to our clinic by an outside provider and already has a diagnosis of gender dysphoria, the psychological assessment may last from 2 to 4 hours (in addition to the time it takes the family to complete an initial phone screen, paperwork, and questionnaires). Patients ages 12 years or younger complete age-appropriate

techniques designed to help assess gender identity and family functioning. A list of the measures used is provided in the supplementary material (see Supplemental Material Item B).

Our clinic follows clinical practice guidelines established by WPATH (Coleman et al., 2012) and the Endocrine Society (Hembree et al., 2017). At the beginning of the families first appointment, the mental health professional provides information about the gender affirmative model under which we also operate (see Hidalgo et al., 2013). We inform parents that we cannot presume a particular gender identity trajectory, the child must be allowed to explore and express gender identity for themselves, and that the persistence of a transgender or gender diverse identity into adulthood is not viewed as an unwanted outcome. Time is allotted for the mental health professional to meet with the parents and youth together, and to meet with the parents and youth alone. Parents are given verbal recommendations at the end of the assessment appointment (e.g., referral to endocrinology for a consultation, individual or family therapy, psychoeducational resources on gender diversity, connection with support groups, etc.) and are also provided a written report approximately 2 weeks after the assessment.

Analyses

Analyses were conducted using IBM SPSS Statistics 25. A ranking of mean parent ratings on the general and gender-specific q-sorts was used to identify the most and least helpful aspects of the assessment process. Of the 16 parents who responded to the survey, 4 (25.0%) did not complete the parts of the survey reporting on the recommendations they received after the assessment, and 2 (12.5%) did not complete the q-sort survey asking them to rate gender-specific aspects of the assessment. Qualitative responses were understood through the lens of thematic analyses (e.g., Braun & Clarke, 2006) and supplement the interpretation of the q-sort results in the discussion.

Results

Parent q-sort rankings of the helpfulness of 30 non-specific factors of the psychological assessment process, sorted from highest to lowest mean ratings, are displayed in Table 2. The six clinician activities or behaviors that were ranked as most helpful (i.e., the top 20% of items) were: (1) developing a good relationship with the parent, (2) providing respect for what the parent shared during the assessment, (3) seemed open to be themselves, (4) working to clarify the parent's assessment questions, (5) asking insightful or important questions, and (6) giving information about the available treatment options. The six clinical actions that were ranked as least helpful (i.e., bottom 20% of items) were: (1) allowing the parent to explore distressing feelings (e.g., confusion, shame, guilt, or anger), (2) attempting to learn about the family's values, (3) asking about concerns outside the presenting issue (e.g., anxiety, depression, or suicide), (4) seeming to like or care for the parent, (5) demonstrating an interest in and respect for the family's cultural background, and (6) treating the parent with respect.

Parent q-sort rankings of the helpfulness of 20 gender-specific aspects of the psychological assessment process, sorted from highest to lowest mean ratings, are displayed in Table 3. Of these, clinician activities or behaviors that were ranked as most helpful (i.e., top 20%) were: (1) having the child convince them of their gender identity, (2) providing guidance on how to approach school officials about creating a gender-affirming school environment for their child, (3) encouraging parents to explore their views on gender diversity, and (4) conveying the importance of family support for transgender youth. In comparison, the clinical actions ranked as least helpful (i.e., bottom 20%) were: (1) offering information about hormones, (2) providing documentation to facilitate gender-affirming care from the child's other healthcare providers or school, (3) increasing the parent's understanding of the child's gender identity or

gender expression, and (4) giving the family information about social transitioning.

Parent endorsement of the recommendations that were provided as part of their assessment, and the rates at which they followed through with those recommendations, are displayed in Table 1. Interestingly, many parents did not report that they received recommendations that are considered standard practice in the clinic where this research was conducted. Two (16.7%) parents reported that they received recommendations to read psychoeducational books, 2 (16.7%) reported that they were told to increase their child's engagement in social activities, and 8 (66.7%) indicated that they were given recommendations to connect their child with peer supports such as transgender focused youth groups. Nine (75%) parents reported that they were told to use their child's chosen name and pronouns, and 12 (100%) reported that they were encouraged to let their child explore their gender and gender expression. These recommendations were acted on by 100% of parents who reported receiving them in the case of reading books, using the child's chosen name and pronouns, and allowing them to explore their gender and gender expression. In contrast, 1 of 2 (50.0%) reported that they had connected their child with recommended social activities and 5 of 8 (62.5%) reported that they had followed through with recommendations to connect their child with peer support.

