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Informing consent: A grounded theory study of parents of transgender and gender diverse youth seeking gender confirming endocrinological interventions

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Informing Consent: A Grounded Theory Study of Parents of Transgender and Gender Diverse Youth Seeking Gender Confirming Endocrinological Interventions

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DEDICATION

I dedicate this dissertation to Nicki, my devoted partner of more than 14 years and the open, flexible, accepting mother to our two children, Emily Elizabeth and Alice Adele. Your love, patience, wisdom, encouragement, flexibility, and forgiveness have sustained me.

I also dedicate this dissertation to young people everywhere who have the consciousness and courage to tell the truth about themselves and to advocate for their own self-actualization.

May we all live in a world that arcs toward curiosity, understanding, acceptance, and love. May this project make a meaningful contribution to the efforts everywhere to bring that dream to fruition.

"Your son," said an old uncle to Crispin's father, "he's not your typical dragon, is he?"

"No," replied Crispin's father, proudly. "My son is something special."

And then he jumped up and danced to Crispin's music, too.

Excerpt from the children's book *Not Your Typical Dragon*,

by Dan Bar-El and illustrated by Tim Bowers.

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protocol used in this study accurately evoked the targeted information and also was sensitive to the realities of participants. And finally, to every person who identifies as transgender or gender diverse who has been in my life and had the guts to lean in to me, help soften my edges, and light my path to this point, may your work and your suffering not be in vain. May this research contribute to the effort to give transgender youth the open and affirming world you should have had.

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ABSTRACT

Transgender and gender-diverse (TGD) identity during the Twenty-first Century in the United States has been associated with pervasive patterns of mistreatment and discrimination across social, educational, occupational, legal, and healthcare experiences (Drescher, 2010; James et al., 2016; Stryker, 2008). Despite these trends, affirming stances toward TGD identity has been developing almost simultaneously tracing its roots to Christine Jorgensen's transition in the 1950s. About a decade later, endocrinological interventions were pioneered that aimed to medically support TGD patients who wished to feminize or masculinize their bodies to be more congruent with their gender identity without surgery. These gender-confirming endocrinological interventions (GCEI) have been associated with positive physical and mental health outcomes and have been made available to people across the developmental life span from pre-puberty through late adulthood. However, nearly all of the research regarding GCEI has been conducted on adults. GCEI have been growing in popularity among TGD minors, but in the United States minors almost always need their parents or legal guardians to provide informed consent for GCEI. The literature on the long-term risks and benefits of GCEI on minors is ongoing but not complete. This leaves both TGD youth and their parents in a position to make meaningful decisions without a body of rigorous research to instill confidence in giving or denying consent. This qualitative grounded theory study is the first of its kind aimed at better understanding the decision-making process that parents and guardians of TGD youth go through when providing informed consent for the minor in their care to undergo GCEI. Using primarily intensive interviews supported by observational field notes and document review, this study examined the decision-making processes of a

national sample of participants who identified as a parent or legal guardian of at least one TGD youth and who have given informed consent for the youth in their care to undergo GCEI. A variety of inhibiting and contributing factors were illuminated as well as a "dissonance to consonance" model that participants used to combine contributing factors to overcome inhibitors and grant informed consent. Implications for professional counseling practitioners and counselor educators are discussed.

Chapter 1: Introduction

Gender Diversity in the United States

Transgender and gender-diverse (TGD) identity during the Twenty-first Century in the United States has been associated with pervasive patterns of mistreatment and discrimination across social, educational, occupational, legal, and healthcare experiences (Drescher, 2010; James et al., 2016; Stryker, 2008). According to the 2015 U.S. Transgender Survey (USTS), more than half (54%) of the nearly 30,000 adult (i.e., 18 and older) respondents from all fifty states, U.S. military bases, and territories around the world reported being verbally harassed for reasons related to their gender identity. Nearly a quarter (24%) reported being physically attacked and 13% reported being sexually assaulted because of their gender identity. Nearly a third of respondents (30%) reported workplace mistreatment—such as being fired or denied a promotion—in relation to their gender identity, and 17% percent reported experiencing such severe mistreatment that they left school. Closer to home, 10% of respondents whose gender identity was known to their immediate family reported that a family member had acted violently toward them because of their gender identity, and 8% reported that they had been kicked out of their house because of their gender identity.

TGD people have been shown to be overrepresented in populations associated with negative mental, physical, and social health outcomes, such as those suffering from suicidality and homelessness (James et al, 2016). While the rate for attempted suicide in the United States is 4.6%, 40% of USTS respondents reported a suicide attempt within their lifetime. Generally concerning mental health, 39% of USTS respondents reported experiencing serious psychological distress within a year of the survey. Only 5% of the

general U.S. population reported similar experiences during that same time period. Among transgender older adolescents and young adults, 25% to 32% have reported a previous suicide attempt (Grossman & D'Augelli, 2007). As striking as these numbers are, TGD people have also been shown to have had their access to healthcare limited by stigma and discrimination by healthcare providers (James et al, 2016). One-third (33%) of USTS respondents reported experiencing at least one negative experience with a healthcare provider in relation to their gender identity, and nearly a quarter (23%) did not seek services for fear of being mistreated. One-third (33%) did not seek healthcare due to an inability to afford the cost of services. These disparities have been among the motivators of the current movement to make healthcare more affirming of TGD people (Vincent, 2019).

Factors that support the non-affirmation of TGD people can find their roots across a variety of intersecting segments of American society. One of the more prominent influencers of non-affirmation in the United States has been religion. More than 70% of the U.S. population identifies as Christian, with more than half the population practicing Christianity in ways that have been traditionally non-affirming of lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual, and pansexual (LGBTQ+) perspectives and practices (Pew Research Center, 2014). Chronic suicidal thinking among lesbian, gay, transgender, and bisexual (LGBT) people ages 18 to 24 has been associated with parents' non-affirming religious beliefs, and fears about being forced to leave one's religion have been associated with a suicide attempt within a 12-month period for the same population (Gibbs & Goldbach, 2015). According to the LGBT Homeless Youth Survey (Durso & Gates, 2012), LGBT youth comprised 40% of the populations served by

354 agencies serving homeless youth that responded. Of the 381 youth that responded to the survey, 46% reported that they ran away from home because of family rejection of their affectional orientation or gender identity, and 43% reported that they were forced out by their parents because of their affectional orientation or gender identity.

Religion has been closely associated with recent changes in state legislation and federal policy that suggest that disparities in the treatment of TGD people are socially and professional acceptable. At least three states have passed legislation that has included what is known as a *conscience clause*. These healthcare-related laws have allowed for legal protection for healthcare providers to refuse services to clients with requests for help in ways that conflict with particular religious beliefs (Daley, 2017). In 2018, conscience-clause type considerations were expanded to the federal level when the U.S. Department of Health and Human Services (HHS) announced the creation of the Conscience and Religious Freedom Division (CRFD) in the HHS Office for Civil Rights (OCR) (HHS, 2018). CFRD policy has explicitly cited protections for healthcare practitioners who decline to provide services related to abortion and assisted suicide (HHS, 2018b); however, some have noted that the division's loose language could leave room for healthcare providers to deliver sub-standard care for clients and patients with concerns related LGBTQ+ identification (Gonzalez, 2018). In fact, an HHS spokesperson has stated on the record that the department would not interpret prohibitions on sex discrimination in health care to cover gender identity (Gonzalez, 2018).

Despite these non-affirming trends, other TGD affirmation trends in the United States have been developing almost simultaneously. The general social consciousness of gender variance in the United States can be traced to the attention that Christine

Jorgensen commanded during her transition in the 1950s (Drescher, 2010; Stryker, 2008). About a decade later, a Manhattan physician named Harry Benjamin pioneered endocrinological interventions aimed at medically supporting TGD patients who wished to feminize or masculinize their bodies to be more congruent with their gender identity without surgery. Benjamin's work has developed into what have been termed gender-confirming endocrinological interventions (GCEI), have been associated with positive physical and mental health outcomes (Bränström & Pachankis, 2019; Couric, 2017; Drescher, 2010; Murad et al., 2010), and have been made available to people across the developmental life span from pre-puberty through late adulthood (Coleman et al, 2012; Hembree et all, 2017).

To this point in history, nearly all of the research regarding GCEI has been conducted on adults (Couric, 2017); however, GCEI have been growing in popularity among TGD minors (Couric, 2017; Drescher, 2010; Kennedy, 2008; Pew, 2013; Rosin, 2008), i.e., people who have not yet reached the age of majority in their respective state (Fulmer, 2002). In the United States, minors are almost always depended on their parents or legal guardians to provide informed consent for GCEI (Burt, 2016) even though they are likely to be considered by the medical profession to be cognitively capable of making an informed choice to undergo hormone-related treatments (Coleman et al, 2012; Hembree et all, 2017). Studies to contribute to the literature on the long-term risks and benefits of GCEI on minors is ongoing but not complete (S. Rosenthal, personal communication, November 7, 2019). This leaves both TGD youth and their parents—who are unlikely to share their child's gender identity—in the precarious position of making meaningful decisions about the youth's mental and physical health in a climate

dominated by legal, political, religious, and social trends and without a body of rigorous research to instill confidence in giving or denying consent.

The Relationship Between Gender Diversity and Professional Counseling

Professional counselors who work with TGD youth and their families have unique opportunities to serve their clients and the micro-, meso-, and macrolevels. With professional emphases on human development, the helping relationship, and social justice, counselors develop competency related to addressing issues related to gender identity, spirituality, and social systems to enable the empowerment of clients through individual, group, and family counseling in addition to interprofessional consultation and advocacy (ACA, 2014; ACA, 2018). To assist with this process, the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC), the Society for Affectional, Intersex, and Gender-Expansive Identities ([SAIGE] formerly known as the Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling, or ALGBTIC), and the Association for Multicultural Counseling and Development (AMCD) have published relevant counseling competency standards in 2009, 2012, and 2015, respectively, that align with and support the American Counseling Association's stance that TGD identity is a normal part of human development and should be affirmed (ALGBTIC, 2009). This is a stance that aligns with the position of every major healthcare professional organization globally (Drescher, 2010). Professional counselors are likely to be presented with opportunities to provide psychoeducation about gender identity development and best practices regarding the affirming care of TGD clients as well as opportunities to advocate for their clients through the writing of referral letters for GCEI (Coleman et al, 2012).

Background of the Problem

Brief History

Since at least the Nineteenth Century, Western culture has struggled to understand the constructs of gender identity and gender expression and the implications that these aspects of human development present for mental and physical health. Studies related to gender variance began to be published in the United States a little more than 100 years ago (Drescher, 2010; Hill & Menvielle, 2009); however, the consensus of the helping professions at that time, led by psychiatry and psychoanalysis, considered gender variance to be pathological and that treatment should emphasize "reparative" interventions, i.e., efforts to help a person express and identify as a gender that aligns with sex assigned at birth within a binary—male and female—conceptualization (Drescher, 2010; Hill & Menvielle, 2009; Tontonoz, 2017). This perspective aligned with the way that major religious teachings sanctioned gender identity and expression, and substantial contributions to the literature on gender variance were conducted by researchers that ascribed to these religious perspectives and claimed evidence that supported the efficacy of reparative approaches (Dobson, 2001; Drescher, 2010; Hill & Menvielle, 2009; Nicolosi & Nicolosi, 2001; Rekers et al, 1974).

Meaningful challenges to this pathology/reparative perspective began in the 1950s and were supported by innovative, affirming approaches from helping professionals like Benjamin and the influence of notable social events like the transition of Jorgenson in 1952 and the riot at the Stonewall Inn in 1969 (Drescher, 2010; Hooker, 1957; Marcus, 2002; Riess, 1980; Siegelman, 1972; Stryker, 2008). Benjamin became well known in the 1960s for providing gender-confirming endocrinological interventions (GCEI), such as

cross-sex hormone replacement therapy (HRT). While this practice has been associated with improved physical and mental health outcomes in adults (Bränström and Pachankis, 2019; Coleman et al, 2012; Couric, 2017; Murad et al, 2010). However, there are currently no peer-reviewed, published studies regarding the long-term physical and mental health outcomes for minors in the United States and research is scant generally on GCEI with youth (Bunim, 2015; Coleman et al, 2012; Hembree et al, 2017).

The success of GCEI with adults, changing social attitudes, and the insistence of youth have contributed, at least in part, to the growing popularity of minors gaining access to GCEI (Couric, 2017; Drescher, 2010; Kennedy, 2008; Pew, 2013; Rosin, 2008). The limited knowledge base about the comprehensive and long-term effects of GCEI on developing bodies has left room for other factors to complicate the decision-making processes of parents—who almost always have the power to grant informed consent—who have a child interested in GCEI (Burt, 2016). Factors such as persistent religious condemnation and governmental challenges to this practice contribute to what have been termed conflicts of conscience for parents, youth, and the counselors who serve them (Almasy, 2019; Andrew, 2020; Asmelash, 2020; Dailey, 2017; Grinberg, 2019).

Influence of Religious Perspectives

Religion and LGBTQ+ affirmation have a long and contentious history, and this form of conscience conflict has impacted TGD people across social, occupational, legal, and familial domains of life. Conscience conflicts in the United States have been dominated by contributions from Christian activists, researchers, and governmental representatives.

The Bible, which contains the primary religious texts of Christianity and Judaism, references LGBTQ+ related topics a handful of times between its Old and New Testaments. These references are considered by many to condemn same-sex erotic/romantic relationships (Karslake, 2007; Vines, 2014). A few other biblical passages reference, and are considered by many to condemn, behavior common amongst the TGD community (Drescher, 2010). Prior to the Renaissance, the construction of social values was primarily the province of religion, and religion has historically considered LGBTQ+ identity and behavior condemnable. The rise of Western secularism in the mid-19th century, however, motivated philosophers and scientific thinkers alike to challenge tradition, perhaps providing the context for the study of sexual and gender-related issues. Further complicating matters is the tradition that religion and science have often developed in close, contentious relationship to each other (Vines, 2014). This continues today in that many non-affirming researchers hale from conservative religious traditions and training (Hill & Mienville, 2009), and many non-affirming religious leaders consider themselves members of the helping professions (Karslake, 2007). Even though every major international medical and mental health professional organization has issued statements endorsing LGBTQ+ affirming practice (Drescher, 2010), clinicians within these organizations continue to protest, eschew ethical guidelines, and advocate for legal protection of their non-affirming practices. Professional counseling has not been immune to this controversy.

The ACA has had some of the most prominent conflicts with members regarding issues of religious values and LGBTQ+ affirmation. The ACA made an effort to clarify its LGBTQ+ affirming position for its members and the field of professional counseling

with its 2014 ACA Code of Ethics. Furthermore, the code clarified that counselors should avoid harming those in their care, and that counselors refrain from referring prospective and current clients based solely on the counselor's personally held values, attitudes, beliefs, and behaviors. New to the 2014 code was a clause stating that counselors avoid imposing their own values upon clients (Kaplan, 2018). These clarifications were spurred, at least in part, by two prominent legal challenges to the 2005 code: *Ward v. Wilbanks* and *Keeton v. Anderson-Wiley* (Kaplan, 2014). Although both cases concluded in ways that affirmed the ACA code of ethics (Kaplan, 2014; Kaplan 2018), the implications of these challenges have impacted the way LGBTQ+ clients are served by a variety of different stake holders across a variety of different disciplines, including clergy, counselors, psychologists, and medical doctors, as well as agents of all three branches of government at the state and federal levels (Paproki, 2014; Prairie et al, 2018).

