PROFESSIONAL RECOMMENDATIONS ON INDIVIDUAL PSYCHOTHERAPY TECHNIQUES FOR WORKING WITH TRANSGENDER AND NONBINARY CLIENTS REGARDING MINORITY STRESS: A DELPHI STUDY

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ABSTRACT

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This project is an analysis of current professional methods used by mental health professionals who work with transgender and nonbinary individuals in individual psychotherapy. Because of the minority status these individuals have, they are subjected to minority stress which can lead to increases in depression, anxiety, substance use, and suicidal ideation (Mueller, 2020). Minority Stress is defined as harassment and discrimination, perceived negative stereotypes about minority identities, and internalized transphobia or negative thoughts of self, based in minority identities (Meyer, 2003; Hendricks & Testa, 2012). While the need for therapeutic services for transgender and nonbinary individuals is widely recognized, there is little to no empirically backed methodologies for helping these individuals cope with minority stress. This project's purpose was to compile expert practices currently being used and create a consensus on the best methodologies to create the possibility for future research on agreed upon techniques. Results from the study suggested that professionals find person-centered techniques (e.g. validation, acceptance, empathy) to be the most helpful interventions. Additionally, the importance of advocacy and community as well as material support were highly rated suggestions by experts. Experts were also asked about the assessments they use to measure the success of these

interventions and rated basing success on the client's level of comfort with themselves and ability to cope with difficulties as the most helpful forms of assessment. Future research should attempt to create statistical evidence for the effectiveness of these techniques and should explore how those in treatment feel about these techniques.

Literature Review

The term transgender is an umbrella term that refers to an individual whose gender identity is different from the sex they were assigned at birth and also includes individuals who identify as gender non-binary or gender queer, which are terms often used for individuals whose gender identity does not fall within the binary of man or woman (American Psychological Association, 2018). These are not the only ways a person may identify themselves, and there are many labels used that help express gender identity. A study done examining the gender identity and sexual identity labels used in U.S. high school students reported that while most students identified with either male, female, trans man, trans woman, at least twenty-three other labels for gender identity were used (White et al., 2018). The extent to which an individual uses a label or term is personal, but for the purposes of this research gender minority, TGNC (transgender and gender non-conforming), and transgender or transgender and nonbinary will be used to describe this community in order to encompass all those who may experience the social consequences of being in a minority due to their gender identity. Conversely, the term cisgender is used to describe someone whose gender identity is the same as the sex they were assigned at birth (American Psychological Association, 2018).

Mental Health Discrepancies

Transgender individuals have higher rates of psychological disorders than the general population including higher rates of depression, anxiety, suicidality, self-harm, substance use and eating disorders (Connolly et al., 2016; Olson-Kennedy, 2016; Bartholomew et al., 2019). Youth who identify as transgender attempt suicide at a rate of 25-52%, representing a significant mental health crisis for this population (American Foundation for Suicide Prevention, 2019). In a study done by Toomey and colleagues (2018), it was found that 19% of transgender individuals ages

11-19 reported attempting suicide compared to 8.6% in the general population. This rate was higher in different gender identities. For example, half of transgender men reported attempting suicide. These studies show a clear discrepancy between the mental health of the transgender population and the mental health of the general population.

Along with psychological distress, transgender individuals commonly seek out psychotherapy as a way to pursue personal growth, focus on gender related issues, or deal with the impact of stigma (Rachlin, 2002). Although there are numerous guidelines, new therapeutic models, and adaptations of existing therapies aimed at this population, very few have been empirically tested. Some suggestions in the literature are also vague and contradictory, which may leave therapists unsure about best practices. Finally, much of the literature focuses on general skills for working with transgender clients as opposed to providing techniques that can be applied to specific issues transgender clients may face. For these reasons, this study aims to determine commonly agreed upon techniques for helping transgender clients navigate the impact of minority stress, such as discrimination, stigma, social rejection, and internalized transphobia. It is hoped that the results can give therapists more clear and specific techniques that can be use when working with transgender clients and suggest techniques that can be validated empirically in the future.

Minority Stress Model

Minority stress, or the negative experiences of an individual due to their minority status, has been shown to increase distress among transgender individuals independently of distress caused by gender dysphoria. Distress was associated with enacted and perceived stigma which is another reason why transgender individuals may seek individual psychotherapy (Bockting et al., 2013). Because of the high prevalence of discriminatory experiences in this population, the focus

of this study will be examining how individual psychotherapy can alleviate this distress associated with minority stress. The clear delineation in mental health from the rest of the population for transgender individuals is partially the result of high rates of discrimination.

Originally developed to address distress in the sexual minority community, the minority stress model (Meyer, 2003) can also be applied to help explain mental health disparities in gender minority individuals. Specifically, gender minority individuals have different experiences than their cisgender peers due to stigma associated with their identity. Hendricks and Testa (2012) published a framework adapting the model to the lives of transgender and gender nonconforming individuals in order to help clinicians provide services for transgender individuals outside of gender transitioning. This model, when applied to transgender individuals, describes three main contributors to transgender minority stress. The first is stressful external events such as physical and sexual abuse, attempted suicide, substance abuse, being fired from a job, and harassment which happen at higher rates for transgender individuals (Lombardi et al., 2002; Xavier et al., 2005; Bradford et al., 2013). Transgender and gender nonconforming individuals have reported discrimination in a variety of setting including healthcare, social service settings, mental health settings, school settings, and places of employment (Rodriguez et al., 2018; Grant et al., 2011). The high levels of discrimination experienced by these individuals have increase their likelihood of taking part in health harming behaviors including attempted suicide, drug/alcohol abuse, and smoking (Miller & Grollman, 2015).

The second and third are proximal and internal minority stress factors. These include expectation of discrimination and stigma from others (perceived stigma) and internalized transphobia (Hendricks & Testa, 2012). Expectations of negative experiences or stereotypes by others is often called perceived stigma or stigma consciousness (Pinel, 1999). This may include

the expectations that others will cause external harm to a person or will simply not help or think negatively of then due to their transgender identity. Expectation of violence and discrimination can be implied through the statistics reported that only 10% of transgender individuals who had experienced a violent attack reported to the police (Testa et al., 2012). Perceived stigma was also measured in a 2016 post-election study of gender minority individuals where 66.1% of the participants reported being concerned for their own safety and 75% reported a high level of concern about discrimination (Veldhuis et al., 2018). Higher rates of stigma consciousness have been correlated with higher rates of anxious and depressive symptoms as well as suicidal ideations (Kelleher, 2009). While this study does not support a causative effect of stigma consciousness it supports the theory that this aspect of minority stress is linked to severe mental health consequences in transgender individuals.

The last contributor to the minority stress model adapted to transgender individuals is internalized transphobia. Internalized transphobia is negative self-beliefs a transgender person may have of themselves due to internalizing societies gender attitudes and beliefs about transgender individuals (Hendricks & Testa, 2012). Internalized transphobia has been shown to mediate the relationship between anti-transgender discrimination and mental health (Scandurra et al., 2018). While little other research has been done on internalized transphobia, it is reasonable to expect it could have negative impacts on mental health similar to that of internalized homophobia including substance abuse, depression, anxiety, suicidal ideation, shame, low self-esteem and guilt (Allen & Oleson, 1999; Herek et al., 1997; Meyer, 2003; Shidlo, 1994). This is not backed with empirical evidence and more research should be done to understand the role that internalized transphobia plays in distress and decreased mental health.