Parent-reported follow through with individualized assessment recommendations provided also varied considerably. Referrals to endocrinology for information or screening regarding pubertal suppression medications were completed by 8 of the 9 (88.9%) families. Comparatively, referrals for further information or screening about gender-affirming hormones were completed by 5 of 8 (62.5%) families. Those parents who reported that they were referred for psychotherapy followed through in 6 of 6 (100%) cases where the recommendation was individual child therapy and 2 of 4 (50.0%) cases where the recommendation was for family

therapy.

Discussion

The items ranked as most helpful on the q-sort of non-specific factors, which were related to general counseling processes and therapeutic assessment, confirmed what is already known in the literature to be helpful (e.g., genuineness, respect for client, warmth). One parent wrote:

> Being able to articulate our feelings and concerns and to do so without feeling judged, is really comforting. It helps put things in perspective so that we can understand what is going on with our child and how to align our parenting with the needs of our child.

The finding that the psychological assessment process can result new perspectives for parents provide support for a therapeutic model of assessment (i.e., that is the idea that the assessment process itself can be therapeutic) versus an information gathering model of assessment (i.e., the idea that assessment's sole purpose is to arrive at an accurate diagnoses) (see Finn & Tonsager, 1997).

One of the most surprising findings of this study is that parents found that having their child convince the clinicians of their gender identity was one of the most helpful aspects of the assessment process. The item was derived from the literature review and written for the parallel youth version of the survey, which was not administered, in recognition that the psychological assessment process may be seen as gatekeeping (e.g., Gridley, 2016). It was anticipated (that had we secured a sample of youth to complete the study), youth would have ranked this as one of the *least* helpful items. While this may be a misalignment between parents of gender diverse youth and youth themselves, one parent wrote that the assessment process "helped me understand and clearly see the gender dysphoria through my son's life." Another parent wrote "we were wanting to know if our child is transgender. We wanted to be able to provide our child with support

should this be the case." Yet another parent wrote, "providing a clinical way to process and assess what our child is experiencing, helped us understand his perspective and explore what causes our resistance." It appears as though the parent's perception that their child had to authenticate their transgender identity also helped parents to better empathize with or understand their child. We are not aware of any psychological assessment that will tell parents definitively if their child is transgender. In our view, gender is something the child has to explore (without criticism or rejection) and articulate for themselves. The clinical value obtaining a "gender history" from a youth in the presence of their parents may be that the parents hear the unfolding of gender, over time. Youth may be much more reluctant to engage in such extensive discussions with their parents outside of a therapeutic environment. This issue may explain why some disclosures of gender identity are perceived by parents as "coming out of the blue," (Littman, 2018), while, in our experience, most gender diverse youth report contemplating their gender identity for years prior to disclosing to their parents.

Parents also reported that receiving guidance on how to approach and work with school officials to create gender-affirming school environments for their child was the second most helpful gender-specific aspect of the assessment process. Therefore, clinicians may benefit from developing strategies to support parents in creating change in their local school systems as well as having working knowledge of local school systems themselves (see also dickey, Singh, Chang, & Rehrig, 2017). One parent wrote:

> Putting a name to what my child has felt all her life was liberating for her. We were able to talk about the great things to come but also the seriousness of it all. How to talk to family, friends, school... and what the reactions might be and how to handle it was crucial to starting her transition.

Parents also appeared to have benefited from being gently encouraged to explore their views on gender diversity as well as having conveyed to them the importance of family support for their child. One parent wrote the "assessment helped us be more comfortable using the new name and pronouns." At the same time, parents want to feel supported. One parent wrote, "because my child is alive and safe, and at the time of assessment [my child] was too young to understand what other aspects of transitioning entails, it was more helpful for me to know that I am supported."