As was referenced earlier, legislative and executive branches of government have moved at the state and federal levels to provide protection to human-services practitioners who wish to deny or refer services based on sincerely held religious beliefs. Even with legal and regulatory protection, these measures often put counselors of faith at odds with their own profession. This runs the risk of putting religiously affiliated parents, in seeking the assistance of a religiously affiliated counselor, at odds with their child. Meanwhile, service refusal, referral, and non-affirming responses to same-sex affectional orientation and gender variance have been shown to be closely associated with higher rates of suicide and victimization (Gibbs & Goldbach, 2015; Kralovec et al, 2012).

People of faith, however, are not necessarily required by their religious guidelines to act in non-affirming ways. LGBTQ+ affirming perspectives on theology and the

interpretation of sacred texts like the Bible, have existed for hundreds of years (Karslake, 2007). Furthermore, there is a growing body of literature across the conservative to progressive continuum that supports LGBTQ+ affirmation among people of faith (Vines, 2014; Gushee, 2015). These voices appear to be describing a pathway toward ally-ship for people of faith, and counselors appear to be well positioned to lead the way in that direction.

Scientific Perspectives

Many people who encounter conscience conflicts regarding TGD affirmation engage in an effort to integrate scientific understanding of an issue and relevant theological perspectives. Whether or not science and theology can be practically and meaningfully integrated is complicated by the fact that interpretation of scientific methods and interpretation religious writings often require different tools and approaches (Tenneson, Bundrick, & Stanford, 2015). Religiously rooted scholars across scientific and theological domains have provided models for this task that range from privileging traditional interpretations of religious scripture over the interpretation of the results of a scientific study of a phenomenon (Yarhouse, 2011) to viewing science and theology to been in superficial conflict but deep harmony (Tenneson et al., 2015). The resolution to a conscience conflict appears to depend heavily on the mode one uses to integrate these two phenomena; however, there is a growing call for LGBTQ+ affirmation even among traditionally conservative religious circles (Gushee, 2015). One study found that the switch from LGBTQ+ non-affirmation to more affirming perspectives and practices actually led to a deepening of religious faith and practice rather than a dissolution thereof (Minnix, 2018).

For more than a century, there have been scientific results that confirm that gender identity and expression are not binary, and acceptance of gender variance has been growing in the scientific and healthcare professions since the 1980s to the point that every major healthcare professional organization has espoused TGD affirmation (Drescher, 2010).

Gender Identity within Human Development

Studies of cisgender and binary gender identity have shown that a person's awareness of gender identity emerges with some stability as early as 3 years of age (Gülgöz et al, 2019) and early studies of what would currently be considered transgender identity included participants who reported an awareness of their transness at an early age (Drescher, 2010). More recently, Gülgöz and colleagues (2019) reported that in a study of more than 300 transgender children between the ages of 3 and 12 years, transgender children strongly identified as members of their current and self-identified group and showed gender-typed preferences and behaviors strongly associated with that identity; transgender children's gender identity and gender-typed preferences did not differ from the two cisgender. The researchers suggested that early sex assignment and parental rearing based on that sex assignment do not always define how a child identifies or expresses gender, perhaps lending support to the earlier theories of Hirschfeld and Money that gender identity was formed and crystalized during early childhood, and Benjamin's theory in that it appears to develop and crystalize more independently of parental rearing or other environmental factors than biological (Brill & Kenny, 2016; Brill & Pepper, 2008; Drescher, 2010).

Role of Parents in Supporting TGD Youth: Developmental and Legal Questions

Parents and legal guardians of TGD youth, regardless of their religious affiliation, often have concerns about the trustworthiness of childhood and adolescent gender identity development, questionable adolescent emotional regulation and impulse control, and the potential consequences for a young person who regrets the decision to transition after receiving partially reversible interventions. Prominent child and family therapy researchers, such as Siegel (2013), have noted that adolescents are notorious for poor executive functioning related to their ongoing neurological development, especially of the prefrontal cortex of the brain. Nevertheless, key developmental tasks like improving impulse control, planning and follow through, and emotional regulation have been shown to be best supported by a parent-child relationship that is characterized by inclusivity. As Wallin (2007) noted, this means that "the parent makes as much space as possible for the full spectrum of the child's subjective experience" and attends not just to what the child says but also what the child does (p. 116). This has important implications for a young person's experience of affirmation, especially as it pertains to accessing GCEI because the burden of providing informed consent almost always rests with the parents or guardians (Burt, 2016).

At issue in the case of a TGD minor whose wishes to receive GECI conflict with their parents' or legal guardian's consent are what legal scholars call the *doctrine of parental rights* and the *mature minor rule* (Coleman, 2019; Coleman & Rossoff, 2013; Priest, 2019). The doctrine of parental rights generally allows that parents have the final authority to give consent for medical care and treatments for their children who have not reached the age of majority in their respective jurisdiction (i.e., state of residence). The

mature minor rule allows for older teenagers, in at least some instances, to give consent to medical care and treatment.

With historical, developmental, religious, psychological, and legal factors outlined above in mind, there is little argument that the parents of TGD youth, charged with whether to grant informed consent or not for their minor child to access GCEI, carry a heavy burden. However, very little is understood about the experiences of the parents of TGD youth generally, much less the process by through which they go to provide consent for their child's GCEI.

Role of Counselors in Supporting TGD Youth and their Families

With conscience conflicts impacting the intervention of religious and governmental leaders, the approaches of healthcare providers, and given the relative lack of instructive research, the responsibility of TGD-affirming professional counselors and other mental health providers to assist children and families through this process is immense. The navigation of difference between parents and children is one of the more common dilemmas of family therapy. For example, a father may struggle to understand the experience of his pre-adolescent daughter and therefore be inhibited in his ability to skillfully guide her through the developmental challenges she encounters. This is the type of dilemma that will affect every family in some form or fashion at every developmental stage of the individuals within the family system (Gladding, 2019; Minuchin, 1974). Fortunately, best practices for assisting families as they feel and deal with these challenges generally are well established and supported by a wide body of literature (Gladding, 2019; Wallin, 2007). However, these challenges are often complicated by the nuanced stressors—such as those of a social, developmental, and legal nature—that affect

families on a case-by-case basis. One of the more controversial dilemmas currently faced by families and family counselors involves how to best address the needs of transgender or gender-diverse (TGD) youth. This dilemma is further complicated by a variety of extra- and intra-familial stressors, and best practices are not well understood or delineated by the current body of literature (Bunim, 2015; Coleman et al, 2012; Hill & Menvielle, 2009).

Statement of the Problem

The experiences of parents and guardians of TGD youth are not well represented in the literature (Hill & Menvielle, 2009). Furthermore, the long-term risks and benefits of GCEI on developing bodies is not well understood (Coleman et al, 2012). When the variety of religious, legal, and political influences are considered, parents, guardians, youth, and the professionals who serve them have little choice than to make choices regarding informed consent and access to GCEI in a highly charged social environment without a body of research to inform their process. Nevertheless, more and more youth are showing interest in GCEI from pre-puberty through adolescence.

Purpose of the Study

The purpose of this research was to explore the process by which parents or legal guardians of TGD youth (i.e., TGD people who have not yet reached the age of majority in the jurisdiction in which they reside) develop affirmative understandings and approaches to their children's gender-identity, affirm their related transition needs, and grant informed consent for the TGD youth in their care to undergo GCEI.

Significance of the Study

To this researcher's knowledge, there are no studies related to the process that the parents and guardians of TGD minors go through to give informed consent for GCEI. This research appears to be the first of its kind related to this topic, and it appears likely to inform best practice for helping professionals serving TGD youth who wish to have an endocrinologically supported transition and those charged with giving informed consent for these interventions.

Research Questions

The primary research question of this grounded theory study is "How did the parents or legal guardians of TGD youth who have undergone GCEI decide to give informed consent?" Secondarily, "Are their specific themes that emerge for Christian, heterosexual, cisgender parents who go through this process?" Finally, "What part, if any, did a professional counselor play in the process?" This research aims to contribute to the body of literature that can inform parents—and the family counselors who support them—on how to make the best decisions possible in regard to their TGD minor.

Method

Based on these research questions, a qualitative grounded theory method was employed because this method is used by researchers attempting to understand how participants go about resolving a particular concern or dilemma (Charmaz, 2014; Glaser & Strauss, 1967). Unlike other forms of qualitative research, grounded theory guides the researcher with a set of general principles, guidelines, strategies, and heuristic devices rather than formulaic prescriptions to help the researcher direct, manage, and streamline data collection so that analyses and emerging theory are well grounded in the data

collected (Charmaz, 2014). Grounded theory methodology was developed by Glaser and Strauss in the 1960s, at least in part, to buoy the emphatic shift to quantitative methodology in the social scientific community during that era (Charmaz, 2014; Glasser & Strauss, 1967). Since then, the grounded theory approach has been further developed to accentuate its postmodern, constructivist roots.

Currently, the two popular approaches to grounded theory are the more modernist positivistic approach of Corbin and Strauss and Charmaz's more postmodern constructivist approach (Charmaz, 2014; Corbin & Strauss, 2015; Creswell, 2013). This researcher followed guidelines that blended these two approaches for the purposes of following more traditional research procedures that satisfy the structure typically embedded in the dissertation process as well as to emphasize a flattering of power hierarchies to better evoke the lived experiences of participants as they relate to this research. More constructivist aspects of this study included active coding and the avoidance of the minimization of the role of the researcher (Charmaz, 2014; Creswell, 2013).

Summary

With the improving understanding of the positive effects of gender identity affirmation and GCEI to support TGD people's transition to a gender expression congruent with gender identity, more TGD youth have shown interest in accessing these interventions. This trend is controversial for multiple reasons. Firstly, TGD youth are almost always dependent on a parent or legal guardian to provide informed consent to participate in GCEI. Secondly, the research available to guide these parents and guardians, the youth in their care, and the professional counselors that serve them is

scant. Finally, the religious, political, and legal influences on the process are immense. This study aimed to better understand the process these parents and guardians worked through to provide informed consent for their youth to undergo GCEI in an effort to contribute to the literature on this topic.

Overview of the Study

This dissertation is comprised of five chapters. Chapter 1 has framed the need for more qualitative data around issues related to the processes that parents of TGD youth go through to resolve conflicts of conscience and affirm their child's gender identity and expression. Chapter 2 explores relevant literature related known risks and benefits of GCEI and a variety of complicating factors influencing conflicts of conscience. Topics explored in Chapter 2 include definitions of relevant terms, the history of TGD awareness and treatment in the United States, the practice of GCEI for TGD youth, the role of counselors, psychological concerns, developmental and safety concerns, and legal concerns. Chapter 3 describes the research design and methodology for this project. It addresses sampling techniques, participant features, data collection techniques, analysis methods, and procedures to increase trustworthiness of the study. Chapter 4 includes a description of participants and reports the results from intensive interviews and field observations. Lastly, Chapter 5 provides a discussion of the results of the study in light of the research questions. Applications and implications of the results are discussed, specifically highlighting their relevance to the professions of counseling and counselor education profession.

Chapter 2: Literature Review

Chapter Overview

Chapter 1 described the ways in which this research hopes to contribute to the literature about the experiences of parents of TGD youth and the processes through which they go to affirm the youth in their care. Chapter 2 aims to provide the definition of a variety of terms relevant to the project; the historical context of the controversies relevant to TGD mental health; the role of mental health practitioners in the development of TGD affirming and non-affirming heathcare; and a description of the dilemma that parents of TGD youth face without a well-formed base of research to access to assist with their decision-making.

Introduction

One of the more controversial topics currently addressed in family counseling involves gender identity and access for gender-confirming interventions for transgender or otherwise gender-diverse (TGD) youth. To this point, there has been considerable struggle in Western culture to understand the constructs of gender identity and gender expression and the implications that these aspects of human development present for mental and physical health. The Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling (ALGBTIC), a division of the American Counseling Association (ACA), has defined gender identity as a person's "internal sense of being a man, woman, both, or neither" (Burns et al, 2010, p. 158). The same organization has defined gender expression as "the outward manifestation of a person's gender identity through their clothing, hairstyle, mannerisms, or other characteristics" (p. 158). While most people's gender identity and expression match their sex assigned at birth (i.e., the categorization of

a person as male, female, intersex, or another sex at birth based on physical anatomy or karyotyping), it is quite often the case for a person that they do not (Burns et al, 2010; Trans Student Educational Resources, *n.d.*).

When gender identity, expression, and sex assigned at birth are congruent (e.g., a birth-assigned male identifies and expresses as a man) a person is considered to identify as *cisgender*, drawing on the Latin word *cis* for *same*. *Transgender* draws on the Latin word *trans* for *across* and is "an umbrella term used to describe those who challenge social gender norms, including genderqueer people, gendernonconforming people, transsexuals, crossdressers, and so on. People must self-identify as transgender for the term to be appropriately used to describe them" (Burns et al, 2010, p. 159). Cisgender and transgender are often shortened to cis and trans within gender-related contexts. For the purposes of this study, this researcher has elected to use the term transgender or gender-diverse (TGD), a term also common in the counseling and psychological literature (American Psychological Association, 2009), for its simplicity and its implication that there is no single or binary norm to which gender should conform.

According to the 2015 U.S. Transgender Survey (USTS), 62% of people who identify as TGD wish to make efforts to bring their gender identity, gender expression, and sex into congruence (James et al, 2016). This is a process known as *gender transitioning*, and it may involve interventions related to social, psychological, and medical aspects of a person's life singularly or in combination (Burns et al, 2010; James et al, 2016). A person engaged in *social transition* may make efforts to bring their appearance into alignment with their gender identity through gender-congruent clothing, makeup, and hairstyles. They may also select a name different than the one given to them

at birth that is more congruent with their gender identity and expect that others refer to them with gender-congruent pronouns. TGD people may also seek to have their social transition legitimized through legal processes, such as name changes and updates to government-issued identification documents. Social transition efforts are generally considered non-permanent and non-invasive to the person's body.

A larger majority of TGD respondents to USTS (77%) also wished to engage in counseling for gender-related concerns, including to support their transition (James et al, 2016). Counseling may include psychosocial assessment and diagnosis of mental health-related concerns, such as gender dysphoria, as well as more typical mental health, couples, and family counseling interventions. Counseling may also include advocacy interventions such as writing referral letters for clients (Coleman et al, 2012) to access medical interventions to support transition, such as gender-confirming endocrinological interventions (GCEI) and gender-confirming surgery (GCS). Similar to those wishing to participate in counseling for gender-related concerns, 78% of USTS respondents wanted to receive GCEI at some point to support their transition; a smaller percentage (25%) wanted to undergo GCS (James et al, 2016). Not surprisingly, GCEI and GCS are considered more invasive interventions, and most are likely to produce permanent results. For these reasons, guidelines for providing these interventions have been formalized by the World Professional Association for Transgender Health (WPATH) and by guidelines co-sponsored by five other international professional associations of endocrinologists (Coleman et al, 2012; Hembree et all, 2017).