Transgender Experiences of Mental Health Services

Because of the experiences detailed in the minority stress model, it is not surprising that transgender individuals seek counseling services more than their cisgender peers (Bartholomew et al., 2019). The general population reports that 3.18% of individuals have used outpatient therapy (Olfson & Marcus, 2010). Transgender individuals, however, seek mental psychotherapy services at a rate of 58%, and 77% report wanting counseling or therapy relating to their gender identity or transitioning (James et al., 2016). The two primary reasons a transgender individual seeks out therapy is to help with personal growth and to be supported through the process of gender transitioning (Rachlin, 2002). Transgender individuals also report a need for psychological support during the process of "coming out" or disclosing their identities to others (Budge et al., 2013). Due to the fear of rejection and the realistically high rates of family rejection (50% experienced at least one form of rejection from a family member), many transgender individuals may seek support through therapy (James et al., 2016). Unfortunately, a fear of being discriminated against by mental health professionals is a key factor in why many transgender individuals may choose to not seek out psychological services they want when exploring their gender identity (Hunt, 2014). Historically, transgender individuals have faced discrimination and the pathologization of their identity in the fields of psychology and psychiatry. Only with the release of the DSM-5 was gender identity disorder, a diagnosis that pathologized the transgender experience, removed in place of gender dysphoria (American Psychiatric Association, 2013). This recent change, while an indication of progress, shows the need for growth in mental health services in order to support transgender individuals.

Transgender individuals who have decided to seek out mental health services have reported on their feelings and experiences in a variety of studies. The reaction of this population to their current treatment is an important consideration to understanding the difficulties current

mental health professionals may face when treating a transgender individual. Experiences of transgender individuals in psychotherapy vary, but many report negative experiences with their therapists due to microaggressions and discrimination in mental health settings. Reports of therapists lacking respect for transgender identities, lack of competency from the therapist, saliency of identity, and gatekeeping (Morris et al., 2020). Along with this, transgender individuals reported negative experiences when therapists put the burden of education on their clients, inflated or narrowed clients gender identity, or pathologized their gender identity (Mizock & Lundquist, 2016). Because of this, transgender individuals go through different stages of fear and acceptance when in psychotherapy. These stages include fear of discrimination and stigma, becoming comfortable with personal gender identity, valuing the relationship with the practitioner, and a sense moving beyond therapy into the real world as a transgender person (Applegarth & Nuttall, 2016). Backgrounds and attributes of the therapist play a role in whether a therapy experience is helpful for a transgender individual (Israel et al., 2008). Therapists who are affirming and use affirming practices when working with transgender individuals are more positively perceived by their transgender clients (Bettergarcia & Israel, 2018). Even with this knowledge, very few therapists (30%) report ever receiving training in working with transgender individuals and how to provide affirming therapy or counseling (APA TFGIGV, 2009; Rutherford et al., 2012). Training in using affirmative practices, however, has been shown to improve skills, knowledge, and reduce trans negativity regardless of how long a professional has been practicing (Pepping et al., 2018). With this knowledge, it is clear the vital importance of creating knowledge and training materials for both current and future professionals who may have transgender clients.

Current Standards of Care

The World Professional Association for Transgender Health (WPATH) has published and updated a set of guidelines and standards of care (WPATH SOC) for professionals in all areas of health for working with transgender individuals (Coleman et al., 2012). These standards of care in mental health include guidance for what psychotherapy might entail. According to the WPATH SOC, psychotherapy is not a requirement for hormone therapy or surgery but is highly recommended for any transgender individual who feels it is needed for reasons surrounding their gender identity or any other mental health concerns. Psychotherapy should not be used to try to alter a person's gender identity but should help the individuals explore their gender and alleviate gender dysphoria if possible. Specifically, it is suggested therapists do the following:

1. Clarify and explore gender identity and gender roles
2. Address stigma and minority stress and its impact on mental health including promoting skills to deal with the world
3. Facilitate the coming out process
4. Aid in alleviating any co-existing mental health concerns such as depression or anxiety

Therapy should also help achieve comfort in their gender identity to help give them a better chance of success in relationships, education, and work. This can be done through individual, group, couple, and family therapy and follow-up care at different points in the individual's life may be needed (Coleman et al., 2012). These guidelines are helpful in that they provide a framework for what therapy should achieve for transgender individuals. Unfortunately, specific methods of therapy that may be most helpful have not been backed by empirical research which leaves professionals to use their own methods of psychotherapy that will address these guidelines.

Frameworks and Methodologies for Counseling Transgender Individuals

There is very little empirically backed research on methodology for the counseling of transgender individuals on how to deal with minority stress and the effects of societal reactions to their identity. Rapport building techniques such as providing a safe environment where identity is respected, maintaining a strong client-therapist relationship, openly discussing privacy, using preferred name and pronouns, and using visual cues of support (posters, flyers, flags) are suggested (Bockting et al., 2007). Other broad techniques include using assessments to determine goals for therapy and being compassionate and flexible as the understanding of gender and gender expression is changing and may be unique to each individual (Bockting et al., 2007; Fraser, 2009). The WPATH SOC discusses the use of the narrative approach and the psychodynamic approach although recognize neither have empirical backing. The narrative approach allows for transgender individuals to express their identity and story in their own words while the therapist acts as a guide for finding purpose, significance, structure, and goals through learning about the client's story (Lev, 2004). The psychodynamic approach, in simple terms, is based off of developmental models and attachment theory where the concerns arise from not being able to witness or mirror in order to develop a healthy ego (Fraser, 2009).

Outside of these recommendations there has been a growing body of literature on using the transgender affirmative framework. The transgender affirmative approach (TA) is a form of therapy that emphasizes multiculturalism, social justice and advocacy, the minority stress model, and resilience (dickey & Singh, 2020). This framework can be applied to a variety of methodologies including, but not limited to, cognitive behavioral therapy (CBT), narrative exposure therapy (NET), psychodynamic therapy, and interpersonal therapy (Budge et al., 2013; Austin & Craig, 2015; Bradford & Syed, 2019; Lange, 2020). TA involves the therapist explicitly discussing an inclusive perspective of gender, using gender neutral language or

whatever language the client identities with, and clarifying the clinician's role as an advocate and a source of support for whatever growth or wellbeing the client wishes to pursue (Austin & Craig, 2015). TA-CBT focuses on psychoeducation surrounding negative experiences and how they relate to psychological distress, challenging transphobic negative self-beliefs, modifying the cognitive cycles associated with hopelessness and suicidality, and encouraging affirming social connections (Austin & Craig, 2015). TA-NET emphasizes two main ideas. These are that there is nothing wrong with being a transgender person and that transgender individuals live in a flawed culture that does not always accept them which may require them to plan for safety and support. This is done through creating historical timelines and chapters that will be homework assignments for the client, writing narratives that are read aloud and processed with the therapist, and concluding with goals for the future (Lange, 2020). While these methods provide actionable techniques, they are not empirically tested and don't address all aspects of minority stress.