Parents rated receiving psychoeducation about gender-affirming hormones (GAH) among the least helpful items (while psychoeducation about pubertal blockers was rated relatively higher in helpfulness). One implication of this is that clinicians may want to lessen the time spent educating parents on the effect of GAH (using clinical judgment to determine when this is appropriate and/or leaving this discussion to endocrinology). Two parents reported dissatisfaction with the speed at which consultation referrals with endocrinologists were made. One parent wrote they "wish[ed] there was a way to navigate this confusing time before discussing hormones and rushing into name changes and things."

Participants also rated being connected to supportive groups and resources (for both parents and youth) of relatively high importance. One parent wrote that our clinic provided them the resources to help connect their child "to an entire affirming and supportive network of people. Feeling connected and included decreased her depression and allowed us to treat her physical body without fearing that she would end her own suffering." Another parent reported "It's helpful to feel as if you are not the only person or family going through this experience." Although it should be noted that, while being connected to resources was rated of relatively high importance by parents overall, not all parents felt they had sufficient help and guidance in being

connected to resources. Some clinics specializing in pediatric transgender care have a care manager/program coordinator position whose primary role is to link families and youth to community resources and mental health supports. This finding suggests that clinics specializing in pediatric gender affirming care may benefit and improve the patient experience by having such an employee available as a resource.

Among our findings were some surprising results (e.g., "attempting to learn about the family's values" as being ranked among the lowest in terms of relative helpfulness) and seemingly contradictory results (e.g., rating "respected what I shared during the assessment" as helpful and "treating me with respect" as lower in terms of relative helpfulness). It may be that "attempting to learn about the family's values" was rated as less helpful due to the lack of heterogeneity of the sample. With regard to the possible discrepancies, multiple participants noted that sentiments akin to "[all] these factors were relevant and present, they just weren't what I benefited the very most from." Other items may have been ranked of lower importance due to similar reasons and/or their applicability. For example, providing information on social transition was ranked low in terms of relatively helpfulness which may be due to the fact that some transgender youth come to our clinic having already socially transitioned (in which case additional information about social transitioning may be irrelevant or unneeded).

The psychological assessment process appeared to have engaged parents and encouraged them to act to support their child. In fact, all (100%) parents who recall being recommended to read transgender-related books, use their child's chosen name and pronouns, and allow their child to explore their gender and gender expression reported acting upon these recommendations. Five of 8 (62.5%) reported that they had followed through with recommendations to connect their child with peer support. Parent-reported follow through with individualized assessment

recommendations provided also varied considerably. Referrals to endocrinology for information or screening regarding pubertal suppression medications were completed by 88.9% of families. Comparatively, referrals for further information or screening about GAH were completed by 62.5% of families. Those parents who reported that they were referred for psychotherapy followed through in 100% of cases where the recommendation was individual child therapy and 50% of cases where the recommendation was for family therapy. Ultimately, our study indicated that the psychological assessment process may be therapeutic in, and of itself, by increasing family, social, and school support for gender diverse youth while at the same time facilitate access to next steps of gender affirming medical care.

Limitations and Direction for Future Research

Results of this study should be interpreted in light of its limitations. In particular, this was a small sample study where participants provided retrospective surveys about assessments completed one to five years after their last clinic visit. The q-sort methodology used further precluded us from evaluating the degree to which clinicians adhered to best practice guidelines in the assessment process. Instead, the present results are most conservatively interpreted as parents' perceptions of aspects of the psychological assessment process. Future research is needed to determine whether making changes to the assessment process based on these results will lead to improvements in parent and child satisfaction.

Additionally, results of this study do not represent the views of all parents of transgender youth, particularly since parents in this study were predominantly White mothers who consented for their child to participate in gender-affirming healthcare. More research is needed with parents who are unwilling or unable to participate or consent to gender-affirming mental health care for their child. For this reason, the relative helpfulness of certain items should not be completely

discounted by clinicians or researchers. Potentially, strategies rated at the lower end of helpfulness (e.g., allowing them to discuss distressing feelings about the process) in the current study may be beneficial in developing strategies to engage parents who are skeptical of gender-affirming practices.