Both GCEI and GCS have been shown to have positive outcomes for those who access them. According to their systematic review and meta-analysis of quality of life and

psychosocial outcomes for people who underwent GCEI and GCS, Murad and colleagues (2010) found that 80% of participants reported improvements in gender dysphoria; 78% reported improvements in mental health symptoms; 80% reported improved quality of life; and 72% reported improved sexual functioning. Furthermore, Bränström and Pachankis (2019) found a longitudinal association between undergoing GCS and the reduced likelihood of mental health treatment. These studies appear to lend support for a person having access to GCEI and/or GCS if they wish.

In addition to being considered gender confirming, GCEI and GCS align with what lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual (LGBTQ+) advocates have termed *affirming practices*. LGBTQ+ affirmation includes practices that validate, support, and advocate for LGBTQ+ individuals in a way that does not advocate that LGBTQ+ persons change their sexual/affectional orientation or gender identity (Matthews, 2007; Ritter & Terndrum, 2002). Nevertheless, access to GCEI and GCS remain controversial in the United States, especially for *TGD youth*, i.e., people who identify as TGD but who have not yet reached the age of majority in their respective state (Burt, 2016).

At the heart of the controversy regarding general access to GCEI and GCS are what are commonly known currently as *conflicts of conscience*. This term refers to the phenomenon that people encounter when faced with a choice, often regarding participation in a health-related intervention, that has support on multiple sides of an ethical argument. The term has been most prominently popularized during the past decade by state and federal governmental bodies that have attempted to pass legislation or policy with *conscience clauses* that protect healthcare providers from repercussions if

they decline to provide a service based on a sincerely held religious belief, even if the denial of that service appears to conflict with the provider's professional code of ethics (Dailey, 2017; *Franciscan Alliance v. Burwell*, 2016; Office of the Federal Register, 2019). Conflicts of conscience are often so sensitive that they have been considered "third rail" issues, meaning "a topic that is so charged that those who take it on may suffer" (Bieschke and Mintz, 2009, p. 779). Though most commonly associated with religious beliefs, conscience conflicts are also informed by a variety of historical, human developmental, psychological, and legal factors.

History of TGD Awareness and Treatment in the United States

The first studies of people who might identify as TGD under the current understanding began to be published in the United States during the early part of the 20th Century (Drescher, 2010; Hill & Menvielle, 2009). These studies noted that desires related to transgender expression commonly occurred during childhood and adolescence and that transgender expression or identity was thought to signal *same-sex affectional orientation* (also known as homosexual orientation or homosexuality). By this time, psychiatrists—who were the primary mental healthcare providers of the era—mostly considered same-sex affectional orientation to be pathological, and many psychoanalysts claimed to have developed "cures" as the middle of the century approached (Drescher, 2010). This gave birth to the so-called *reparative therapy* or *conversion therapy* movement, which sought to change affectional orientation and transgender identity and expression through psychological and behavioral intervention.

In the United States, psychoanalytic theories about human sexuality and approaches to changing same-sex attraction were majorly affected by the work of Sandor

Rado (Tontonoz, 2017), who broke from the theories of Sigmund Freud, and claimed that there was no such thing as innate bi- or homosexuality but rather heterosexuality "was the only biological norm and homosexuality (was) a 'phobic' avoidance of the other sex caused by inadequate parenting" (Drescher, 2010, p. 433).

By the 1970s, the reparative approach to gender identity was led by George Rekers (Hill & Menvielle, 2009), who in 1974, with colleagues at the University of California at Los Angeles (UCLA), published *The Behavioral Treatment of a "Transsexual" Preadolescent Boy* (Rekers et al, 1974). In this single-case study, the researchers administered Applied Behavior Analysis (ABA) procedures to an 8-year-old boy that were designed to "suppress feminine sex-typed behaviors and increase masculine sex-typed behaviors" (p. 99). The subject had a history of what might be currently termed gender dysphoria, and treatment was administered across clinical, home, and school environments. The primary intervention strategies were the use of a token economy at home (taught to and administered by the mother) and response-cost at school (taught to and administered by a teacher). Following a treatment period of more than 15 months, the researchers reported that results of their study demonstrated that the subject's observable, gender-related behaviors had been changed and that his "sex-role development may have been normalized" (p. 114). Rekers went on to publish two notable books in the 1980s as guides for parents wishing to intervene in their children's developing sexual and gender identities in ways that promoted opposite-sex affectional orientation and cisgender norms (Hill & Menvielle, 2009; Rekers, 1982a; Rekers, 1982b).

Others publishing parenting guidebooks for supporting these opposite-sex attraction and cisgender norms were James Dobson and Joseph Nicolosi (Dobson, 2001;

Drescher, 2010; Hill & Menvielle, 2009; Nicolosi & Nicolosi, 2001). Dobson founded the organization Focus on the Family, a conservative Christian multimedia organization that has produced a popular, family advice-oriented syndicated radio broadcast for more than 40 years (Focus on the Family, *n.d.*). Nicolosi co-founded the National Association for Research and Therapy of Homosexuality (NARTH), which has been renamed the Alliance for Therapeutic Choice and Scientific Integrity (Sutton, 2015; Throckmorton, 1998; Quandt, 2014). These organizations advocated for the value of reparative therapy and opposed the 1973 exclusion of homosexuality from the Diagnostic and Statistical Manual of Mental Disorders ([DMS] Drescher, 2010; Karslake, 2007; Socarides, 1995).

Meanwhile, the case for LGBTQ+ affirmation was gaining scientific support. The American Psychiatric Association's decision to exclude the diagnosis of homosexuality per se from DSM-II in 1973 was based in large part on Evelyn Hooker's groundbreaking study *The Adjustment of the Male Overt Homosexual* (Drescher, 2010; Hooker, 1957). Published 15 years before the exclusion of the diagnosis (and also at UCLA where Reker would later publish), Hooker compared 30 self-identified homosexual men who were not participating in any mental health-related service with a 30 member control group of self-identified heterosexual men who were also not involved in mental healthcare. She administered the Thematic Apperception Test (TAT), the Make A Picture Story (MAPS) test, and the Rorschach inkblot test, and reported that her results demonstrated that there was no direct link between same-sex affectional orientation and psychopathology. The study was confirmed in further study during the next three decades (Drescher, 2010; Marcus, 2002; Riess, 1980; Siegelman, 1972). Later, one of Hooker's colleagues, Robert Stoller, was credited with coining the term gender identity (Drescher, 2010).

Stoller was part of a quartet of psychological, sexological, and medical practitioners and researchers who contributions to transgender affirming theory and practice during the latter half of the 20th Century played a significant role in the decision to include transsexualism as a diagnosis in DSM-III (APA, 1980; Drescher, 2010). John Money, whose theories were based on studies of children born with intersex conditions (i.e., with traits of both male and female sex organs), posited that the phenomenon currently understood as gender identity was primarily influenced by environmental, rather than biological, factors; that one's gender identity was crystalized by age 3; and that efforts to change a person's gender identity were more-or-less futile in older individuals (Drescher, 2010). Harry Benjamin, a physician in private practice who believed that gender identity was primarily biologically based, pioneered cross-sex hormone replacement therapy (HRT) as a treatment for gender dysphoric patients (Drescher, 2010). Benjamin became a strong ally for the transgender community in the 1960s and 1970s, and the organization now known as WPATH was founded in 1979 as the Harry Benjamin International Gender Dysphoria Association ([HBIGDA] Coleman et al, 2012; Drescher, 2010). Stoller was an influential psychiatrist and psychoanalyst who, like Money, developed theories about gender identity from his work with intersex and transsexual patients. Also like Money, he espoused a view that environmental factors were primarily at play in the development of gender identity and family dynamics in particular (Drescher, 2010). Richard Green was the common thread between the previous three contributors, first studying transgender behavior under Money while at student at Johns Hopkins University, then learning psychiatry under Stoller as a medical resident at UCLA, and finally befriending Harry Benjamin prior to Benjamin's death in the 1980s.

Green and Money co-authored groundbreaking scholarly works and treatment texts, and Green and Stoller were among the most prominent voices to advocate for the exclusion of homosexuality and the inclusion of transsexualism in DSM-III (Drescher, 2010).

Another important factor motivating the LGBTQ+ affirmation movement was the social activism of laypeople (Drescher, 2010; Marcus, 2002; Stryker, 2008). Violent protests and direct actions of LGBTQ+ individuals began to increase in frequency and intensity during the late 1950s and came to a head during the four-day riot at the Stonewall Inn in the summer of 1969. According to Susan Styker's account in her book *Transgender History* (2008), The Stonewall Inn was a hole-in-the-wall type bar in Greenwich Village, a neighborhood in New York City well known for its multi- and counter-cultural scene. Its patrons were primarily members of the LGBTQ+ community, and it was run by the Mafia like many other gay-centric establishments of the time due to the fact that homosexuality and crossdressing were illegal. Police raids were commonplace and typically uneventful (peacefully ending once bar owners had paid bribes). However, the raid that began in the early morning of June 28, 1969 turned violent and the subsequent riot became synonymous with the beginning of the LGBTQ+ rights movement (Drescher, 2010; Marcus, 2002; Stryker, 2008).

After a large crowd had gathered as police entered the bar and ordered and escorted customers to the street, people began taunting the police by throwing coins at them in reference to the bribes. Sylvia Rivera, a transgender woman, has been credited with throwing the first beer bottle that ignited the violence after she was hit with a police baton (Stryker, 2008). A crowd of more than 2,000 people gathered and outnumbered police, who barricaded themselves inside the Stonewall Inn and called for reinforcements

who arrived in riot gear. Rioters reportedly uprooted a parking meter and used it as a battering ram against the bar door, and another group attempted to throw a Molotov cocktail through a window to force the police into the street. Furthermore, the riot has been considered the first time that pro-LGBTQ+ activities were published or broadcast nationally by major news outlets (Marcus, 2002). Even though much of the coverage was negative and published on less-prominent pages, enough interested LGBTQ+ people and cisgender, straight allies were energized enough to create a groundswell of support in large cities and university towns across the country (Marcus, 2002; Stryker, 2008). The first of these organizations, the Gay Liberation Front (GLF) was founded within a month of the Stonewall Riots. By 1970, Rivera and Marsha P. Johnson—another transgender woman who was present at the riots—founded Street Transvestite Action Revolutionaries (STAR), a transgender-centric group that advocated for transgender rights and housed transgender youth who were homeless (Marcus, 2002; Stryker, 2008).

LGBTQ+ activists protested at the American Psychiatric Association's annual meetings in 1970 and 1971 on the premise that psychiatric theories were a major contributor to antihomosexual social stigma (Drescher, 2010). These protests have been credited with motivating panels at the American Psychiatric Association annual meetings that ultimately helped to change, not only the way that the international medical and mental health communities viewed affectional orientation and gender identity, but also the very definition of a mental disorder (Drescher, 2010; Marcus, 2002). Starting in 1971, with the panel entitled "Gay is Good", many psychiatrists heard for the first time about the harmful consequences of the homosexuality diagnosis. In 1972, an anonymous gay-identifying psychiatrist (currently known to be John Fryer), appeared on a panel to

explain to his colleagues the discrimination that gay psychiatrists faced from their own profession. At the 1973 annual meeting, the debate about whether or not homosexuality should appear in the DSM and other psychiatric nomenclature was hotly debated and motivated the body's Nomenclature Committee to review the definition of a mental disorder. Robert Spitzer (1981), the chairperson of the subcommittee charged with this task, reported that the group had "reviewed the characteristics of the various mental disorders and concluded that, with the exception of homosexuality and perhaps some of the other 'sexual deviations,' they all regularly caused subjective distress or were associated with generalized impairment in social effectiveness of functioning" (p. 211). The Nomenclature Committee subsequently agreed that homosexuality did not meet this new definition of a mental disorder, and their decision was approved by other organizational committees reviewing their work. By the end of 1973, the American Psychiatric Association's Board of Trustees voted to remove homosexuality from the DSM and a subsequent referendum by voting members upheld the decision by a 58% majority (Drescher, 2010).

It should be noted that this move did not serve to fully depathologize homosexuality, nor did it declassify gender-related diagnoses, in subsequent editions of the DSM. In fact, not until Ego-Dystonic Homosexuality—which refers to the distress caused by a person's unwanted same-sex attractions—was excluded from the revised version of DSM-III (i.e., DSM-III-R) in 1987 was the American Psychiatric Association credited with considering homosexuality in general as a normal variant of human sexuality (Drescher, 2010). As for gender-identity related classifications, the DSM, now in its fifth edition (American Psychiatric Association, 2013) includes Gender Dysphoria

and Gender Dysphoria in Adolescents and Adults, which have evolved during the past five decades from classifications such as Transvestic Fetishism, Transsexualism, Gender Identity Disorder in Children, and Gender Identity Disorder in Adolescents and Adults. The inclusion has often put the TGD community at odds with lesbians, gays, and bisexuals (LGB), and left TGD persons in the awkward position of fighting for normalization and needing the diagnostic categorization in order to access gender-confirming healthcare and mental healthcare (Drescher, 2010; Stryker, 2008.)

For this reason, some have posited that the transgender community's advocacy regarding access to treatment has aligned better with the reproductive rights movement than that of the gay liberation movement. As Stryker (2008) noted:

> Transgender people, like people seeking abortions, wanted to secure access to competent, legal, respectfully provided medical services for a nonpathological need not shared equally by every member of society, a need whose revelation carried a high degree of stigma in some social contexts, and for which the decision to seek medical intervention in a deeply personal matter about how to live in one's own body was typically arrived at only after intense and often emotionally painful deliberation (p. 98).

This alignment is conspicuously at issue in a variety of governmental efforts to address conscience conflicts within the past decade (Daley, 2017; *Franciscan Alliance v. Burwell*, 2016; Gonzalez, 2018; HHS, 2018a; HHS, 2018b; Office of the Federal Register, 2019).

The difference between the LGB orientations and TGD identity were not unknown phenomena in the 1970s. German physician Magnus Hirschfeld has been

credited as the first scholar to differentiate transgender inclinations from same-sex affectional orientation with his “third sex” theories at the turn of the 20th Century (Drescher, 2010). Hirschfeld coined the term *transvestite* to describe people with the “erotic urge for disguise” that led them to wear clothing associated with the customs of the social gender not assigned at birth, and he considered them among a variety of “sexual intermediaries” that “occupied a spectrum between ‘pure male’ and ‘pure female’ (Stryker, 2008, 16-17). Hirschfeld’s European contemporaries began trials of GCS in the 1920s; however, it wasn’t until 1952 that the idea of gender variance and surgical gender confirmation gained widespread public attention (Drescher, 2010). That was the year that George Jorgenson, who assigned male at birth in the United States, went to Denmark for GCS and returned as a transsexual woman and going by the name Christine Jorgenson. The event made international headlines (Stryker, 2008). Benjamin took up the mantel of pioneering GCEI about a decade later.

As has been previously noted, both GCEI and GCS have been shown to produce positive physical and mental health outcomes; however, the research has been conducted almost exclusively on adults (Couric, 2017). Nevertheless, by the turn of the 21st Century, due in part to success with adults, changing social attitudes toward LGBTQ+ acceptance, and children’s insistence, the practice of administering GCEI to TGD youth was growing in popularity (Couric, 2017; Drescher, 2010; Kennedy, 2008; Pew, 2013; Rosin, 2008). This scarcity of TGD youth-focused research has added context to the multiple state legislative efforts have been made within the past decade that directly impact the TGD community, and TGD youth in particular. Bills that would impact access to public bathrooms, scholastic sports, and the ability of businesses to turn away TGD

customers have all been proposed since 2016 (Almasy, 2019; Asmelash, 2020; Grinberg, 2019). In 2020, six different states proposed legislation that would prevent TGD youth from accessing GCEI (Andrew, 2020) and possibly penalize healthcare professionals from providing these treatments.