Other proposed methodologies and frameworks for working with transgender clients include the feminist approach, the Gender Affirming Lifespan Approach (GALA), interpersonal psychotherapy, acceptance and commitment therapy (ACT), and functional analytic psychotherapy (Richmond et al., 2017; Rider et al., 2019; Budge, 2013; Bennett & Dillman, 2019; Coyne et al., 2011; Skinta et al., 2018). While these approaches vary in explaining specific actions for therapy and to what extent they address all aspects of minority stress, their true weakness lies in their lack of empirical evidence that they sufficiently address the needs of transgender clients. Thus, clinicians are left with multiple options for working with transgender and gender non-binary clients which provide limited and at times contradictory suggestions on the specific issue of minority stress.

The Delphi Method and LGBTQ Findings

The Delphi method (Linstone & Turoff, 1975) is a research methodology that allows for the structuring of group opinions of a complex topic in order to create consensus. This is done, in its most basic form, through individual feedback by experts and then a group assessment of these views anonymously allowing for experts to revise, refine, and provide new information on a given topic. The purpose of the Delphi method is to seek information which can generate consensus, correlate informed judgements on a topic, and educate about the diverse and interrelated aspects of the topic (Linstone & Turoff, 1975). The use of psychotherapeutic interventions for helping gender minority individuals cope with minority stress is an appropriate topic for such a methodology as it is complex and does not have a singular agreed upon intervention technique. The Delphi methodology has been used to address the needs of the LGBTQ (Lesbian, Gay, Bisexual, Transgender, and Queer) community in other studies covering a range of topics including transgender fertility treatment, counselor concerns and curricula, facilitating the coming-out process for LGB individuals, service accessibility and mental health first aid (Kolbuck et al., 2020; Herlihy & Dufrene, 2011; Godfrey et al., 2006; Solomon et al., 2018; Acevedo-Polakovich et al., 2013; Bond et al., 2017). While many of these studies focused on sexual minorities (individuals who do not identify as heterosexual or straight), some information concerning the transgender and gender minority community was brought to light. This included counselors voicing concerns of discrimination and difficulties faced by their transgender clients, researchers establishing priority content areas in basic transgender reproduction needs for medical professionals, barriers to care for transgender adolescents specifically were explored by adolescent mental health experts, and basic skills needed to do mental first aid for transgender individuals determined in order to publish an educational

document (Kolbuck et al., 2020; Herlihy & Dufrene, 2011; Acevedo-Polakovich et al., 2013; Bond et al., 2017). Delphi studies have and will provide the professional community with guidelines and professional consensus on topics concerning the transgender community through analysis of the complex issues this population faces in order to improve understanding and quality of life for these individuals. These studies and others do not represent the thoughts of every professional but provide a good framework on which future empirical research can be built in order to establish evidence-based basis of care.

The Current Study

While there has been an increase in literature surrounding the experiences of transgender individuals, there is still little information on practices that can be used in therapy. The body of empirically based research on the effectiveness of therapy methodologies is practically nonexistent at this point in time. In order for clinicians to be educated on effective methods for helping transgender individuals in therapy, there is a need for new empirically based research to establish what practices should be used; however, generally agreed upon techniques must first be established in order determine what therapeutic interventions should be tested. The myriad of extant suggested therapies makes testing each one difficult, particularly given the lack of indication home much any of them are being used in practice. Furthermore, this paper aims to identify, specifically, methods used to treat and combat the negative effects of minority stress as identified by Hendricks and Testa (2012). Medical and psychological treatment for issues in this community, such as gender dysphoria, are more heavily researched, but the lives of transgender individuals are more complex than just the experiences concerning their physical bodies. As discussed earlier, many transgender individuals experience adverse social and internal prejudices against their minority identity that are associated with adverse mental health effects that could be

helped through therapeutic intervention. Very few of the methods discussed above specifically target the adverse experiences of transgender individuals due to minority stress and no empirical evidence exists for the effectiveness of treatment methods. Additionally, there is little consensus in the psychological community on what methods should be used in order to help transgender individuals cope with minority stress which includes experiences of discrimination, perceived stigma, and internalized transphobia that negatively impact mental health and therefore, quality of life.

The goal of this study is to answer the following questions: (A) What techniques and methods do current mental health professionals use to help their transgender clients combat and cope with minority stress? (B) How useful do other professionals consider these methods? It is hoped that developing a consensus will help future researchers to determine what practices should be empirically tested.

Methodology

Modified Delphi Method

A Delphi methodology was used to obtain professional consensus on therapeutic techniques and methods used by mental health professionals to help their TGNC clients cope with minority stress. The Delphi method is a mixed-method approach that consists of a qualitative and quantitative question set that allows the researcher to establish expert consensus on a given subject (Linstone & Turoff, 1975). The procedure used was a two round Delphi study also called a modified Delphi procedure. While some Delphi studies suggest three rounds of surveys, past studies have suggested that two rounds prevent fatigue in participants (Hasson et al., 2000). This two-survey model has also been used in multiple different LGBTQ Delphi studies (Kolbuck et al., 2020; Solomon et al., 2018; Acevedo-Polakovich et al., 2013). This study

consisted of finding professionals that fit criteria for being an expert in TGNC issues and then using two rounds of surveys to explore the opinions of current experts on therapeutic techniques to help transgender individuals cope with minority stress as well as the assessments experts use to assess the success of these techniques. The first round of surveys established a list of techniques and assessments endorsed by experts through responses to open ended questions and the second round created professional consensus on which techniques and assessments from the first-round lists are most helpful and most used.

Participants

Participant selection. Delphi studies select participants or experts so they may apply their knowledge to a problem and create consensus on a currently debated or under researched area of the profession. Participant selection is based on criteria that are developed given guidelines and literature on the topic that is under investigation (Hasson et al., 2000). For this study, expert criteria were modeled on those employed in previous Delphi and qualitative studies using LGBTQ therapy experts (e.g., Solomon et al., 2019; Israel et al., 2003) and by the definition of the WPATH SOC. These standards are listed as having a master's degree or equivalent in a clinical behavioral science field granted by an accredited institution and having a license to work in that field, competency in using the DSM for diagnosis, ability to recognize co-occurring mental health concerns along with gender dysphoria, documented training and competence in psychotherapy or counseling, knowledge on gender nonconforming identities, and continued education on gender dysphoria and cultural competence for working with transgender individuals. These standards were integrated into the criteria for the present study. All participants met three preliminary criteria and one out of two additional criteria items that showed experts' involvement in the pursuit of knowledge pertaining to TGNC psychotherapy.

These guidelines were used to determine which participants met expert status. All qualified participants met the following three criteria to be considered experts:

1. Have worked with at least 5 transgender clients in the last 5 years
2. Worked as a counselor or a therapist for at least 20 hours a week for three out of the last 5 years
3. Are a licensed mental health professional

Experts were also required to meet one out of the following two criteria:

1. Participated in one or more trainings associated with working with gender minority or LGBTQ+ individuals
2. Are a part of a professional organization that focuses on transgender or LGBTQ+ individuals mental health

These areas were assessed in the demographic section of the survey given electronically and extrapolated upon below. Along with the WPATH standards, real experience with working with TGNC clients to establish a personal standard of care is important and was the focus of choosing interviewees from the participant pool.