Finally, we were also unable to recruit youth into participating in this study, and further research is needed to examine the degree to which parents and their children agree when evaluating various aspects of the gender-specific psychological assessment process. We recommend future studies enroll parents and youth in the months following the conclusion of the assessment process and conduct on-going (rather than retrospective) studies to secure larger sample sizes. Finally, this study examined a process which occurs in a highly specialized pediatric transgender health clinic, and the results are most applicable to families seeking services at similar multidisciplinary settings.

Conclusion

Transgender youth often cannot access gender-affirming medical interventions without the permission of their parents. Our study provides important information for mental health professionals and transgender health specialty clinics working with gender diverse youth and their families. It highlights how mental health professionals can promote family engagement and parental acceptance of their child's gender identity. Our study indicated that the psychological assessment process may be therapeutic in, and of itself and facilitate access to appropriate medical care. Our findings suggest that mental health professionals should show genuine respect for the parents' perspectives, allow the parent to explore their own views of gender diversity and to clarify their questions about their child's gender dysphoria. Parents appeared to value hearing the story of the unfolding of their child's gender identity over time. These factors appear to pave

the pathway for parents to accept gender-affirming recommendations to increase family, social, and school support for gender diverse youth and to take next steps of gender-affirming medical care. We hope clinicians will be able to use these findings to refine and improve upon their own evaluation processes and procedures when working with transgender youth and their families to ultimately improve care, increase social support and access to care, which in turn promote health, positive development and well-being for gender diverse youth.

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Tables

Table 1. *Participant Assessment Recommendations Received and Completed (N = 12)*

	Received		*Completed*	
Recommendation	*N*	%	*N*	%
A referral to endocrinology for information or screening about pubertal suppression medication	9	75.0	8	88.9
A referral to endocrinology for information or screening about hormones	8	66.7	5	62.5
Individual therapy for your child	6	50.0	6	100.0
Family therapy	4	33.3	2	50.0
Reading books (e.g., The Transgender Teen) [a]	2	16.7	2	100.0
Connecting your child social activities (e.g., athletics, extracurricular clubs) [a]	2	16.7	1	50.0
To connect your child with peer supports (e.g., GSA or transgender focused youth groups) [a]	8	66.7	5	62.5
To use the children's chosen name and pronouns in the home [a]	9	75.0	9	100.0
To allow your child to explore gender and gender expression (e.g., choosing their own hairstyle and clothes) [a]	12	100.0	12	100.0