GCEI for TGD Youth

Since 1979, WPATH has published the *Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People* (SOC), which is currently in its seventh edition (Coleman, et al, 2012). WPATH was also one of six cosponsoring associations involved in the development and publication of the clinical practice guidelines (CPG) of an international society of endocrinologists (Hembree et al, 2017). Both the SOC and CPG devote sections for guiding GCEI for TGD youth. The SOC, in particular, notes key differences between gender dysphoria in children and gender dysphoria in adolescents in the likelihood that gender dysphoria will persist into adulthood and sex ratios for each age group. While the SOC cites studies that have shown between 6% and 27% of childhood dysphoria persisting into adulthood and the stronger likelihood that boys in these studies grew up to identify as gay rather than transgender, the SOC suggests that the likelihood that adolescent dysphoria will persist into adulthood appears to be much higher. Furthermore, the male/female ratios in gender-dysphoric children under the age of 12 range from 6:1 to 3:1 while the ratio in gender-dysphoric adolescents is nearly 1:1. Consistently with the SOC, the CPG recommends against GCEI for prepubertal children gender dysphoria and gender incongruence. Also notably, due to its irreversibility, GCS is not recommended prior to the age of majority for giving informed consent in a person's given jurisdiction, nor is it recommended prior to living

continuously in the gender role consistent with a person's gender identity for 12 months (Coleman et al, 2012).

Typical GCEI for TGD youth fall into two categories: fully reversible interventions and partially reversible interventions (Coleman et al, 2012). Fully reversible interventions are puberty-supressing hormones—often referred to as *puberty blockers*—which delay the development of secondary sex characteristics and allow a person more time to explore and develop their gender identity and enhance the process of giving informed consent for partially reversible interventions at later stages of development. The CPG recommends that pubertal suppression—when possible—be the initial treatment interventions. The CPG also recommends the administration of gonadotropin-releasing hormone (GnRH) agonists as the primary method to suppress estrogen or testosterone production, although progestins (e.g., medroxyprogesterone) or other medications may be used to suppress the androgens secreted by testicles and the continuous use of oral contraceptives may be used to suppress menstruation (Coleman et al, 2012; Hembree et al, 2017). The SOC and CPG recommend that puberty blockers begin at the onset of pubertal changes and prior to Stage 2 on the Tanner five-point scale for rating pubertal development (Coleman et al, 2012; Hembree et al, 2017; Vermont Department of Health, 1999).

Partially reversible interventions involve the administration of gender-confirming cross-sex hormone treatment, or HRT (Coleman et al, 2012; Hembree et al, 2017). People assigned male at birth who wish to transition to female (M-to-F) are administered a regimen that includes estrogen, and a regimen including testosterone is administered to people assigned female at birth who wish to transition to male (F-to-M). The

masculinizing effects (e.g., growth of facial hair, deepening of the voice) and feminizing effects (e.g., softening of facial features, growth of breasts) cease if the regimen is stopped; however, changes that have occurred up to the point of cessation will be permanent. Regimens for HRT for adolescents differ considerably from those administered to adults as they are adapted to physical and psychological development specific to adolescence (Hembree et al, 2017). However, due to these partially reversible characteristics of the treatments, the SOC and CGP recommend that adolescent patients begin HRT preferably with parental or legal guardian consent. Nevertheless, these guiding documents also acknowledge that most people have the mental capacity to give informed consent for medical treatment by the age of 16 (Coleman et al, 2012; Hembree et al, 2017), which may put TGD youth and their parents in the awkward position regarding who has the power to make this kind of decision given that there is conflict between them about the appropriateness of HRT to support gender transition.

The Role of Professional Counselors for TGD Youth Seeking GCEI

Both the SOC and CPG make special note of the important role that mental healthcare providers play in the affirming care of TGD people across the lifespan, and the SOC delineates the recommended minimum credentials who serve this population (Coleman et al, 2012; Hembree et al, 2017). Generally, it is recommended that mental health professionals working with TGD clients possess a conferred master's degree in a clinical behavioral science field that has come from an institution accredited by an appropriate and recognized national and/or regional accrediting board and also possess a license to practice in their field issued from an appropriate governing body. They should be able to demonstrate competence with using the most current DSM or the International

Classification of Diseases (ICD), recognizing coexisting mental health concerns that are distinguishable from gender dysphoria, and practical knowledge specific to addressing the needs of TGD clients. For mental health professionals working with TGD youth, additional training in childhood and adolescent developmental psychopathology and competency in the diagnosis and treatment of the "ordinary problems of children and adolescents" is also recommended (Coleman et al, 2012, p. 13).

The SOC recommends that mental health professionals provide the following services for TGD clients:

- Direct assessment of gender dysphoria;
- Family counseling and supportive psychotherapy to assist with gender identity exploration and development;
- Assessment and treatment of coexisting mental health concerns as a part of the overall treatment plan;
- Referral for physical interventions such as GCEI;
- Advocacy and community-based education on behalf of TGD youth and their families; and
- Information and referral for peer support.

These recommendations for training, credentialing, and intervention align with professional counselor professional identity (Lawson, 2016; Mellin et al, 2011), and the SOC includes clinical mental health counselors in its list of identified qualified professionals (Coleman et al, 2011).

Of these recommended tasks, the practice of making interprofessional referrals to assist clients with access to GCEI is the only one that may not be specifically addressed

during graduate training in programs accredited by the Council on Accreditation for Counseling and Related Educational Programs (CACREP). To be eligible for puberty-suppressing hormones, TGD youth must:

- Demonstrate intense and persistent gender dysphoria and gender-diverse identity (not necessarily expression);
- Worsening dysphoria upon the onset of puberty;
- Reasonable control over any coexisting mental health concerns; and
- Provide informed consent, ideally in concert with a parent or legal guardian (Coleman et al, 2012).

To be eligible for HRT, TGD youth must meet the criteria for puberty suppression as well as to have reached the age of majority in their given jurisdiction or also have the consent of a parent or legal guardian (Coleman et al, 2012). These criteria can, and are recommended, to be supported by a discrete psychosocial assessment (Coleman et al, 2012; Hembree et al, 2017; Shulman et al, 2017). A variety of validated psychosocial assessments are available for professional counselors to use; however, Shulman and colleagues (2017) recommended the use of the Gender Minority Stress and Resilience Scale (GMRS) for its basis in minority stress theory and focus on vulnerability and resiliency factors (Testa et al, 2015). Also of note is that there is a version available specific to the assessment of gender dysphoria in adolescents (Hidalgo et al, 2019). The results of the psychosocial assessment are recommended to be included in any referral letter for GCEI along with the following:

- The client's general identifying characteristics;

- The duration of the referring health professional's relationship with the client, including the type of evaluation and therapy or counseling to date;
- An explanation that the criteria for GCMI have been met, and a brief description of the clinical rationale for supporting the client's request;
- A statement that informed consent has been obtained from the patient;
- A statement that the referring health professional is available for coordination of care and welcomes a phone call to establish this (Coleman et al, 2012).

It should be noted that, for providers working within a multidisciplinary specialty team, a letter may not be necessary. Rather, the assessment and recommendation can be documented in the patient's chart (Coleman et al, 2012).

Psychological concerns of TGD Youth

The TGD community has been shown to have considerably higher rates of negative mental health and quality of life outcomes. According to the USTS (Jones et al, 2016), 39% of respondents reported experiencing serious psychological distress within a month of completing the survey, which is nearly eight times higher than the U.S. population (5%). Similarly, 40% of respondents reported a previous suicide attempt, which is nearly nine times higher than the national rate (4.6%). While LGB youth have been shown to be five-times more likely to report a previous suicide attempt than their straight counterparts (21.5% vs. 4.2%), between 25% and 32% of transgender adolescents and young adults have reported a previous suicide attempt (Grossman & D'Augelli, 2007; Hatzenbuehler, 2011). According to Gibbs and Goldbach (2015), chronic suicidal thoughts have been associated with parental anti-homosexual religious beliefs while leaving one's religion and parents' religious beliefs about LGBTQ+ identity were

associated with suicide attempt in last year among LGBTQ+ people between the ages of 18-24. LGBTQ+ youth have also been shown to be overrepresented among homeless populations with LGBTQ+ youth representing 30% to 43% of youth served by drop-in centers, street-outreach programs, and housing programs (Durso & Gates, 2012).

Concerning disparities also exist in the frequency with which TGD people seek and access healthcare. The USTS (Jones et al, 2016) found that a third (33%) of respondents reported at least one negative experience with a healthcare provider related to their TGD identity. Nearly a quarter (23%) of respondents did not seek healthcare they needed for fear of mistreatment. It is often the case that conflicts of conscience play a major role in parental and professional openness to accepting and working with TGD people to mitigate these psychological and general health concerns (Gibbs & Golbach, 2015; Minnix, 2018; Paproki, 2014; Prairie et al, 2018).

GCEI and Conflicts of Conscience

Conflicts of conscience affect TGD youth, their parents, spiritual leaders, and mental health professionals, and, thereby, complicate these difficult informed-consent and treatment decisions. While these conflicts have most prominently been evoked around perceived religious prohibitions, in the case of GCEI for TGD youth the dearth of information regarding the long-term effects of these treatments has left many parents and legal guardians with questions about the safety of their child that have not yet been answered in satisfying ways.

Religious Concerns

Religion and LGBTQ+ affirmation have a long and contentious history. The sacred texts of the world's three major religions—Christianity, Judaism, and Islam—all

contain passages that have been interpreted to condemn same-sex affectional and TGD orientation, identity, and behavior (Drescher, 2010; Karslake, 2007; Vines, 2014). In the United States, more than 70% of the population identifies as Christian with less than 6% affiliating with non-Christian religions (Pew Research Center, 2014). As such, conscience conflicts in the United States have been dominated by contributions from Christian activists, researchers, and governmental representatives.

The Bible, which contains the primary religious texts of Christianity and Judaism, references LGBTQ+ related topics a handful of times between its Old and New Testaments. Genesis 1:27, 18:20, and 19:1-29; Leviticus 18-22 and 20:13; Deuteronomy 23:17-18; Romans 1:16-32; I Corinthians 6:9; and I Timothy 1:10 all contain references considered by many to condemn same-sex erotic/romantic relationships (Karslake, 2007; Vines, 2014). A few other biblical passages reference, and are considered by many to condemn, behavior common amongst the TGD community (Drescher, 2010). Deuteronomy 22:5 and Leviticus 22:24 are instructive examples. The former is considered by many to forbid cross-dressing, and the latter has been interpreted to forbid GCS. Prior to the Renaissance, the construction of social values was primarily the province of religion, and religion has historically considered LGBTQ+ identity and behavior condemnable. The rise of Western secularism in the mid-19th century, however, motivated philosophers and scientific thinkers alike to challenge tradition, perhaps providing the context for the study of sexual and gender-related issues detailed earlier. Further complicating matters is the tradition that religion and science have often developed in close, contentious relationship to each other (Vines, 2014). This continues today in that many non-affirming researchers, such as Reker, hale from conservative

religious traditions and training (Hill & Mienville, 2009), and many non-affirming religious leaders, such as Dobson (who holds a doctorate degree in child development from the University of Southern California), consider themselves members of the helping professions (Dr. James Dobson's Family Talk, *n.d.*; Karslake, 2007). Even though every major international medical and mental health professional organization has issued statements endorsing LGBTQ+ affirming practice (Drescher, 2010), clinicians within these organizations continue to protest, eschew ethical guidelines, and advocate for legal protection of their non-affirming practices.

The ACA has had some of the most prominent conflicts with members regarding issues of religious values and LGBTQ+ affirmation. The ACA made an effort to clarify its LGBTQ+ affirming position for its members and the field of professional counseling with its 2014 ACA Code of Ethics. Like the previous iteration from 2005, the 2014 code explicitly stated that "counselors do not condone or engage in discrimination against prospective or current clients, students, employees, supervisees, or research participants based on" their membership in a variety of protected classes of people (ACA, 2014, p. 8). Clients who represent gender variance as well as those who represent same-sex affectional orientation were included among these protected classes. Furthermore, the code clarified that counselors should avoid harming those in their care, and that counselors refrain from *referring* prospective and current clients based solely on the counselor's personally held values, attitudes, beliefs, and behaviors. New to the 2014 code, according to David Kaplan (2018), the former ACA President who appointed the 2005 Ethics Revision Task Force who later served as the ACA staff liaison to the 2005 and 2014 code revisions, was the clarification in Section A.4.b that "Counselors are

aware of—and avoid imposing—their own values, attitudes, beliefs, and behaviors" (ACA, 2014, p. 5).

These clarifications were spurred, at least in part, by two prominent legal challenges to the 2005 code: *Ward v. Wilbanks* and *Keeton v. Anderson-Wiley* (Kaplan, 2014). The implications of these challenges have impacted the way LGBTQ+ clients are served by a variety of different stake holders across a variety of different disciplines, including clergy, counselors, psychologists, and medical doctors, as well as agents of all three branches of government at the state and federal levels (Paproki, 2014; Prairie et al, 2018).

In *Ward v. Wilbanks*, the Alliance Defense Fund (ADF; also known as the Alliance Defending Freedom) filed a lawsuit in U.S. district court on behalf of Eastern Michigan University (EMU) graduate counseling student Julea Ward, claiming that the EMU counseling program violated her rights to—among other things—free speech and free exercise of religion (Kaplan, 2014). At issue was that in 2009, Ward, then enrolled as a practicum student at a clinic operated by the EMU counseling program, was assigned a client who stated on the intake form that he wanted help with feelings of depression and issues related to a same-sex relationship. Ward sought to refer the client to another practicum student because:

> Based on Biblical teachings, Ms. Ward believes that God ordained sexual relationships between men and women, not between persons of the same sex. As such, Ms. Ward believes that homosexual conduct is immoral sexual behavior. Ms. Ward also believes, based on her sincere religious beliefs, that individuals are capable of refraining from engaging in

homosexual conduct (*Ward v. Wilbanks*, 2009, Compl. at 3-4, as cited in Kaplan, 2014).

The EMU counseling program informed Ward that refusing to see a client on the basis of affectional orientation was a violation of the 2005 ACA ethics code, and her wish to refer, therefore, was not acceptable. She was offered remediation to assist her with developing the competency necessary to serve clients whose beliefs and values differed from her own, but she refused the offer because she was "unwilling to violate her beliefs by affirming homosexual conduct within the context of the counseling relationship" (*Ward v. Wilbanks*, 2009, Compl. at 9, as cited in Kaplan, 2014). Ward and ADF lost their suit by summary judgment. Subsequent appeals were dropped, which allowed the summary judgment to stand and set legal precedent for subsequent challenges (Kaplan, 2018).