Participant recruitment. A total of 38 participants met qualifications for and completed the first round of the Delphi study and 39 qualified and completed the second round. Past Delphi studies in LGBTQ topics and literature suggests 20 or more participants is sufficient for mental health research (Solomon et al., 2016; Jorm, 2015). Participants were recruited through individual email based on their self-identification as a professional who specialized in working with TGNC or LGBTQ+ clients. Recruitment was done through individual email based on information found on Psychology Today and The Queer and Trans Therapists of Color Network

as these provided easy and effective means of communication to many professionals. When contacted, the goals and purpose of the study were described and the email included a link to an initial survey inquiring about professionals' demographic information, professional credentials, qualifications for the study, and if criteria was met, the first round of questions or potential times for a follow-up phone interview if the professional preferred. Participants remained quasi-anonymous in so far that their email was known to the researcher in order to allow for retention throughout the study but not to other participants to allow for openness and unbiased ratings when responding (Hasson et al., 2000). Over 500 emails were sent to professionals to recruit for the first round of the study and out of these, 77 responses were received, and 38 individuals met qualifications and completed the required questions for the initial round of the survey. All vetted experts had at least a Master's or professional degree, and represented a range of mental health specialties including mental health counselors (36.84%), doctoral level psychologists (26.32%), social workers (18.42%), marriage and family therapists (10.52%), and "other" (7.89%) which included two individuals who reported they were licensed professional counselors. They ranged in age from 27 to 66 years old. Of those that chose to identify their gender identity (92.30%), 36.11% identified as being on the transgender and/or nonbinary spectrum. Of those that identified as being cisgender, most (78.26%) identified as a sexual minority. Only one participant from the initial round did not reside in the United States. Many participants reported practicing in a suburb (47.37%), while most other practiced in either urban areas (26.32%) or towns (21.05%). Only two participants reported practicing in rural areas. One participant reported an ethnicity of African American (2.63%), one participant reported an ethnicity of Latinx (2.63%), and one reported an ethnicity of Middle Eastern/North African (2.63%) and one individual reported being

both Latinx and Middle Eastern/North African (2.63%). The remaining 89.47% of the sample (*n* = 34) reported an ethnicity of Caucasian or person of European descent

In the second round of the study, 23 participants were retained from the first round and an additional 16 were recruited through the same methods as round one to meet the same number of participants as round one. Demographic and identifying information for the 23 returning participants were not gathered in the round two data set to avoid fatigue. The newly recruited 16 additional participants reported on the same demographic information as those in round one. All vetted experts had at least a Master's or professional degree, including social workers (37.50%), doctoral level psychologists (31.25%), mental health counselors (25.00%), and marriage and family therapists (6.25%). They ranged in age from 29 to 60 years old. Of these 16 new participants, most identified as being on the transgender or nonbinary spectrum (56.25%). Of those that identified as being cisgender, only one identified as straight/heterosexual. All 16 new participants were currently living in the United States. Many participants reported practicing in urban areas (37.50%), while most others practiced in either suburbs (31.25%) or towns (18.75%). Only two participants reported practicing in rural areas. One participant reported an ethnicity of African American (6.25%), one participant reported an ethnicity of Latinx (6.25%), and one reported an ethnicity of Asian (6.25%) and three individual reported being one or more races (18.75%). The remaining 62.50% of the sample (*n* = 10) reported an ethnicity of Caucasian or person of European descent.

Round I Method

Participants responded to a digital questionnaire with items inquiring about a variety of demographic and qualifying information including their age, gender identity, sexual orientation, geographical location, as well as racial and ethnic background. Items focused on professional

credentials and criteria to determine the level of expertise in therapy with transgender clients included number of transgender clients, affiliation with LGBTQ professional groups, continuing education on transgender topics, letter writing for gender affirming medical interventions, and theoretical frameworks used when working with the general population and then, specifically with transgender clients. Participants were provided with an explanation and informed consent screen before starting the survey and had to give electronic consent in order to begin. If they meet criteria for "expert status" the survey included five open-ended qualitative questions that let experts have freedom in expressing their opinions and allow for exploration of the topic (Hasson et al., 2000; Iqbal & Pipon-Young, 2009). The prompts addressed how professionals treat minority stress related to the constructs identified by Meyer (2003) and Hendricks and Testa (2012) in individual psychotherapy as well as how experts address resilience and assessment. The specific questions that experts were asked to answer are as follows:

1. What methods do you use to help transgender individuals cope with stressful external events related to their identity (Ex: harassment, discrimination, or violence)?
2. What methods do you use to help transgender individuals cope with expectations of violence and discrimination due to their identity (perceived stigma)?
3. What methods do you use to help transgender individuals cope with internalized transphobia?
4. What methods do you use to encourage resilience in your transgender clients?
5. What methods do you use to assess success of your transgender clients in coping with minority stress?

Participants who met the criteria described above were given the option of responding to these questions online through an open answer written format (Bond et al., 2017, Kolbuck et al.,

2020) or to schedule a phone interview (Solomon et al., 2016). This allowed for flexibility in scheduling for highly qualified professionals (Iqbal & Pipon-Young, 2009). Three of the original 35 clients chose to do their initial interview via audio zoom call with the primary researcher. During audio interview, the researcher confirmed with the interviewee that they have written down and understood each suggested therapeutic technique of assessment method correctly. These methodologies were then added to the written responses gathered from online open-ended responses.

Technique Compilation and Ratings

Although the initial interview questions were broken into 5 distinct questions, experts gave similar or the same suggestions for the questions about techniques used for external harassment, perceived stigma, internalized transphobia, and building resiliency. For the purpose of clarity and efficiency, these four techniques were combined and/or further defined in order to create 56 clear and nonredundant therapeutic techniques provided by experts to help their TGNC clients cope with minority stress. If a technique was recommended for a single aspect of minority stress, that information was added to the technique to clarify its purpose (e.g. education, validation, and normalization around internalized transphobia including how it shows up, how it is developed, power systems that contribute to it, and how to take a new perspective). To compile results, the first author compiled suggestions into an initial list and then went through an iterative process of reviews with the second author. The second author is a doctoral level licensed psychologist with 10 years of experience conducting therapy. This author also assisted with clarification of terms and identifying which techniques warranted being consolidated or left independently due to their differences with other suggestions. For some techniques, further clarification or definition was needed in order to provide explanation to professionals who may

have been unfamiliar with its use (e.g. instead of "emotional regulation therapy for anxiety" the final list item was presented as "emotional regulation therapy such as the identification and management of difficult emotions for the treatment of anxiety"). After distilling the lists to the final 56 therapeutic techniques and 27 assessment techniques, a third researcher, who is a professor in clinical psychology with experience teaching graduate-level psychotherapy coursework, was then asked to read over the results to determine clarity of the written techniques for practitioners who may be unfamiliar with one or more of the presented suggestions.

Round II Method

The second round of the study included 25 of the original qualifying experts as well as 14 additional experts that were recruited in order to maintain the number of participants from the first round of the study. Additional experts have been recruited in past literature (Solomon et al., 2016) if some of the round one experts do not respond or drop out of the study to keep a continuous number of participants. Additional experts were recruited through the same process as the initial experts and were required to meet the same qualifications established for round one. These experts were sent a survey with the same initial materials as first round candidates. The only difference was, if qualification were met, experts in the second round were asked to rate first round techniques instead of providing their own suggestions. The second round of questions involved qualified experts rating a compiled list of techniques from round one in order to determine which therapeutic techniques and assessments experts use and find to be most helpful in relieving minority stress for TGNC individuals. Experts were asked to rate 56 therapeutic techniques and 27 methods of assessment. Experts used a seven-point Likert scale to rate the frequency and perceived helpfulness of each therapeutic technique and only the helpfulness of each assessment technique. Frequency was not measured for assessment techniques as many

experts endorsed using only one or no methods of assessment. For rating frequency, a seven-point Likert scale with one being "never use" and seven being "always use" was used. The midpoint 4 was neutral. For rating helpfulness, a seven-point Likert scale with 1 being "absolutely detrimental" and 7 being "absolutely essential" to the client was used. The midpoint 4 was "not helpful but not harmful".