Note.
[a] Standard practice

Table 2. *Nonspecific Factors Q-Sort Item-Level Descriptive Statistics (N = 16)*

Item	*M*	*SD*	Range
I developed a good relationship with the clinician(s)	4.38	1.71	1–6
The clinician(s) respected what I shared during the assessment	4.25	1.77	2–6
The clinician(s) seemed open to be themselves	4.06	1.65	1–6
The clinician(s) worked with me to clarify my questions for the assessment	3.87	1.71	1–6
The clinician(s) asked insightful or important questions	3.81	1.87	1–6
The clinician(s) gave us information on the available treatment options (expectations for treatment, outcomes, risks)	3.81	1.80	1–6
The clinician(s) clearly explained the results of the assessment	3.81	1.76	1–6
The clinician(s) recognized any anxiety I had about attending the assessment	3.75	1.65	1–6
The clinician(s) gave me hope that my child's concerns would get better	3.63	1.78	1–6
The clinician(s) spent time with me individually	3.63	1.78	1–6
The clinician(s) gave me written feedback that was relevant to my assessment questions or concerns	3.63	1.82	1–6
The clinician(s) provided books and other materials to help us with our concerns	3.63	1.82	1–6
The clinician(s) seemed to understand my feelings	3.56	1.79	1–6
The clinician(s) seemed to understand the causes of my child's concerns	3.56	1.90	1–6
gave me advice	3.50	1.93	1–6
The clinician(s) helped me develop a clear plan of action for addressing my child's concerns	3.50	1.71	1–6
The clinician(s) were detailed or thorough in their assessment	3.44	1.79	1–6
The clinician(s) clearly explained the reason for each part of the assessment	3.44	1.67	1–6
The clinician(s) referred me to other providers relevant to my child's medical or mental health needs	3.38	1.93	1–6
The clinician(s) addressed my questions or concerns	3.37	1.86	1–6
The clinician(s) involved me in the treatment planning process	3.37	1.20	1–5
The clinician(s) used assessment tools (e.g., surveys, tests, or measures) that were relevant to my concerns	3.31	1.45	1–6
The clinician(s) seemed to understand my child's concerns	3.25	1.84	1–6
The clinician(s) helped me feel as if I was not alone	3.25	1.95	1–6
The clinician(s) treated me with respect	3.13	1.75	1–6
The clinician(s) demonstrated an interest in and respect for my cultural background	3.13	1.59	1–5
The clinician(s) seemed to like or care for me	3.06	1.48	1–6
The clinician(s) asked about a variety of concerns beyond my presenting issue, such as anxiety, depression, or suicide	3.00	1.37	1–5
The clinician(s) attempted to learn about our family values	2.81	1.64	1–6
The clinician(s) allowed to me explore any distressing feelings (e.g., confusion, shame, guilt, or anger)	2.69	1.35	1–5

Note. Participants were instructed to think of each item on the left beginning with "..." as starting with "The clinician(s) ...".

Table 3. *Gender-Affirming Care Q-Sort Item-Level Descriptive Statistics (N = 14)*

	M	*SD*	Range
My child had to convince the clinician(s) of their gender identity	3.71	1.27	1–5
The clinician(s) provided guidance on how to approach school officials about creating a gender-affirming school environment	3.50	1.51	1–5
The clinician(s) encouraged me to explore my views about gender diversity	3.50	1.51	1–5
The clinician(s) conveyed the importance of family support for transgender youth	3.36	1.50	1–5
The clinician(s) offered to connect us with local supports groups or resources	3.36	1.22	2–5
The clinician(s) gave us information about pubertal suppression medication	3.29	1.38	1–5
The clinician(s) used assessment tools (e.g., surveys, tests, or measures)	3.29	1.33	1–5
The clinician(s) that seemed biased or did not allow me to fully express my gender identity			
The clinician(s) offered information about legal name or gender marker changes	3.14	1.23	1–5
The clinician(s) helped my child communicate their own experience of their gender to me	3.07	1.44	1–5
The clinician(s) respected my views about gender identity and gender expression	3.07	1.44	1–5
The clinician(s) explained that children benefit from being allowed to explore or express their gender in their own way	2.86	1.29	1–5
The clinician(s) provided guidance on how to speak with friends and family about my child's changes (e.g., provided guidance and strategies on how and when to disclose a transgender identity to family members)	2.86	1.61	1–5
The clinician(s) explained a way of thinking about each gender-affirmative step (e.g., exploring gender, using appropriate names, and pronouns, consultation with endocrinology, prescription of medications for pubertal suppression or gender-affirming hormones) as one step	2.79	1.58	1–5
I was referred to online supports and resources (e.g., Genderspectrum.org or theTrevorProject.org)	2.79	1.42	1–5
The clinician(s) offered to connect us with other families going through similar experiences	2.71	1.20	1–5
The clinician(s) offered information about a range of gender identities and gender expressions	2.64	1.50	1–5
The clinician(s) gave us information about social transitioning	2.64	1.55	1–5
The assessment process gave me a better understanding of my child's gender identity and gender expression	2.64	1.60	1–5
The clinician(s) provided documentation to facilitate gender-affirming care from my child's other healthcare providers or school staff	2.57	1.28	1–5
The clinician(s) gave us information about hormones	2.21	1.31	1–5

Note. Participants were instructed to think of each item on the left beginning with "..." as starting with "The clinician(s) ...".