In *Keeton v. Anderson-Wiley*, Augusta (GA) State University (ASU) graduate counseling student Jennifer Keeton filed a verified complaint and sought a preliminary injunction based on alleged violations of her civil rights hoping to avoid taking part in a remediation plan imposed by the ASU counseling program and to avoid expulsion from the program if she were to fail to complete the plan (Pritchard, 2011). The facts of the case were similar to those in *Ward v. Wilbanks*. After multiple instances during academic activities of Keeton voicing her condemnation of homosexual behavior and support for reparative therapy based on her religious beliefs, ASU faculty grew concerned that the student would be unable to separate her religiously based moral judgments from her professional role as a counselor (Pritchard, 2011). To address these concerns, ASU counseling faculty developed a remediation plan in accordance with program policy and

the 2005 ACA ethical code. Relying in part on *Ward v. Wilbanks*, the Southern District of Georgia denied the preliminary injunction and threw out the case on the basis of ASU's "right to impose reasonable academic standards in its curricular program despite (Keeton's) religious apprehension" (Pritchard, 2011, p. 1014).

Despite these court decisions, this debate appears to be far from over as legislative and executive branches of government have moved at the state and federal levels to provide protection to human-services practitioners who wish to deny or refer services based on sincerely held religious beliefs. Since 2012, three southern states—Kentucky, Tennessee, and Arkansas (Dailey, 2017)—have passed so-called conscience-clause legislation that allows legal protection for healthcare providers to refuse services to clients with requests for help in ways that conflict with particular religious beliefs. In January of 2018, the U.S. Department of Health and Human Services (HHS) announced the creation of the Conscience and Religious Freedom Division (CRFD) in the HHS Office for Civil Rights (OCR) (HHS, 2018). The CRFD announced its final rule protecting statutory conscience rights in health care in May of 2019 (Office of the Federal Register, 2019).

The CRFD website explicitly cites protections for healthcare practitioners who decline to provide services related to abortion and assisted suicide (HHS, 2018b); however, some have noted that the division's loose language could leave room for healthcare providers to deliver sub-standard care for clients and patients with concerns related LGBTQ+ identification (Gonzalez, 2018). In fact, an HHS spokesperson told *WIRED* magazine that the department would not interpret prohibitions on sex discrimination in health care to cover gender identity, citing *Franciscan Alliance v.*

Burwell (Gonzalez, 2018). In this 2016 case, filed in the U.S. District Court for the Northern District of Texas, Franciscan Alliance, a Catholic organization of healthcare providers, challenged an HHS regulation that interpreted sexual non-discrimination clauses in the Affordable Care Act to include prohibitions of discrimination on the basis of gender-identity and termination of pregnancy. The plaintiffs argued that the regulation would require them to perform and provide insurance coverage for gender transitions and abortions regardless of their contrary religious beliefs or medical judgment (*Franciscan Alliance v. Burwell*, 2016). The Northern District of Texas granted the preliminary injunction based on its finding that the regulation was "contrary to law and exceeded statutory authority" and based on the national scope of the law in question (*Franciscan Alliance v. Burwell*, 2016).

Even with legal and regulatory protection, these measures often put counselors of faith at odds with their own profession. This runs the risk of putting religiously affiliated parents seeking the assistance of a religiously affiliated counselor, at odds with their child. Meanwhile, service refusal, referral, and non-affirming responses to same-sex affectional orientation and gender variance have been shown to be closely associated with higher rates of suicide and victimization (Gibbs & Goldbach, 2015; Kralovec et al, 2012).

People of faith, however, need not be non-affirming. LGBTQ+ affirming perspectives on theology and the interpretation of sacred texts like the Bible, have existed for hundreds of years (Karslake, 2007). Furthermore, there is a growing body of literature across the conservative to progressive continuum that supports LGBTQ+ affirmation among people of faith (Vines, 2014; Gushee, 2015). These voices appear to be describing

a pathway toward ally-ship for people of faith, and counselors appear to be well positioned to lead the way in that direction.

One of the descriptions of the Judeo-Christian messiah (or savior), first introduced in the Old Testament book attributed to the prophet Isaiah, is Wonderful Counselor (Isaiah 9:6, English Standard Version [ESV]). It should come as no surprise then that many professional counselors are trained at Christian institutions of higher education and that there are multiple professional organizations for counselors of Christian faith, such as the American Association for Christian Counselors (AACC). This organization refers to itself as the world's premier Christian counseling organization (AACC, 2018). When reviewing the AACC code of ethics, which like the ACA code was updated in 2014, it would seem that there is little difference in the ethical approaches purported by each with themes that promote the dignity and welfare of clients (ACA, 2014) and references to the Hippocratic Oath (AACC, 2014).

There are, however, clear points of divergence. First of all, according to section ES1-550, the AACC code allows for referrals based on differences between counselor and client values. This allowance appears to neglect key factors from the counseling-related research regarding referrals. The ACA code states that referrals must be made on the basis of skill-based competency, not values. Furthermore, the client experience of referral is often quite different than the clinician's. While counselors may have reason to believe that they are making a referral "out of the goodness of our heart," clients experience it as abandonment (Kaplan, 2018).

A second key point of divergence revolves around the AACC's position that its members do not "condone or advocate for" their clients engaging in "homosexual,

bisexual, or transgendered behaviors or lifestyles" (AACC, 2014, p. 15). Instead, the AACC ethics code indicates that its members should encourage celibacy or "biblically-prescribed [*sic*] sexual behavior" whenever LGBTQ+-related issues are part of counseling services. The current edition of the AACC ethics code notably excluded language from the 2004 edition that endorsed reparative therapy. Nevertheless, the AACC has not published a clear position on this practice since it updated its ethics code. In stark contrast, the ACA has taken the position since 1998 that interventions aimed at changing a client's affectional orientation or gender identity are unnecessary and have been shown to be harmful (Whitman et al, 2013).

The AACC non-position is particularly troubling in light of the developing research and events during the past two decades. In 2001, then-Surgeon General David Satcher published a "call to action" report that included the statement that there is no valid evidence that affectional orientation can be changed (Peterson, 2001). A few years later, Christian psychologists and researchers Stanton Jones and Mark Yarhouse, who currently serve as faculty at Wheaton College and Regent University, respectively, published the results of one of the first scientifically rigorous and longitudinal studies of religiously mediated change in affectional orientation (Jones & Yarhouse, 2007). Their study relied on interviews of participants in a ministry supported by Exodus International, a then well-known group associated with reparative interventions. According to their published results, only about 38% of participants fell into their two "success" categories with only 15% claiming conversion from homosexual to heterosexual attraction. The other 23% reported feeling satisfied by practicing celibacy while continuing to experience attraction to members of the same sex. Though conservative religious leaders

hailed their study at the time as the empirical answer to this debate (Stafford, 2007), Jones and Yarhouse's relatively low success rate led others to be skeptical. This skepticism was reinforced when, in 2013, Exodus International shut its doors. The group's president, Alan Chambers, publicly apologized to the LGBTQ+ community for the "pain and hurt" the organization caused, and he admitted that he, too, experienced continual sexual attraction to men even though he was married to a woman (Newcomb, 2013).

The "pain and hurt" Chambers referenced have been well documented in the peer-reviewed literature. Gibbs and Goldbach (2015) found that lesbian, gay, and bisexual young adults were five times more likely to report a previous suicide attempt as, compared to their straight counterparts. Their findings were even more grim for those who identify as transgender, with 25% to 35% of transgender late adolescents and young adults reporting a previous suicide attempt. Ironically, suicide risk appears to be closely related to religiosity among LGBTQ+ persons. Religion has typically been considered a protective factor, but LGBTQ+ people who mature in a religious community context report increased discrimination and internalized homophobia, which are closely linked with increased suicide risk (Kralovec et al, 2012).

Exacerbating entrenchment along opposed viewpoints are the echo chambers created and supported through pervasive *confirmation bias* and *false consensus*. Confirmation bias, or the tendency to interpret new evidence as confirmation of one's existing beliefs or theories, seems to be evident in the acceptance of Jones and Yarhouse's study as resolving the argument in favor of the non-affirming perspective. Their identified success rates were remarkably low, and the contradictory evidence was

overwhelming. Often, counselors of faith feel a strong sense of loyalty to, and guidance from, religious scripture. In fact, the AACC cites the Bible as its first of seven foundations to its 2014 code (AACC, 2014, p. 12). However, when it comes to ethical questions regarding LGBTQ+ acceptance and affirmation, there is much debate about how to accurately interpret these passages for application to a modern helping context (Karslake, 2007, Vines, 2014).

The concept of false consensus, a type of bias characterized by an overestimation of the extent to which one's opinions, beliefs, preferences, values, and habits are normal and typical of those of others, has strong influence on conflicts of conscience as they are framed in this article. Terms like biblical and ethical are often used with specific meanings in the mind of the user, but they do not necessarily align with the perspective of the hearer. For example, the AACC code of ethics uses the word biblical 33 times and uses it to refer to terms like "biblical truth" and "biblically-based *[sic]* values."

One prominent way that false consensus has been illustrated recently is the dichotomy between the views on affectional and gender diversity purported by the drafters and signatories of the *Nashville Statement*, the *Charlottesville National Call to Conscience*, and the *Boston Declaration*. The *Nashville Statement* was published online on August 29, 2017 by the Council on Biblical Manhood and Womanhood (CBMW) and initially signed by more than 150 prominent evangelical and Protestant Christian leaders, including Dobson and pastors John Piper and R. C. Sproul. The 14-article statement focused mainly on promoting sexuality as expressed exclusively within a marriage context between one man and one woman, condemning not only more diverse sexual and gender expression, but also Christians who support such diversity based on the drafters'

"biblical conviction" (CBMW, 2017). The *Charlottesville National Call to Conscience* was published online just prior to the *Nashville Statement* in response to the violence that erupted during the Unite the Right rally (UTR) held in Charlottesville, VA, on August 11 and 12, 2017. Drafted by Congregate Charlottesville, a group of clergy and faith leaders that organized in counter-protest to UTR organizers in the lead-up and aftermath of the violence, the Charlottesville document affirmed a wider range of diversity and conspicuously stated "Queer Lives Matter" (Congregate Charlottesville, 2017). The *Boston Declaration*, published online in November of 2017 and signed by a host of other prominent clergy and faith leaders, such as William Barber II and Shane Claiborne, also addressed a wider range of diversity and explicitly stated "We reject homophobia and transphobia and all violence against the LGBTQ community" (*Boston Declaration*, 2017). Each group used the same Bible upon which to base their documents.

Whether or not science and theology can be practically and meaningfully integrated is complicated by the fact that interpretation of God's world (scientific methods) and interpretation of God's Word (scriptural interpretation) often require different tools and approaches (Tenneson, Bundrick, & Stanford, 2015). Wheaton College's Jones—among many others—has posited three modes of relating religion and science: the *critical-evaluative* mode, the *constructive* mode, and the *dialogical* mode (as cited in Yarhouse, 2011). In the critical-evaluative mode, scientific advances are incorporated into the curriculum and interpreted through a conservative interpretation of the Bible. This means that traditional interpretations of scriptural passages that are often used to demonstrate explicit prohibition of homosexual behavior, such as Romans 1:21-32, are privileged over the American Psychiatric Association's removal of homosexuality

from the DSM. Religiously informed perspectives that continue to support reparative approaches are likely to espouse this mode.

In contrast, Yarhouse embraced the constructive mode and maintained that a "focus on orientation can mistakenly assume that the traditional Christian sexual ethic in some way hinges on the causes of homosexuality and whether a homosexual orientation can change" (2011, p. 7). The constructive mode appears to be at the heart of a recent trend that promotes celibacy as a spiritual discipline for LGBTQ+ Christians who ascribe to a scriptural interpretation that homosexual behavior or gender variance is prohibited (Yarhouse, 2010).

The dialogical mode is essentially religion and science informing one another on a relatively equal plane (Yarhouse, 2011). This mode seems notably similar to the *partnership* viewpoint in Carlson's typology (as cited in Tenneson, Bundrick, & Stanford, 2015) and *concordism* paradigm proposed by Tenneson, Bundrick, and Stanford (2015). Carlson's partnership describes a full integration of science and theology in which they work together as partners theorizing about important matters. Science and theology are not seen as threats to each other; rather the two enterprises influence each other and the contributions of both are valued (Tenneson, Bundrick, & Stanford, 2015). In concordism, there is no expectation of a one-to-one relationship between biblical and scientific propositions; rather, the two are seen to be in superficial conflict and in deep harmony. There appears to be support for this perspective, ironically, in Romans 1:20, the verse that precedes the passage introduced above: "For (God's) invisible attributes … have been clearly perceived … in the things that have been made" (ESV). What is science if not the study of what has been made?

In his essay *Gay Suicide and the Ethic of Love*, Reitan lamented that conservative Christians have described the debate among themselves about the ethics of LGBTQ+ affirmation as if it pits those who hold firmly to traditional Christian values and those who have "sold out to secular culture" (2011, p. 25). This way of framing the debate, Reitan wrote, ignores the real motivations of other people of faith that are sparked by real human tragedies. The essay went on to describe the narrative of Zach Harrington, a young gay man who died by suicide in October of 2010. About a week prior to his untimely death, Harrington attended a city council meeting at which a proposal to recognize LGBT History Month in the town was debated. Although the council approved the proposal, opponents vehemently protested and referenced biblical passages for justifying their opposition. Reitan posited that to a young man like Harrington, the messages must have sounded like fundamental rejection.

Even an allegedly more compassionate position often promoted by LGBTQ+ non-affirming Christians—hate the sin, love the sinner—has its limits. Reitan took this argument on by acknowledging its merits; however, he added the caveat that sometimes it is unloving to consider something a sin in the first place. To make his point, Reitan shared a scenario of a father who forbade all childhood play. Even if the father intended to promote his children's welfare, the strategy is seriously misguided and detrimental to the children's healthy development. The father's actions "reveal a sharp disconnect between what the father means to do and what he is actually doing," and "no loving person would endorse this prohibition if they knew the truth" (Reitan, 2011, p. 25).

Coinciding with the development of LGBTQ+ affirming practices within healthcare fields has been the development of spiritual support for LGBTQ+ persons of

faith, as well. And while more mainline and progressive churches like the United Church of Christ (UCC) and the Episcopal Church, as well as parachurch organizations like the Reformation Project, have led the way, the landscape is also beginning to change in the more traditionalist evangelical denominations. David P. Gushee, Distinguished University Professor of Christian Ethics at Mercer University (a traditionally Baptist university with multiple campuses in Georgia), wrote that within the past few years, "a number of new books have been written and organizations have been founded by avowed evangelicals attempting to open up conversational space, plead for better treatment, reframe the issues, or revise the traditionalist posture" (2015, p. 141). What many evangelicals have considered to be a sexual ethics issue is actually much more complex and comprehensive than that. Gushee lamented that, despite the overwhelming research and the appeals of leading scientists, clinicians, and mental health experts, non-affirming Christians have labeled as sinful or as rebellion a form of human diversity that has shown up in every society in human history. He concluded: "It is time to end the suffering of the church's own most oppressed group. It is time to reconcile evangelical Christianity with our sexual minorities" (Gushee, 2015, pp. 153-154). Supporting this view, Minnix (2018) found that Christian mental health providers who changed from a non-affirming to an affirming approach to LGBTQ+ concerns experienced a deepening of their faith rather than the dissolution thereof.

With this support available, there appears to be an emerging opportunity for ally development among professional and laypeople who have up to now been non-affirming of LGBTQ+ clients. However, for the cisgender, heterosexual parents of TGD youth

seeking GCEI, the values-based conflicts do not stop if and when religious dilemmas are resolved.