Results were analyzed using SPSS software in order to determine measures of central tendency and interquartile range (IQR) for frequency and helpfulness of therapeutic techniques and helpfulness for assessment suggestions. All suggested therapeutic techniques are reported in Table 1 along with their mean rating, mode rating, IQR, and *n* for both their frequency of use and helpfulness. IQR is a measure of dispersion. Interquartile range was calculated to summarize the variability in the sample and to determine the consistency of ratings provided by participants. A smaller IQR value, indicates more agreement on a technique's level of helpfulness. All suggested assessments are reported in Table 2 along with their mean rating, mode rating, IQR, and *n*.

Results

Frequency of Therapeutic Techniques

Professionals rated the frequency at which they used each of the 56 therapeutic techniques identified in Round I. All techniques were rated by at least 38 out of the 39 total qualified experts. The most highly used therapeutic technique was empathy, normalization, acceptance, and validation of client's feelings and experiences (M = 6.92). Experts also frequently endorsed using the techniques of externalizing discrimination and negative beliefs that lead to minority stress by placing blame for discrimination and negative events on those who perpetrate it and not on the client's identity (M = 6.36), helping clients identify stressor and working on effective coping strategies (M = 6.31), helping clients connect with an affirming

community for the client which includes other trans and nonbinary folks (M = 6.18) and tailoring work to consider other diversity factors such as race, where they are in transitioning, willingness, openness, neurodivergence, etc. (M = 6.18). Out of 56 items, 48.21% had a mean score of 5 or above indicating professionals, on average, use them "frequently" or more often. 18.52% of items had a mean score of 3 or less indicating they were endorsed at a rate of "occasionally" or less on average by professionals. These values indicate that techniques tended to be used more frequently than not. The least frequently used technique was hypno therapy for trauma processing (M = 1.36). Other less frequently used techniques were eye movement desensitization and reprocessing (EMDR) future-oriented protocols to help clients be empowered and build safe and secure neuro networks and social networks that promote positive belief systems (M = 2.31), having clients people watch in a local busy area to see cis people come in all shapes, sized, and presentations of masc and femme to break down gender expectations (M = 2.38), use of eye movement desensitization and reprocessing (EMDR) to process traumatic memories, emotional distress, core beliefs, and stress responses (M = 2.46), and ecotherapy such as the use of nature and connection to the natural world to ease anxiety and stress (M = 2.69). Lower rated items, tend to be those that require specific training (e.g. EMDR) or are not commonly known or named techniques in therapeutic treatment (e.g. people watching).

Helpfulness of Therapeutic Techniques

Professionals additionally rated the helpfulness of the 56 suggested therapeutic techniques. All techniques were rated by at least 38 out of the 39 total qualified experts. The technique rated most helpful was empathy, normalization, acceptance, and validation of client's feelings and experiences (M = 6.82). Experts also frequently endorsed the high helpfulness of advocating for your client's needs and rights (M = 6.62), tailoring work to consider other

diversity factors such as race, where clients are in transitioning, willingness, openness, neurodivergence, etc. (M = 6.59), evaluating the support the client has and find/discuss resources where needed (legal, physical, community, money, housing, etc) (M = 6.54), and education, validation, and normalization around internalized transphobia including how it shows up, how it is developed, power systems that contribute to it, and how to take a new perspective (M = 6.49). Out of 56 items, 92.86% had a mean score of 5 or above indicating professionals, on average, found them "somewhat helpful" or better. 7.14% of items had a mean score of less than 5 but of those values, none dropped below 4 or a "neutral" rating. This indicates that, overall, professionals found the suggested techniques to be helpful or neutral even if they were not techniques the professionals often used themselves. Nineteen items received individual scores of "somewhat harmful" from professionals and two items received "absolutely detrimental" individual ratings from professionals. Only one item was rated "somewhat harmful" by more than 3 individuals and that item was using reality therapy to help clients take responsibility and choose behaviors that meet their needs. This low rating may be explained by reality therapy being a rather unique orientation but also by the inference that transgender and nonbinary clients are doing something wrong that needs to be taken responsibility for, regarding minority stress. The two items that received scores of "absolutely detrimental" were thought selection and change through positive affirmations and self-disclosing your identity as a therapist. These techniques may have been viewed as harmful for different reasons. There is much debate among professionals in mental health fields about the appropriateness of self-disclosure which may explain why some rated this technique as detrimental. As for thought change through positive affirmation, this technique may have been found as dismissive of the thoughts being changed related to minority stress, which may be seen as invalidating to the client and therefore harmful.

The technique rated least helpful was hypnotherapy for trauma processing (M = 4.46). Other techniques rated less helpful were reality therapy to help clients take responsibility and choose behaviors that meet their needs (M = 4.61), having clients people watch in a local busy area to see cis people come in all shapes, sized, and presentations of masc and femme to break down gender expectations (M = 4.62), reducing fear through physical self-defense such as martial arts training (M = 4.74), ecotherapy such as the use of nature and connection to the natural world to ease anxiety and stress (M = 5.03). Of the techniques with lower average helpfulness, many were from very specific modalities often requiring additional training such as reality therapy, hypno therapy, and EMDR. This rating may be due to theoretical differences between practitioners and disagreements on the effectiveness of some techniques. Other techniques rated low in helpfulness tended to be stand-alone techniques that were less well known and were very specific such as marital arts, people watching, yoga, etc.

Helpfulness of Assessment Techniques

Professionals were also asked to rate the helpfulness of techniques used to assess success of techniques used to combat minority stress. Techniques were rated by at least 33 out of the 39 total qualified experts. The assessment technique rated most helpful was measuring success through personal report from the client through their subjective sense of improvement of overall well-being including changes in behaviors, unwanted symptoms, and feelings surrounding their identity (M = 6.34). Experts also frequently endorsed the high helpfulness of measuring success by clients' levels of self-esteem and confidence in their identity as well as feeling comfortable with gender exploration and their gender expression, tailoring work to consider other diversity factors such as race, where they are in transitioning, willingness, openness, neurodivergence, etc. (M = 6.20), assessing success through the client's ability to function in the world including living

as they would like, coping with internal and external stressors with minimal emotional distress, and level of engagement in with social, vocational, and educational systems (M = 6.17), assessing success through client feedback on the specific issue or problem that the client presented with and whether they have reached their general goals for treatment (M = 5.97), and assessing success through health of the client's relationships including being able to have positive social interactions, ask for what they need, and an increased ability to connect with others such as family and friends (M = 5.94). Out of 27 items, 66.66% had a mean score of 5 or above indicating professionals, on average, find them "somewhat helpful" or better. 33.33% of items had a mean score of less than 5 but of those values, none dropped below 4 or a "neutral" rating. This indicates that, overall, professionals found the suggested assessments to be helpful. The technique rated least helpful was success measurement using APA Cross Cut symptom severity to judge improvement over time (M = 4.36). Other techniques rated less helpful were success being measured using the Clinician Outcomes in Routine Evaluation-Outcome Measure (CORE OM) (M = 4.42), success measurement by using a privately developed scale to measure process outcome effects (M = 4.44), success measurement using a mood assessment that is done each week (M = 4.45), and success measurement using Beck Depression Inventory (BDI) and Beck Youth Inventory (BYI-2) to assess clients at different times in treatment (M = 4.50). Based on these results, it seems to be the consensus among current experts that more person-centered forms of assessment may be more appropriate for assessing the success of interventions relating to TGNC and minority stress instead of more formalized measures.

Discussion

The purpose of this study was to create a basis of knowledge for the methodologies current professionals working with TGNC clients are using to help their clients cope with the

effects of minority stress. To accomplish this goal, a mixed-method Delphi approach was used to elicit consensus on the frequency and perceived helpfulness of techniques currently used to help TGNC individuals cope with minority stress in mental health fields. To accomplish this, professionals were asked to answer open ended questions relating to what techniques they used for each component of minority stress, building resilience, and assessment of success. After this data was complied, experts were asked to rate each item based on how often they used it, and the item's perceived helpfulness and/or harmfulness. This project resulted in the compilation of three sets of data. The first and second set is a list of 56 techniques used by professionals to help TGNC individuals cope with minority stress, and ratings of how often these techniques are used and the perceived helpfulness of these techniques by professionals in the field. The third set of data that was gathered through this project is the perceived helpfulness of different ways to assess the success of the technique's clinicians are using to help with minority stress.

Perceived Helpfulness and Frequency of Minority Stress Interventions

Experts identified 56 techniques that can help support TGNC individuals coping with minority stress. While there were differences of opinion, overall, there was a fair amount of agreement on the most helpful techniques. The most highly rated helpful technique was empathy, normalization, acceptance, and validation of the clients' feelings and experiences. This technique is consistent with the foundational teachings of affirmative and person-centered approaches including unconditional positive regard, validation, and empathy (Knotson & Koch 2022). A qualitative study on the experience of talk therapy for transgender individuals found many TGNC individuals still feel fearful of the therapy space but the relationship and affirmation provided from the therapist can bring acceptance and hope once this fear has subsided (Applegarth & Nuttall, 2016). With that in mind, the importance of basic skills such as empathy,

acceptance, and normalization cannot be overlooked. Based on this data, it is considered of the utmost importance by current experts for working with transgender individuals and is also one of the most commonly used techniques.

Other highly rated techniques included advocacy work, education, validation, and normalization around internalized transphobia. This included how internalized transphobia shows up, how it is developed, power systems that contribute to it, and consideration of diversity factors among those who identify as transgender or nonbinary. These suggestions are reflective of the multicultural and social justice-oriented approach often brought to trans affirmative care that is inclusive of the multiple identities and power systems that may impact a TGNC client. Specifically, it echoes the core tenants of the transgender affirmative approach (TA) which is a form of therapy that emphasizes multiculturalism, social justice, advocacy, the minority stress model, and resilience (dickey & Singh, 2020). This couples with the core tenants of the American Counseling Association, which prioritizes the use of advocacy by counselors on behalf of their clients, particularly the competencies of identification and confrontation of barriers (ACA, 2018). Further research on the effect this advocacy has on TGNC clients and their therapeutic experience, has yet to be studied and may lead to interesting findings related to the importance of this recommendation.

In that same area, securing basic physical needs and community for the client was also rated highly which may reflect the known social stigma and external discrimination faced by many transgender individuals that leaves the community with higher rates of homelessness and social isolation (Grant et al., 2011). From these recommendations, understanding the needs of clients, whether they are physical, social, or emotional, were all rated highly by practitioners. Moving forward, these suggestions may help encourage clinicians to be aware of the ways they

can support their transgender clients both inside and outside the therapy space. This may include knowledge of outside resources or systemic barriers that practitioners will have to work to educate themselves on in their own local areas.

Perceived Helpfulness of Assessments

After identifying techniques that may be helpful to TGNC individuals, professionals provided recommended ways to assess the success of their therapeutic interventions. The helpfulness of these techniques was then rated. The assessment technique found to be most helpful was to measure success based on the client's levels of self-esteem and confidence in their identity/selves as well as increases in feeling comfortable with gender exploration and their gender expression. This assessment technique also touches on the importance of empowerment and the individualistic nature of growth that may be seen as someone explores their identity and learns to cope with external stressors. Overall, techniques of assessment based in the client's personal growth and ability to cope were rated much more highly than formalized assessment measures. In fact, formal assessment measures were the assessment techniques rated least helpful by participants. This may reflect the more humanistic approach in so far as it reflects the affirmation and empathy to an individual's experience and does not categorizing it with a standardized assessment. It may also reflect the lack of comprehensive and culturally competent assessments that are available for practitioners to use with transgender and nonbinary individuals that fully encompass both symptoms of psychological distress and the impact of minority stress factors (Oberheim et al., 2017). Other highly rated ways to assess success included looking at the client's ability to effectively cope and function, progression towards client's transition goals, and client feedback on whether they feel they have reached their goals. This way of measuring success, based on the clients view of their own success in treatment, is commonly used in

therapy to both strengthen therapeutic alliance and empower the client to advocate for their own mental health needs and is often considered a "common factor" to early practitioner success (DeFife & Hilsenroth, 2011). For these clients, that advocacy may also be a useful skill to have as they navigate the larger social environment in which self-advocacy may be a necessity.

Limitations

While findings from this study provide insight to current practice, there were several limitations to the project. The first limitation comes from the limited distribution and response rate of professionals who work with this population. Professionals were identified based on Psychology Today or The Queer and Trans Therapists of Color network. Individuals in mental health care who serve this community but are not a part of either of these databases would only have been exposed to the research through friends or coworkers that took the initiative to send it along. This could limit the number of professionals who may have valuable insight that were not exposed to the possibility of discussing the techniques they used. Another limiting factor was the use of reporting via typed responses and phone calls. While typed responses provided a flexibility that phone calls could not, the quality of responses varied greatly from professional to professional with some giving in depth explanations of specific techniques and some only naming a therapeutic framework such as cognitive behavioral therapy. The lack of detail in some responses made it difficult to fully and accurately incorporate the suggestions provided by some professionals into the technique list. Lastly, while the suggestions of qualified professionals with expertise is of great value and importance, this list and project included no input from the individuals who are receiving the services listed. Because that is the case, the effectivity or even responsiveness of clients to these techniques is unknown and is a future avenue of research that should be explored in order to truly begin understanding how best to help this population cope

with the difficulties of minority stress. The history of discrimination and pathologization of transgender and nonbinary individual cannot and should not be ignored. To prevent this in future practice and recommendations, the opinions and responses of these individuals is vital to producing thorough and helpful techniques for professionals. An additional limitation is that these techniques primarily apply to adults. While some professionals worked with adolescents, these individuals were in the minority. Due to this, these techniques may not be appropriate for those who are not adults and additional research should be conducted in order to determine the efficacy of this project as it relates to children.