Developmental and Safety Concerns

Although the experiences of parents of TGD youth are not well documented in the peer-review literature, their concerns about the safety of their children is prominent (Hill & Menvielle, 2009). As is noted in the SOC, "neither puberty suppression nor allowing puberty to occur is a neutral act" (Coleman et al, 2012, p. 20). In addition to the permanent effects of HRT detailed previously, concerns also remain about the physical side effects of puberty blockers, which may have a negative effect on bone development and height (Coleman et al, 2012). Rigorous and longitudinal studies detailing the effects of both puberty blockers and HRT are generally scant (Bunim, 2015; Coleman et al, 2012; Hembree et al, 2017). Some of what is available, however, appears promising. For example, Turban and colleagues (2020) reported evidence of a statistically significant inverse correlation between access to puberty blockers and suicidal ideation among adults ages 18 to 36.

The first study in United States to examine the longterm effects of GCEI on TGD youth is currently underway (Bunim, 2015). According to one of the co-investigators, two-year follow-up data on all participants is not expected until September of 2020, and the important mental health and physiological outcomes could take more than 10 years of follow-up (S. Rosenthal, personal communication, November 7, 2019). In the meantime, "refusing timely medical interventions for adolescents might prolong gender dysphoria and contribute to an appearance that could provoke abuse and stigmatization. …

withholding puberty suppression and subsequent feminizing or masculinizing hormone therapy is not a neutral option for adolescents (Coleman et al, 2012, p. 21).

A review of the literature produced no peer-reviewed studies focused on the experiences and thought processes of parents related granting informed consent for the TGD youth in their care; however, the literature has documented a variety of adjunctive concerns. Parents may have concerns about the trustworthiness of adolescent gender identity development, questionable adolescent emotional regulation and impulse control, and the potential consequences for a young person who regrets the decision to transition after receiving partially reversible interventions. Prominent child and family therapy researchers, such as Siegel (2013), have noted that adolescents are notorious for poor executive functioning related to their ongoing neurological development, especially of the prefrontal cortex of the brain. Nevertheless, key developmental tasks like improving impulse control, planning and follow through, and emotional regulation have been shown to be best supported by a parent-child relationship that is characterized by inclusivity. As Wallin (2007) noted, this means that "the parent makes as much space as possible for the full spectrum of the child's subjective experience" and attends not just to what the child says but also what the child does (p. 116).

Gülgöz and colleagues (2019) did this very thing with a cohort of more than 300 children between the ages of 3 and 12 years old to examine gender-diverse identity in early childhood (as compared to two control groups of cisgender children: their cisgender siblings and more than 300 non-relative cisgender children in the same age range). The research team reported four key findings: 1.) transgender children strongly identified as members of their current and self-identified group and showed gender-typed preferences

and behaviors strongly associated with that identity; 2.) transgender children's gender identity and gender-typed preferences did not differ from the two comparison groups; 3.) transgender and cisgender children's patterns of gender development showed coherence across measures; and 4.) there were no or minimal differences in gender identity or preferences as a function of how long transgender children had lived in their current gender. The researchers suggested that early sex assignment and parental rearing based on that sex assignment do not always define how a child identifies or expresses gender, perhaps lending support to the earlier theories of Hirschfeld and Money that gender identity was formed and crystalized during early childhood, and Benjamin's theory in that it appears to develop and crystalize more independently of parental rearing or other environmental factors than biological (Brill & Kenny, 2016; Brill & Pepper, 2008; Drescher, 2010).

A review of the literature produced a variety of individual anecdotes, published in non-scientific media, about post GCEI-supported transition regret. It appears to occur, but there is not yet enough peer-reviewed evidence to provide reliable guidance on the frequency, intensity, or duration of post-transition regret. Meanwhile, parents are often faced with legal decision-making responsibility, making them the de facto gatekeepers when it comes to their child's access to GCEI.

Legal Concerns

At issue in the case of a TGD minor whose wishes to receive GECI conflict with their parents' or legal guardian's consent are what legal scholars call the *doctrine of parental rights* and the *mature minor rule* (Coleman, 2019; Coleman & Rossoff, 2013; Priest, 2019). The doctrine of parental rights generally allows that parents have the final

authority to give consent for medical care and treatments for their children who have not reached the age of majority in their respective jurisdiction (i.e., state of residence). The mature minor rule allows for older teenagers, in at least some instances, to give consent to medical care and treatment.

Priest, a philosophy professor at Arizona State University (ASU) and Coleman, a law professor at Duke University, laid out arguments that support the mature minor rule and the parental rights doctrine, respectively, in exchange published in *The American Journal of Bioethics*. Priest, in advocating that the mature minor rule apply to transgender teenagers seeking GCEI generally, argues that due to general consensus that a parent's legal authority should not protect them when their actions (or inactions) severely and permanently harm a minor in their care and/or prevent the minor in their care from accessing standard medical care, transgender teenagers should have the right to consent to their own puberty blocking treatment and that the state has an obligation to disseminate information about gender dysphoria. Coleman counters with an argument that the mature minor rule is not useful in this context because, even though the minor in question may be cognitively mature and have the capacity to give consent (Coleman, 2019; Coleman et al, 2012, Coleman & Rossof, 2008; Hembree et al, 2017), "most children who want puberty blockers are not legally mature; very few states recognize the rule in a form that would encompass this treatment; and it is otherwise constitutionally vulnerable" (Coleman, 2019, p. 83). Further complicating matters is that the age of majority in the United States is not consistent across all 50 states, with Alabama (19), Nebraska (19), and Mississippi (21) the notable exception to the 18-years-old standard in the other 47 (Fulmer, 2002).

Legal options for minors in this context appear to be limited by a variety of legal entanglements. Noting this factor, Priest makes and effort to cast the issue as more one of the risk of physical harm rather than the more legally murky psychological risks. However, Coleman notes that this move remains unlikely to resolve the issue:

> The law only authorizes the state to intervene in the family where it has evidence of parentally inflicted serious physical harm. … There is authority but no duty to intervene in any case; and by definition, a child's self-harm is not parentally inflicted. … (T)he law is rationalized on the basis that there are innumerable choices parents make that cause their children deep, long-lasting emotional pain, teenagers threaten self-harm in lots of contexts, and the state has neither the authority nor the resources to intervene in all of these cases (Coleman, 2019, p. 83).

Contextual Impact on the Parents of TGD Youth

With these historical, developmental, religious, psychological, and legal factors in mind, there is little argument that the parents of TGD youth, charged with whether to grant informed consent or not for their minor child to access GCEI, carry a heavy burden. Furthermore, with

conscience conflicts impacting the intervention of religious and governmental leaders, the approaches of healthcare providers, and given the relative lack of instructive research, the responsibility of TGD-affirming professional counselors and other mental health providers to assist children and families through this process is immense.

Very little is understood about the experiences of the parents of TGD youth generally, much less the process by through which they go to provide consent for their

child's GCEI. A review of the literature produced only one qualitative study examining the experiences of parents of TGD children and adolescents. Hill and Menvielle (2009) conducted a phenomenological inquiry into the experiences of 43 parents of TGD youth from across the U.S. The researchers' goal was to document issues that the parents' faced related to the history of their child's gender identity, experiences and thoughts about how to best parent TGD youth, their own gender beliefs, the acceptance of their child, and the main challenges that they faced. Themes that emerged from the data included confirmation of a lack of family discord influencing gender identity development, unconventional parenting styles, various paths to and levels of parental acceptance of the child, and parental fears and concerns. The study, however, did not illuminate a distinct theory of how the participants learned about gender identity, adjusted their parenting style, or came to a place of new or greater acceptance of their child's gender identity. The study did not address the experiences of parents who gave or denied informed consent for GCEI.

The current study aims to take this next step of understanding the process by which parents of TGD youth—who more often than not are cisgender and heterosexual—develop affirmative understandings and approaches to their children's gender-identity and related transition needs. To that end, the primary research question of this grounded theory study was "How did the parents or legal guardians of TGD youth who have undergone GCEI decide to give informed consent?" Secondarily, "Are their specific themes that emerge for Christian, heterosexual, cisgender parents who go through this process?" Finally, "What part, if any, did a professional counselor play in the process?"

Summary

Chapter 2 has provided comprehensive and detailed context for the influences upon the parents of TGD youth who are faced with granting informed consent for the youth in their care to undergo GCEI. Key terminology, the risks and benefits of GCEI, and the history of the understanding of the construct of gender identity in the United States have been presented as have the influences of religion, human development, politics, and laws governing informed consent that must be considered in a parent or guardian's decision-making process. The limitations in the literature have been discussed and the research questions have been defined. Chapter 1 described the ways in which this research hopes to contribute to the literature about the experiences of parents of TGD youth and the processes through which they go to affirm the youth in their care. Chapter 3 will present the research design and methodology of this project.

Chapter 3: Methodology

Chapter Overview

Chapter 3 describes the research design and methodology for this study. Proposed sampling techniques, sample size, participant inclusion criteria, data collection and analysis techniques and procedures to increase the trustworthiness of the study's findings will be addressed. Based on the research questions defined in Chapter 2, the qualitative grounded theory method seems most appropriate for this study because its purpose is to understand how participants go about resolving a particular concern or dilemma (Charmaz, 2014; Glaser & Strauss, 1967).

The researcher assumed a role that prioritizes a postmodern constructivist approach to grounded theory methodology while blending some elements of the method that come from the more modernist, positivistic guidelines to the method. The rationale for this will be addressed in subsequent sections. The researcher appreciates postmodern epistemology that asserts that there are many accurate worldviews derived from the various cultures, systems, and individual perspectives of the clients with whom professional counselors work. This is in contrast to the modernist epistemology that asserts that there is one reality—or absolute truth—and that it can be objectively known (Hansen, 2010).

Introduction

Unlike other forms of qualitative research, grounded theory guides the researcher with a set of general principles, guidelines, strategies, and heuristic devices rather than formulaic prescriptions to help the researcher direct, manage, and streamline data collection so that analyses and emerging theory are well grounded in the data collected

(Charmaz, 2014). Grounded theory methodology was developed by Glaser and Strauss in the 1960s, at least in part, to buoy the emphatic shift to quantitative methodology in the social scientific community during that era (Charmaz, 2014; Glasser & Strauss, 1967). The positivistic quantitative approach emphasized confirmation of inductively and logically deduced theory and guided researchers who connected theory and research to test logically deduced hypotheses from an existing theory; therefore, new theories were rarely constructed (Charmaz, 2014; Glasser & Strauss, 1967). Glaser and Strauss systematized qualitative inquiry in a revolutionary way for its time by refocusing the practice on methods of analysis. Their defining components of grounded theory practice included: (a) the simultaneous involvement of data collection and analysis; (b) constructing analytic codes and categories from the data rather than preconceived logically deduced hypotheses; (c) the use of constant comparison for data analysis; (d) the advancement of theory development during the data collection and analysis process; (e) memo-writing to elaborate categories, specify their properties, and illuminate relationships between them; (f) theoretical sampling rather than representative sampling; and (g) conducting the literature review after developing an independent analysis.

Currently, the two popular approaches to grounded theory are the more modernist positivistic approach of Corbin and Strauss and Charmaz's more postmodern constructivist approach (Charmaz, 2014; Corbin & Strauss, 2015; Creswell, 2013). In Strauss and Corbin's method, the researcher systematically develops a theory that explains a process, action, or interaction on a phenomenon, such as the topic of the present study. However, one of the criticisms of this approach is that it does not go far enough to escape the positivistic influences of quantitative research to fit the postmodern

era. Charmaz (2014) is among these critics, and she has proposed a constructivist approach that emphasizes "learning about the experience within embedded, hidden networks, situations, and relationships," while also "making visible hierarchies of power, communication, and opportunity" (Creswell, 2013, p. 87).

This researcher followed guidelines that blend these two approaches for the following reasons. First of all, the Strauss and Corbin (2015) model follows more traditional research procedures (e.g., including an exhaustive literature review in research proposals and prior to data collection) that serve the needs for prescribed organization and structure of the novice researcher as well as satisfying the typical procedures of the dissertation process. Secondly, the Charmaz approach aligns better with this researcher's professional identity in that it emphasizes the flattening power hierarchies (Duffey et al, 2016). To accomplish this, the researcher made modifications to the traditional research procedures in response to the guidance of his dissertation committee. For example, the literature review will be limited to research reviewed prior to March 15, 2020 and emphasize self-disclosure to support the trustworthiness of the findings (Charmaz, 2014; Corbin & Strauss, 2015; Creswell, 2013). When collecting and analyzing data, this researcher used features of the constructivist approach, such as active coding and avoiding the minimization of the role of the researcher (Charmaz, 2014; Creswell, 2013).

Problem Statement

As was described in Chapters 1 and 2, there is a paucity of research for counselor educators, practitioners, supervisors, and trainees to use as guidance for addressing the experiences and decision-making processes of parents of TGD youth. This is of particular importance and urgency because parents often hold substantially more decision-making

power than the youth in their care who are seeking access to GCEI. These semi-permanent medical interventions have been shown to be effective in supporting TGD people's transition, which in turn has been shown to be associated with positive mental health outcomes. Without sufficient guidance, counselors and parents operate at a deficit for making sound decisions that are likely to have a profound impact on the mental health of TGD youth.

Purpose of the Study

The purpose of this research was to understand the process by which parents of TGD youth—who more often than not identify as cisgender and heterosexual—develop affirmative understandings and approaches to their children's gender identity and related transition needs and grant informed consent for the TGD youth in their care to undergo GCEI. This process is affected by the limited research available to decision makers that provides details about the long-term effects of GCEI on preadolescent and adolescent bodies. Understanding this process is likely to assist parents—and the counselors who support them—to make the best decision possible with the information available.

Procedure and Sampling

According to Charmaz (2014), grounded theory procedure involves coding and categorizing data, then writing analytic memos about the identified categories. Theoretical sampling is the preferred strategy for grounded theory because it helps support the robustness of categories and reaching saturation during data analysis. Charmaz defines theoretical sampling as a strategy "in which the researcher aims to develop the properties of (their) developing categories or theory, not to sample randomly selected populations or representative distributions of a particular population" (p. 345).

The process of theoretical sampling involves seeking people, events, or other information to identify and define the properties, limits, and relevance of a category or set of categories to the study. A tentative theoretical category must have already been developed by the researcher for the researcher to engage in theoretical sampling. Therefore, an initial sampling method is necessary.

Initial Sampling

The researcher used snowball sampling to recruit a national, purposive sample of adult participants who self-identify as (a) a parent and/or legal guardian of a person who self-identifies as TGD and who have (b) given informed consent for their TGD child to receive GCEI. This was accomplished by sharing study information and a request for assistance with identifying participants with national organizations that advocate for TGD rights and services. The researcher primarily contacted representatives at the national headquarters and local chapters of Parents and Friends of Lesbians and Gays (PFLAG) and local chapter leaders of Transparent USA to recruit study participants. The researcher also shared study information and a request for assistance with identifying participants on the listserv of the Society for Sexual, Affectional, Intersex, and Gender-Expansive Identities (SAIGE), a chapter of ACA, and on social media with colleagues known to the researcher. In keeping with the snowball sampling method, prospective participants were asked to contact the researcher and forward the information to others that they believed met the study criteria. Participant screening consisted of an online Qualtrics survey that included confidentiality and informed consent information, inclusion criteria, and demographic items.