Conclusions

As the needs of transgender clients are more widely recognized, mental health professionals will have to be prepared to help their clients cope with the minority stress factors that may influence their mental health and overall well-being. To reach consensus on this topic, a Delphi method was use in order to obtain expert consensus on the helpfulness and frequency of use on recommended therapeutic techniques and assessments. Experts recommended techniques and then provided consensus through an anonymous rating system. Our study found that current experts in the field recommend the use of empathy, normalization, validation, and acceptance of individual clients' feelings and experiences relating to minority stress as the most helpful way for mental health professionals to assist their clients in coping with minority stress. Secondary to this, professionals suggested the use of advocacy, community and need-based support, and consideration of multicultural factors that clients may bring into sessions. Expert consensus on assessment techniques suggested the use of formal measures are not helpful for these clients, but instead, assessment through looking at the improvements clients show in self-esteem, confidence, coping, and functioning are helpful measures of success. It was also suggested by

many experts that using client goals for treatment and basing success on the completion of those goals was a very helpful assessment tool.

This project creates many future avenues of study that can aid the field of mental health care in its quest to support TGNC individuals. Most fundamental to the purpose of this study, future research should explore empirical support for the highly rated suggested techniques. Creating evidence-based practices for working with individuals within minority identities allows for mental health professionals to support their clients in a way that is known to be helpful to them. Particularly for communities who have been wronged by mental health fields in the past, evidence would provide a basis for interventions that are shown to be helpful, and not just assumed to be. Along with this, research should continue to investigate the perceived helpfulness of these methods according to the clients they are meant to serve. Information as to how transgender individuals feel about these interventions may be helpful in tailoring techniques to be more affirming or inclusive of their experiences.

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Table 1

Table 1. Expert's Ratings of Techniques Used to Assist Transgender and Nonbinary Clients in Coping with Minority Stress

	Frequency of Use				**Helpfulness**			
Techniques	**Mean**	**Mode**	**IQR**	**n**	**Mean**	**Mode**	**IQR**	**n**
1. Empathy, normalization, acceptance, and validation of client's feelings and experiences	6.92	7.00	0.00	39	6.82	7.00	0.00	39
2. Externalizing discrimination and negative beliefs that lead to minority stress by placing blame for discrimination and negative events on those who perpetrate it and not on the client's identity	6.36	7.00	1.25	39	6.36	7.00	1.00	39
3. Helping clients identify stressor and working on effective coping strategies	6.31	7.00	1.25	39	6.33	7.00	1.00	39
4. Tailoring work to consider other diversity factors such as race, where they are in transitioning, willingness, openness, neurodivergence, etc.	6.18	7.00	2.00	39	6.59	7.00	1.00	39
5. Help client connect with an affirming community for the client which includes other trans and nonbinary folks	6.18	7.00	2.00	39	6.38	7.00	1.00	39
6. Advocating for your client's needs and rights	6.08	7.00	2.00	39	6.62	7.00	1.00	39
7. Education, validation, and normalization around internalized transphobia including how it shows up, how it is developed, power systems that contribute to it, and how to take a new perspective	6.03	6.00	1.00	39	6.49	7.00	1.00	39
8. Working with the client on developing problem-solving skills	5.92	7.00	2.00	39	6.38	7.00	1.00	39
9. Teaching assertiveness and practicing skills such as conflict management skills, self-	5.92	7.00	2.00	39	6.26	7.00	1.00	39

advocating, and boundary setting								
10. Managing and discussing the loss that comes from being transgender/nonbinary whether that is loss of friends, rights, old identity, understanding, acceptance, etc.	5.85	7.00	2.00	39	5.97	6.00	2.00	39
11. Clarification of the client's values, goals, and strengths and working to base actions on these values, goals, and strengths while making sure the goals are attainable	5.85	7.00	2.00	39	6.41	7.00	1.00	39
12. Addressing trauma, using trauma informed care, and exploring systemic oppression through a social justice-oriented intervention	5.84	7.00	2.00	38	6.15	6.00	1.00	39
13. Processing negative emotions and shame connected with internalized transphobia	5.82	6.00	2.00	39	6.26	7.00	1.00	39
14. Goal planning including identifying desire, feelings, appearance, identity and core beliefs and work on committed action based on values (goals for transitioning)	5.82	6.00	2.00	39	6.26	7.00	1.00	39
15. Treatment of symptoms of depression and anxiety or other disorders that may be causing stress in order for interventions concerning minority stress to be more helpful	5.74	6.00	2.00	39	6.10	6.00	1.25	39
16. Evaluate the support the client has and find/discuss resources where needed (legal, physical, community, money, housing, etc)	5.72	7.00	2.25	39	6.54	7.00	1.00	39
17. Discussions about preparedness including how to anticipate violence/discrimination, problem solving, and safety planning considering the	5.67	7.00	2.00	39	6.13	6.00	1.00	39

information known about a person or situation								
18. Psychological education to explore trauma, systematic oppression, and gender diversity optionally through feminist perspective	5.62	6.00	2.00	39	5.92	6.00	1.00	39
19. Using experience, perspective, and resiliency to help the client learn to cope and be hopeful	5.54	6.00	1.25	39	5.97	6.00	2.00	39
20. Helping clients identify physical and psychological signs of distress or anxiety and how this may limit the activities they choose to pursue	5.49	6.00	2.25	39	6.05	7.00	2.00	39
21. Taking an equal or lesser power role in the relationship to support the client in practicing self-determination, self-discovery, and empowerment.	5.36	6.00	3.00	39	5.64	5.00	2.25	39
22. Self-disclosing gender identity as a therapist	5.36	7.00	3.00	39	5.46	6.00	2.25	39
23. Use of social media to hear other trans and nonbinary stories, tips, and information to lessen loneliness	5.31	6.00	2.00	39	5.64	6.00	1.00	39
24. Using perspective and challenging/reframing negative experiences to prevent internalization and help client move forward	5.15	5.00	2.00	39	5.79	6.00	1.00	39
25. Identify how internalized transphobia limits the client and discuss the impact that it has on their lives	5.13	7.00	3.00	39	5.56	6.00	1.25	39
26. Encouraging curiosity over fear	5.08	5.00	2.00	39	5.69	6.00	1.00	39
27. Mindfulness exercises such as grounding and breathing techniques	5.08	6.00	2.25	39	5.69	6.00	1.00	39
28. Coordination of care with multidisciplinary team	4.97	6.00	2.00	39	6.10	6.00	1.25	39
29. Use of cognitive behavioral therapy (CBT) for a variety of interventions such as gauging	4.95	6.00	2.00	39	5.49	5.00	1.00	39

the reality of future harm, identifying learned cognitive behavioral patterns and distorted beliefs from cis-normative society, and resolving cognitive dissonance								
30. Interpersonal therapy for working with those who are coming out to others and adapt to a new role in life living as their authentic self	4.72	6.00	2.00	39	5.87	6.00	1.00	39
31. Working with clients to improve emotional distress tolerance such as dialectical behavioral therapy (DBT) skills	4.55	4.00	3.25	38	5.59	6.00	1.00	39
32. Relational interventions used to examine the client's relationship with the therapist or their relationships with others outside of therapy	4.54	5.00	3.25	39	5.64	6.00	1.00	39
33. Using exposure in safer places such as LGBT spaces to allow the client to be authentic and safely face fears then discuss the experience with a therapist	4.47	4.00	1.25	38	5.54	5.00	1.00	39
34. Reframing being and coming out as trans or nonbinary as a form of activism that serves to reduce stigma for the next generation to give difficult experiences meaning	4.42	4.00	4.00	38	5.23	5.00	1.00	39
35. Emotional Regulation Therapy such as the identification and management of difficult emotions for the treatment of anxiety	4.38	6.00	3.25	39	5.67	6.00	1.00	39
36. Thought selection and change through positive affirmations	4.15	1.00	2.50	39	5.21	5.00	1.25	39
37. Counteract internalized transphobia by having client describe positive feelings (e.g., liking, attraction, etc.) towards other trans and gender non-binary individuals	4.15	3.00	3.25	39	5.29	5.00	1.00	38