Theoretical Sampling

Once identified, participants were asked to participate in initial intensive interviews. As theoretical categories emerged in the data, the researcher conducted follow-up interviews as necessary to further examine emergent ideas and provide analytical robustness to the data (Charmaz, 2014). According to Charmaz, theoretical sampling is a strategic, specific, and systematic means for elaborating and refining theoretical categories by delineating and developing the properties and range of variation of the category or categories. Theoretical sampling is an example of how sampling and instrumentation are often synchronized and simultaneous processes in grounded theory methodology. As Charmaz states, theoretical sampling involves memo-writing and abductive reasoning—a mode of imaginative reasoning in which researchers invoke unaccounted for variables in surprising data, make inferences to consider all possible theoretical explanations in the findings, and then test hypotheses until arriving at the most plausible theoretical explanation for an observed phenomenon (Reichertz, 2007, as cited in Charmaz, 2014). Through theoretical sampling, "categories likely become increasingly abstract, hold greater theoretical reach, and demonstrate more theoretical connections when you have examined and coded more data" (Charmaz, 2014, p. 205).

Instrumentation and Data Collection

Grounded theorists use three main instruments for gathering data: observational field notes, in-depth interviews with participants, and document reviews (Corbin & Strauss, 2015; Charmaz, 2014; Glasser & Strauss, 1967). The type of instrument emphasized depends on the topic and access; however, in-depth interviews are typically the main instrument used in grounded theory research. Since the main emphasis of this

study was to understand the process through which parents go to grant informed consent for their TGD child to receive GCEI through the first-person experiences of the parents, intensive interviews were the main instrument of data collection. Environmental observation and document reviews were conducted when they were accessible. Interviews lasted between 30 and 75 minutes and were facilitated through Telehealth video conferencing software that complies with the Health Information Portability and Accountability Act of 1996 (HIPAA). Interviews were transcribed using a professional transcription company that provides confidential transcription services and has been used on previous dissertation projects. Interviews were video- and audio-recorded on a mobile electronic device, and recordings were stored electronically within a HIPAA-compliant version of an Internet-based file hosting service and on an password-protected Universal Serial Bus (USB) drive placed in a double-locked office within a locked filing cabinet in order to comply with HIPAA privacy standards. These media served to improve access to observational data in addition to interview data, and analytic memos were written immediately to capture the researcher's thoughts, observations, and questions in support of the theoretical sampling process (Charmaz, 2014; Creswell, 2013).

The researcher followed Charmaz's guidelines (2014) on intensive interviewing and will focus on the following key characteristics of the practice:

- Selection of research participants who have first-hand experience with giving informed consent for their TGV minor children to receive GCEI;
- In-depth exploration of the parents' experiences and situations;
- Reliance on open-ended questions;

- Focus on obtaining detailed responses;
- Emphasis on understanding the participants' perspectives, meanings, and experiences;
- Practice of following up on unanticipated areas of inquiry, hints, and implicit views and accounts of actions (Charmaz, 2014, p. 56).

During this sustained empathic process, the interviewee talks, and the researcher listens, encourages more information, and learns.

Interview Protocol

Based on the recommendations of Charmaz (2014), the researcher developed an interview protocol (see Appendix E) that emphasized open-ended inquiry and had a clear beginning, middle, and end. The protocol was examined and confirmed for its sensitivity to the experience of parents of TGD youth and its capability for addressing the research questions at hand with two individuals who meet criteria for participation. One of the individuals was the executive director of an LGBTQ+ advocacy organization in a rural part of the Mid-Atlantic Region of the United States. The second was a professional counselor living in the Mountain West Region of the United States who works with TGD clients. Both were parents of at least one TGD child.

Document Review

Data collection through document review primarily focused on a review of peer-reviewed literature that is relevant to emergent theoretical categories during the data collection and analysis process. This illustrates one of the key differences between grounded theory and other forms of research, both qualitative and quantitative in that, when possible, the literature review is recommended to occur as part of the data-

collection process rather than to be completed prior (Charmaz, 2014; Creswell, 2013). Extant documents from the peer-reviewed literature that related to emergent theoretical categories were reviewed. Governmental policy and media reports were also included to add context to interviewees' situations, experiences, and processes. Document review included the context in which the documents were created or published (i.e., who created the documents? what were the authors' intentions? where do the data come from? and who participated in shaping the data?). As categories emerged in the data, this researcher conducted searches within academic databases, such as EBSCO Host, to access peer-reviewed literature that is relevant to the emergent topics. This served to strengthen data analysis and avoid the pitfalls inherent in reviewing documents from the mass media as well as protected healthcare documents (Charmaz, 2014).

Analysis

Data analysis in grounded theory is a process by which researchers use constant comparison to identify and develop emergent ideas across data collected by intensive interviews, field observations, and document reviews (Charmaz, 2014; Creswell, 2013). For the purposes of the present study, the researcher chose and assign pseudonyms randomly to protect participant confidentiality. Beginning with the first interview, the researcher captured data via note taking during interviews and video and audio recording of interviews. Interviews were recorded via an Apple iPad which was secured via password and enrollment in Apple Business Manager's Jamf Now device management program. All recordings were immediately transferred the HIPAA-compliant Internet file hosting service and to the password-protected USB drive and deleted from other devices. Electronic and hard-copy data were stored in a locked filing cabinet in a double-locked

office of a professional mental health practice where the interviews were conducted. Consent forms were signed and stored electronically within Qualitrics. Audio-recorded data was transcribed using the previously referenced professional transcription service. Paper copies of the notes were destroyed using a shredder. The primary researcher had direct access to the data. Data will be kept until the conclusion of the project. Electronic files were deleted from the file-hosting service and also removed from the secure USB drive using the srm syntax to overwrite the drive space. Aggregate data and themes were shared with participants, study auditors, transcribers, and other interested parties using the file-hosting service. Individual level data were transcribed by the transcription service and examined by the researcher and study auditors using the file-hosting service but were not be shared with outside parties.

The researcher used line-by-line coding of interview data and continuously compared new codes with those of previous interviews. Microsoft Excell software (version 16.44) was used for keeping track of the coding matrix. In keeping with the constructivist approach (Charmaz, 2014), the researcher first used initial coding to identify concepts detected in the data and then focused coding to further develop theoretical categories. The coding matrix was reworked until a core theoretical category emerged that explains the underlying concepts inherent in the process parents go through to reach a point at which they grant informed consent for their TGD children to receive GCEI.

Trustworthiness

In qualitative research, a study's rigor is typically measured by trustworthiness of its findings, or the consistency of the results with the data collected (Merriam & Tisdell,

2016). To support this process, the researcher used a variety of strategies including triangulation, member checks, creation of an audit trail, and the researcher's position or reflexivity (Corbin & Strauss, 2015; Creswell, 2013; Merriam & Tisdell, 2016). The processes of member checking and the creation of an audit trail have been detailed above. Additional information related to triangulation and reflexivity is detailed below.

Triangulation

In addition to using the multiple sources of data and methods of data collection previously detailed, triangulation also involves the use of multiple investigators to confirm emerging findings (Merriam & Tisdell, 2016). To accomplish this, the researcher recruited two study auditors. One auditor was a doctoral-level counselor educator who has conducted research and provided counseling with under-represented populations. The other is a doctoral student in a counselor education program accredited by the Council on Accreditation for Counseling and Related Educational Programs (CACREP) who has clinical experiencing working with LGBTQ+ clients as well as certification with respect to inclusion and diversity practices. The auditors conducted blind coding of data samples and reviewed the field memos, study design, procedures, and process of theory integration for accuracy (Creswell, 2013).

Reflexivity

Reflexivity involves the "critical self-reflection of the researcher regarding assumptions, worldview, biases, theoretical orientation and relationship to the study that may affect the investigation" (Merriam & Tisdell, 2016, p. 256). This researcher identifies as a White, middle-aged, cisgender, straight man who has lived his entire life in

the Southern United States. He has been married for more than 14 years, and he is the father of two young children who were assigned female at birth.

The researcher's interest in the present topic is rooted in personal, academic, and professional experiences with conscience conflicts during the past three decades. His first recollection of LGBTQ+-related controversy that involved a governmental entity occurred in 1993 when Cobb County, GA, where the researcher was born and resided throughout his childhood, passed a resolution that stated that lifestyles advocated for by the gay community were incompatible with county standards (Applebome, 1993). Believed at the time to be the first resolution of its kind in the United States, many LGBTQ+ advocates, including Olympic Gold Medalist Greg Louganis, lobbied and won for the 1996 Olympic volleyball competition to be moved from Cobb County to another locality (Applebome, 1993; Associated Press, 1994).

The year after the Atlanta Olympics, the Southern Baptist Convention (SBC), one of the world's largest Protestant organizations, announced that it would boycott the Walt Disney Company in response to the theme park and media empire's support of gay lead television characters and the offering of health benefits to employees' gay partners (Myerson, 1997). This was particularly important to the researcher because he was an active youth member of a relatively large SBC congregation of which his family had been members for multiple generations. The debate in the media and within the pews was often fierce and divided, and it marked for the researcher the first significant intersection of religious practices, sexuality, and social action.

The next year, while attending the University of Georgia as an undergraduate student, the researcher befriended a male peer who identified as a Christian and claimed

to be conscience conflicted regarding his own sexual attraction to other men. This friend was participating in groups—and introduced the researcher to others who were also participating—and psychotherapy that were rooted in reparative approaches. Developing close relationships and empathizing with these friends and their persistent struggle played a major role in the researcher's pursuit of graduate study, and a subsequent career, in counseling.

Initially, the researcher began work toward a master of arts degree in marriage and family therapy and counseling at a small, conservative Christian seminary in the U.S. Deep South in order to gain the skills necessary to help people, particularly men, with what would have then been considered Ego-Dystonic Homosexuality (American Psychiatric Association, 1980), resolve their conscience conflicts in a way that maintained loyalty to interpretations of biblical scripture that did not affirm LGBTQ+ orientation, identity, nor behavior. This perspective was common in this setting and remains that way; in fact, the current chancellor of the seminary was one of the original signatories of *The Nashville Statement* (CBMW, 2017; Duncan, 2018). This intention began to change during the first semester of graduate work when the researcher completed a literature review on the risks and benefits of reparative perspectives and approaches for an assignment on a major area of controversy and research. This was the researcher's first meaningful contact with the peer-reviewed literature on this topic, and the first time this researcher learned about the considerably negative mental health outcomes among the LGBTQ+ communities as compared to the general population.

At this time, the researcher's perspective on the relationship between theology and science, and psychology in particular, began to shift. The researcher entered graduate

school espousing the Jones's (Yarhouse, 2011) critical evaluative mode, privileging scripture over the secular interpretations of scientific research. After completion of the afore-mentioned assignment, this researcher moved to endorse a perspective that better aligned with Jones's constructive mode. Perhaps ironically, it was when this researcher read Jones and Yarhouse's (2007) study about affectional reorientation change that the researcher changed his perspective on the relationship between theology and science to better reflect the dialogical mode (Yarhouse, 2011), partnership, or concordism (Tenneson, Bundrick, & Stanford, 2015): science and theology in superficial conflict, but deep harmony. This was due to the relatively low success rates of Jones and Yarhouse's study as compared with the relatively high rates of suicide attempts for LGBTQ+ people, especially for those with experiences in religiously based non-affirming environments (Gibbs & Goldbach, 2015; Grossman & D'Augelli, 2007; Hatzenbuehler, 2011; Jones, 2016). To this researcher, the loyalty to non-affirming religious beliefs no longer appeared compassionate, which appeared to contradict the over-arching message of the love in the Bible. This contradiction motivated the researcher to re-examine his understanding of Christian scripture in a way that better emphasized cultural and historical context (Karslake, 2007; Vines, 2014). Since that time, this researcher has written, taught, and practiced in ways intended to affirm LGBTQ+ identity. Particular interest in serving TGV individuals and their families emerged from personal relationships with transgender advocates, the review of emerging data (e.g., the USTS), and an influx of TGV youth clients attempting to resolve conscience conflicts for themselves and with their parents.

The researcher's process appears to reflect Minnix's (2018) Relational Equilibrium Model of religious-based value conflict reconciliation. Like the participants in her grounded-theory study, this researcher was previously reluctant to affirm LGBTQ+ identity and behavior due to a fear of a loss of belonging in his spiritual community and having been taught not to question the authority of scriptural interpretations that same-sex affectional orientation and transgender identity were sinful. Since resolving to affirm LGBTQ+ orientation and identity, this researcher has experienced the safety to question previous conceptions on the topic due to going through the process with other, like-minded people; come to the conclusion based on scientific and theological literature that affectional orientation and gender identity are not a choice, nor condemned by God; and experienced a deepening of spiritual awareness and practice rather than a dissolution thereof (Minnix, 2018).

Like Minnix, before beginning the present study, this researcher identified the following personal beliefs: (a) LGTBQ+ affirmation is congruent with mainstream Christian values; (b) scholarly interpretation that considers the cultural and historical contexts of biblical passages can be helpful to the reconciliation process; and (c) paradigmatic shifts typically require a personal and experiential encounter with someone or something. Therefore, throughout this study, the researcher's observations, questions and personal reflections will be recorded in memos and field journals (Charmaz, 2014), and these documents will be included in reviews conducted by the study's auditors. The researcher and the auditors will discuss matters related to these pre-identified beliefs throughout the study and discuss the need to bracket them off in order to be as open and

receptive as possible to learn new things from the study participants (Corbin & Strauss, 2015; Charmaz, 2014; Creswell, 2013).

Summary

This study seeks to contribute to the literature around the experiences of parents of TGV youth and the processes by which they affirm the youth in their care. Data will be gathered through intensive interviews, environmental observations, and extant document review. Data will be analyzed for emerging categories and theory through constant comparison. The researcher will use triangulation, member checks, creation of an audit trail, and reflexivity to bolster the trustworthiness of the findings. Chapters 1 and 2 framed this study within the historical context of the profession and the current literature. Chapter 3 has provided an outline of the study's methodology. Chapter 4 will provide a description of participants and the results of this study, and Chapter 5 will provide a discussion of the implications of the results for individuals and families dealing with the complex focus of this research as well as implications for counseling clinicians working with families so affected and the counselor educators training the next generation of practitioners.

Chapter 4: Results

Chapter Overview

The purpose of this study was to understand the process by which parents of TGD youth—who more often than not identify as cisgender and heterosexual—develop affirmative understandings and approaches to their children's gender-identity and related transition needs and grant informed consent for the TGD youth in their care to undergo GCEI. Chapter 4 presents the results of this qualitative, grounded theory study. The chapter begins with a description of the sample and demographic characteristics of the participants. The second and third sections present the factors that participants reported inhibited their decision-making process, followed by the presentation of factors that participants reported contributed to their decision-making process. The fourth section of this chapter presents a central theme evident in the data, and the chapter concludes with a summary of the findings.

Description of Participants

Following recruitment efforts described in Chapter 3 to collect a national sample of participants, 22 people responded who identified as (a) a parent and/or legal guardian of a person who self-identifies as TGD and who have (b) given informed consent for their TGD child to receive GCEI. Of the respondents, 20 gave consent to participate in the study, and 17 participated in an intensive interview. As shown in Table 4.1, 13 participants identified as cisgender women (76.5%) and four as cisgender men (23.5%). Participants identified as either White (n = 16) or Multiracial (n = 1) and ranged in age between 32 and 61 years old (M = 49, SD = 6.32). The majority of participants were married (n = 14) with a few that were either divorced (n = 2) or separated from a spouse

(*n* = 1). One married participant had divorced the other parent of their TGD child but had remarried. In terms of education, participants had earned doctoral (*n* = 4), master's (*n* = 3), bachelor's (*n* = 5), and associate's (*n* = 2) degrees, and three had completed at least some college coursework. All participants were employed full-time (*n* = 12) or part-time (*n* = 5) across positions defined as professional (*n* = 9), mid-level management (*n* = 2), or sales/marketing (*n* = 2) with one participant each working in an upper-level management position, an office/clerical position, an early-childhood education research position, and a yoga instructor/natural health position.