38. Referral to a group therapy for community building	4.12	4.00	3.00	39	5.38	5.00	1.00	39
39. Provide spirituality resources and/or discuss spirituality if the client wishes.	4.03	2.00	2.25	39	5.34	5.00	1.25	38
40. Using narrative therapy to develop skills and knowledge from the client's personal journey as well as examining and connecting with other people who may have similar experiences	4.00	5.00	3.00	39	5.61	6.00	1.00	39
41. Motivational Interviewing to encourage empathy and support self-efficacy	3.97	4.00	2.25	39	5.46	5.00	1.00	39
42. Using somatic experiencing as a technique for clients to process their physical responses to trauma and find safe spaces either physically or mentally to cope with those responses	3.95	5.00	4.25	39	5.44	6.00	1.25	39
43. Social Emotional Learning to increase self-awareness and management, social awareness, relationship skills and good decision making	3.87	1.00	3.50	39	5.29	5.00	2.00	38
44. Psychodynamic interventions to address distorted beliefs	3.82	4.00	3.25	39	5.13	5.00	1.25	39
45. Somatic experiencing to help individuals build awareness, coherence, and self-regulation by physically releasing the distress that may come from current or past trauma	3.72	1.00	4.25	39	5.34	5.00	1.25	38
46. Creative techniques such as use of an art form or literature to explore thoughts and feelings around internalized transphobia or identity	3.05	1.00	4.00	39	5.18	5.00	1.25	39
47. Body related practices such as yoga	2.90	1.00	3.25	39	5.13	5.00	0.25	39
48. ACT Interventions such as creative hopelessness which is a technique that emphasizes	2.87	1.00	4.00	39	5.05	5.00	2.00	38

examining avoidance behavior and it's cost to the client								
49. Internal Family Systems (IFS) to help externalize the transphobia and related negative beliefs while working on improving relationship with self	2.82	1.00	3.00	39	5.46	5.00	1.00	39
50. Reality Therapy to help clients take responsibility and choose behaviors that meet their needs	2.74	1.00	3.00	39	4.61	4.00	1.00	38
51. Ecotherapy such as the use of nature and connection to the natural world to ease anxiety and stress	2.69	2.00	3.00	39	5.03	5.00	1.00	39
52. Use of eye movement desensitization and reprocessing (EMDR) to process traumatic memories, emotional distress, core beliefs, and stress responses	2.46	1.00	3.25	39	5.05	6.00	2.00	38
53. Have clients people watch in a local busy area to see cis people come in all shapes, sized, and presentations of masc and femme to break down gender expectations	2.38	1.00	3.00	39	4.62	4.00	1.00	39
54. Eye movement desensitization and reprocessing (EMDR) future-oriented protocols to help clients be empowered and build safe and secure neuro networks and social networks that promote positive belief systems	2.31	1.00	3.25	39	5.11	4.00	2.00	38
55. Reducing fear through physical self-defense such as martial arts training	2.13	1.00	1.25	38	4.74	4.00	2.00	39
56. Hypno therapy for trauma processing	1.36	1.00	0.00	39	4.46	4.00	1.00	39

Table 2

Table 2. Expert's Ratings of Techniques Used to Assess the Success of Interventions with Gender Minority Clients

	Helpfulness			
Technique	**Mean**	**Mode**	**IQR**	**n**
1. Success of intervention is measured by personal report from the client through their subjective sense of improvement of overall well-being including changes in behaviors, unwanted symptoms, and feelings surrounding their identity.	6.34	7.00	1.00	35
2. Success of intervention is measured by clients showing higher levels of self-esteem and confidence in their identity and selves as well as feeling comfortable with exploration and their gender expression	6.20	6.00	1.00	35
3. Success of intervention is assessed through the client's ability to function in the world including living as they would like, coping with internal and external stressors with minimal emotional distress, and level of engagement in with social, vocational, and educational systems	6.17	7.00	1.25	35
4. Success is measured using client feedback on the specific issue or problem that the client presented with and whether they have reached their general goals for treatment	5.97	6.00	1.00	35
5. Success of intervention is assessed through health of the client's relationships including being able to have positive social interactions, ask for what they need, and an increased ability to connect with others such as family and friends	5.94	7.00	2.00	35
6. Success is measured by having conversations through a process that allows for conversation so a client can reflect in sessions	5.91	6.00	1.25	35
7. Success of therapy is measured by the progression the client has in their desire transition process including increased insight into their identity and expression, increased comfort in their identity and pursuit of transition goals they may have.	5.89	6.00	0.25	35
8. Success is measured based on the clients increased feelings of hope for the future	5.77	6.00	1.00	35
9. Success is measured by the client no longer needing therapy and allowing them to continue in their next chapter	5.77	6.00	1.25	35

10. Success is measured by the client's ability to identify/articulate themselves and the things they need while achieving a balanced internal locus of control.	5.74	6.00	2.00	35
11. Success is measured using clinical interviews with client to address progress within the treatment plan	5.65	6.00	1.00	34
12. Success is measured using specific treatment goals and measuring movement towards those goals with periodic discussions	5.59	6.00	1.00	34
13. Success is measured by the clients shift in language signaling reduction in fear and internal oppression as well as increased self-positive actions and verbalizations	5.54	6.00	1.00	35
14. Success is measured through the amount of psychological flexibility that the client has and their increased willingness to explore and try new things aligned with their identity	5.29	5.00	1.00	35
15. Success of intervention is measured through the client's engagement with treatment	5.20	5.00	2.00	35
16. Success is measured based on the client's ability to set boundaries	5.15	5.00	1.00	34
17. Success of intervention is measured by clinical observation by the therapist	5.00	5.00	1.25	35
18. Success is measured using WPATH resources	5.00	4.00	2.00	34
19. Success is measured using feedback from a multidisciplinary team	4.94	5.00	1.25	34
20. Success is measured using family reports or changes that others have noticed in the client	4.82	5.00	2.00	34
21. Success is measured using a brief screening tool for improvement in anxiety, depression, self-esteem and/or other mental health symptoms	4.82	5.00	1.25	34
22. Success is measured using BDI and BYI-2 to assess clients at different times in treatment	4.50	4.00	1.00	32
23. Success is measured using BDI-II or BAI	4.50	4.00	1.00	32
24. Success is measured using a mood assessment that is done each week	4.45	4.00	1.00	33
25. Success is measured using a privately developed scale to measure process outcome effects	4.44	4.00	1.00	34
26. Success is measured using the CORE OM	4.42	4.00	1.00	33
27. Success is measured using APA Cross Cut symptom severity to judge improvement over time	4.36	4.00	1.00	33