The participants made up a national sample (see Table 4.2), both in regard to region of birth and region of residence. Participants were born in the Mid-Atlantic (*n* = 6), Midwest (*n* = 3), Southeast (*n* = 2), Northeast (*n* = 1), and Southwest (*n* = 1) regions of the United States, and two participants were born outside the country. Participants were currently living in the Mid-Atlantic (*n* = 12), Mid-west (*n* = 2), Mountain West (*n* = 1), Southeast (*n* = 1), and Southwest (*n* = 1) regions of the United States. The majority had been living in their region of residence for more than 10 years (*n* = 11) with three in their region for 6 to 10 years, and three 0 to 6 years. For the purposes of addressing the role of religion in participants' decision-making processes, participants were asked to identify their religious or spiritual affiliation. As Table 4.3 shows, the majority identified as Mainline Protestant Christian (*n* = 8) while others identifyed as unaffiliated (*n* = 3), Agnostic (*n* = 2), Atheist (*n* = 2), Jewish (n = 1), and ambiguously spiritual (*n* = 1).

With regard to the participants' TGD children (see Table 4), the majority had one TGD child (*n* = 13) while some participants reported that they had two (*n* = 4). The ages of the participants' children ranged from 10 years old to 26 (*M* = 15.78, *SD* = 3.88). The

Table 4.1
Sociodemographic Characteristics of Participants

Demographic characteristic*	*n*	%
Gender		
Cisgender Women	13	76.5
Cisgender Men	4	23.5
Marital Status		
Married	14	82.4
Divorced	2	11.8
Separated	1	5.8
Highest level of education		
Some college	3	17.6
Associates degree	2	11.8
Bachelor's degree	5	29.4
Master's degree	3	17.6
Doctoral degree	4	23.5
Employment status		
Employed full-time	12	70.6
Employed part-time	5	29.4
Professional identity		
Office/clerical	1	5.8
Sales/marketing	2	11.8
Professional	9	52.9
Mid-level management	2	11.8
Upper-level management/ business owner	1	5.8
Other	2	11.8
Household annual income		
More than $90,000	9	52.9
$60,001 to $90,000	6	35.3
$35,000 to $60,000	2	11.8

Note. $N = 17$. *Participants were asked to identify across a variety of different gender identities, relationship statuses, educational statuses, employment statuses, professional identities, and income statuses. Please see Appendix D for the complete demographic questionnaire. Only the identities or statuses selected by participants are shown.

Table 4.2
Participant regions of birth/residence

Region	Place of birth	%	Place of residence	%
Northeast	1	5.8	0	0
Mid-Atlantic	6	35.3	12	70.6
Mid-west	3	17.6	2	11.8
Southeast	4	23.5	1	5.8
Southwest	1	5.8	1	5.8
Mountain West	0	0	1	5.8
Outside U.S.	2	11.8	0	0

Note. $N = 17$

Table 4.3
Participant religious affiliation

Affiliation	*n*	%
Christian (Mainline Protestant)	8	47.1
Christian (Catholic)	0	0
Christian (Evangelical Protestant)	0	0
Muslim	0	0
Jewish	1	5.8
Agnostic	2	11.8
Atheist	2	11.8
Other/unaffiliated	4	23.5

Note. $N = 17$.

Table 4.4
Relevant ages

	M	*SD*	Range
Current age of parents	49	6.32	32-61
Current age of TGD child	15.78	3.88	10-26
Age of TGD child at time of consent	13.93	2.43	10-18

children's ages at which the participants gave consent for GCEI ranged from 10 years old to 18 ($M = 13.93$; SD = 2.43) in accordance with inclusion criteria and respective state laws that define the age of minority.

As described in Chapter 3, participants who consented to participate in an intensive interview were asked 13 open-ended questions intended to evoke the key categories and themes of the decision-making process toward giving consent for the minor in a participant's care to receive GCEI. Each of the 17 participants presented for their interviews on time and ready for their meetings as evidenced by polite greetings, verbal confirmation of consent to participate and to be recorded during the interview, and smooth transitions into the focus of the interviews. Each participant responded to the questions directed to them in ways that conveyed genuineness, and at least four participants were moved to tears during their interview. Through constant comparison-type data analysis, the following inhibitors and contributors to consent were illuminated as well as a central theme, i.e., a means by which participants used contributing factors to overcome inhibiting factors of the consent-giving process.

Inhibitors to Consent

Of the inhibitors to parents granting informed consent for the TGD youth in their care to undergo GCEI illuminated during the course of data collection, lack of knowledge and awareness of issues and concerns related to TGD identity, fear, doubt, grief over a lost parenting narrative, and rejection from healthcare providers (or payors) and parenting partners were identified most frequently. To a lesser degree, lack of access to affirming care due to residential location and the cost of treatments were cited as notable experiences of participants. Inhibitors to consent are detailed below.

Lack of Knowledge

Of the participants, all but one (n = 16) reported that they lacked knowledge or awareness of the issues that TGD youth face when their children either came out to them,

asked to participate in GCEI, or both. The following are some examples of typical responses. When asked what she knew about gender identity and/or gender expression prior to her child coming out, Jaylene (51), a White, cisgender woman divorced from her parenting partner, but remarried and living in the Southeast stated,

> Really not a lot, because I think that transgender people in the past were really colored as men who were sick and dressed like women. And even like, drag queens, I didn't really associate with. But I guess, you know, it was along those veins. It was like, either she's gay or she—but I didn't really have a good concept of how prevalent it is and what it really entails, so I really didn't know what I was dealing with. I was kind of ignorant to it all, but I didn't know I was ignorant is the thing—but I know I was.

Similarly, Lamont (54), a White, cisgender man, married to his parenting partner and living in the Mid-Atlantic region, reported:

> What I knew was very little. Well, let me rephrase that. I think I knew—well, to be honest, I still don't know that I know a lot. I know that I trust my wife, and I know that may sound terrible, but … my wife really kind of dives into the things. … Lack of information, lack of familiarity. Ignorance on my part in the truest sense, just lack of knowledge.

As was the case with Lamont, participants often cited lack of knowledge as a key component of their fear over giving informed consent for their TGD child's GCEI.

Fear

Participants reported experiencing fear in response to their child's request to begin GCEI on multiple levels, including fear of negative future social experiences for

their child, fear of the side effects of the treatments, and political fears. Of the 17 participants, 13 reported fears over negative future experiences. Hilda (50), a White, cisgender woman, married to her parenting partner and residing in the Mid-Atlantic region said:

> It's scary as hell. It's terrifying. … I saw a great quote that I love that says, "I wouldn't change my child for the world, but I'd change the world for my child." It's not that I'm fearful of who she is; I'm fearful of what the world is going to do to her.

Lennon (55), a White, cisgender man, married to his parenting partner and residing in the Mid-West reported worries about his child finding companionship later in life, among other concerns:

> … As long as I look at (child's name) as who he is now—what's his future going to be? Oh, I guess the other thing—the biggest worry initially is how society will look at him. Will he find love? Will he find a partner who loves him for who he is? Because by becoming transgender in my mind—maybe it's wrong, but I think it probably isn't—it reduces your field of people who will accept you. You know, being just a cis White male or a cis White female, it's much easier to find people who will accept you than if you're trans. Someone to love you as a partner. That's always been a worry. It really kind of always will be. Right now, it seems like he's found someone who really loves him for who he is and that's great. Again, that's what you want for your child.

Emma (56), a White cisgender woman, married to her parenting partner and residing in the Mid-West, held back tears as she recounted her experience following her realization that her child identified as TGD:

> The fear was, will he find someone to love him in his life? Because you know he's not going to stay home forever, and you send your child out into that world and you just say, "Please, world. Love him as much as he deserves to be loved." Fear that society would not accept him. Sorry, I'll tear up.

Similar to fear of future experiences for their children, 12 participants cited fear of the side effects of their child's requested GCEI. This fear appeared particularly relevant to this study given the previously cited paucity of research examining the long-term effects of GCEI on developing preadolescent and adolescent bodies. Sharyn (47), a White, cisgender woman, divorced from her child's father and residing in the Mid-Atlantic region who cited this fear also happened to be a medical professional:

> I'm a (medical professional), so I know a little bit, but I mean, I had a lot, a lot of misconceptions—not just about the hormone therapy, but, you know, my child's only 17 now so that was another thing that, that really was kind of heavy for me. I just assumed I wasn't going to be able to do anything until he was like 18 or 21. I mean, he's been on hormones for almost a year now. He's had his top surgery, his name legally changed, like, I'm so happily wrong about a lot of things. So I kind of assumed that there would be more risks with the hormones than there actually are, you know?

Camilla (46), a White, cisgender woman separated from her partner and living in the Mid-Atlantic region, had similar concerns. She reported that her concerns about the long-term side effects of GCEI persisted even after granting consent for her child to undergo GCEI.

> I was more familiar with more of the estrogen-type treatments to become more female, so, I don't know a whole lot about (the use of male sex hormones) honestly. I don't feel like I do. I mean, as a natural health practitioner, I'm familiar with the hormonal systems. But I didn't have a whole lot of information on how testosterone, for instance, would affect (my child). … I didn't have a lot of good, solid information. I had a lot of preconceived ideas, I think, that it would make physical changes, you know, for appearance and voice. Body mass changes. Yeah, and then, of course, it was—for me, it was a concern of how does that affect the long-term health of my child? That's actually a question that I still have.

Finally, at least six participants communicated that fears related to the political climate inhibited their decision-making process. The context for these fears has been detailed in Chapter 2; however, it should be noted that the timing of consent for many participants and their families coincided with prominent, non-affirming events that occurred as a result of conscience conflict-type debate and legislation within local, state, and federal governmental agencies. Honour (43), a White, cisgender woman, divorced from her parenting partner and residing in the Mid-Atlantic region recounted that political fears affected her and her child's decision-making process in a very direct way:

> (Child's name), he's a very bright kid and he really, you know, it's interesting the different options that were available, and (the endocrinologist) looked at me and asked if we had a preference (of puberty-blocking method), and I said, "I'm not the patient. ... What does (child) want?" And I was absolutely surprised at (child's) response, and their response was the (hormone) implant. That surprised me, because it's more invasive, and the physician even seemed surprised and said, "Well, that's unusual. Most young people, that's actually their last choice of the three. Tell me more about why that's your first choice." And you know, here we are, my ex-husband, myself, and (child) in the room with the endocrinologist and a couple residents and fellows, and (child) says, "We have a presidential election coming up, and I don't want to be in a situation where I start monthly or quarterly shot treatments only to have that right taken away from me. If they put a two-year implant in my arm, they're not going to come rip it out."

Doubt

Although a minority of participants (*n*=6) expressed doubt in the genuineness of their youth's TGD identity, it seemed significant in the context of this study given that research that has suggested that transgender identity develops in a way that parallels the gender identity of cisgender children has been published only recently (Drescher, 2010; Gülgöz et al, 2019) and the challenges for adolescents regarding impulse control and executive functioning are well-documented (Siegel, 2013). Berta (48), a White, cisgender woman, married to her parenting partner and living in the Mid-Atlantic region stated:

> It was scary at first because everybody goes to the same place, which is scared for your child. And then, you know, maybe this is a phase? Maybe he's confused? Maybe—you know? And so, you go through all those things.

Tony, 61, a White, cisgender man, married to his child's mother and living in the Mid-Atlantic reported that he affirmed his child's gender identity from the beginning, but when it came to the request to begin HRT, he was more cautious:

> As far as going to the hormonal therapy, we wanted to know more about what that involved? Was this an irreversible process? At that point we were still wondering, is this the final result? You're non-binary. We heard that sometimes kids go fully transgender. It's rare that they would go back to being (cisgender) or whatever. That wasn't really a thing. But some people remain non-binary into adulthood and everything. We just needed that time to learn about it.

Grief

The most prominent inhibiting factor not directly related to lack of knowledge leading to fear or doubt was participants description of grief over their lost parenting narrative. A majority of participants (n=9) reported that the change in their expected future with their child that came as a result of learning that their child identified as TGD, and, notably, all were careful to differentiate between what they were experiencing and the more common usage of grief referring to a loss through death. For example, Adele (32), a White, cisgender woman, married to her child's father and living in the Mountain West described an internal conflict consistent with her peers:

> I think maybe—and I've heard this from other parents as well—that there's this kind of creeping in of grief, and I think we all hate it as parents because in one way the grief feels like it shouldn't be there at all because we have this beautiful, amazing human to celebrate. It doesn't matter what box they fall into or if they break the mold. I think what the grief is it's this sense of loss of the future that you envisioned for this child. Even if you should be able to adapt, it's still there. It's not gone. And so, when we make these choices for hormone therapy and whatnot, it's kind of a step further in the direction of whatever could have been will definitely never be. But it definitely wouldn't have in either way.

For others, the sense of grief lingered for a long time unnamed. In fact, in the case of Hubert (45), a White, cisgender man, married to his child's mother and living in the Mid-Atlantic, the location of his grief came to him for the first time during his interview:

> I guess what sort of apprehension I may have had about the process in general early on and my acceptance of my trans daughter—I have three brothers, and all of my brothers had only daughters. And so, I was the first one in my family to have a male child, and I was very proud of that. I've got an heir to carry on the family name. … I'm wondering if that may have been in the back of my mind and been part of my apprehension to accepting my daughter.

Rejection

A substantial minority of participants (*n*=8) reported experiencing what could be considered some form or rejection, either from a parenting partner or a healthcare

provider. Of the six participants who reported that their parenting partner demonstrated signs of rejection, all were cisgender women (i.e., only cisgender men related to participants in this sample demonstrated at least some rejecting behavior). Of the six participants, only two reported that their parenting partner maintained their rejecting stance in a way that ultimately put informed consent for their TGD youth to undergo GCEI at risk, and only for legal reasons. One participant reported that they won a legal case to have her child's father's rights terminated regarding medical decisions. The other, Sharyn, reported being surprised that her child's father came around on the issue:

> Consent from his dad was sort of unexpected. … It was silence for months from the time we first asked. I wrote a letter (to him); my son wrote some letters. And then, you know, months go by. I was calling the (medical center) saying, "OK, what can we do?" I was about to, you know, get the caseworker there involved, and then, out of the blue, the signed consent form showed up in the mail. So I was on the phone making that appointment right quick.

Mellony (49), a White, cisgender woman, married to her child's father and living in the Mid-Atlantic, recounted an experience that was more typical in the sample:

> My husband, was a little slower, in the beginning, to get on board. Not that he was against anything, I just think he had a harder time—you know, "Is this really real? Is this a phase? Did she learn it on the Internet? What's really going on?" And so, I think that piece of it—that doubt—would have inhibited a little bit. Kind of like, "OK, are we doing the right thing?"

Three participants described that they considered to be rejecting messages and/or behavior from healthcare providers. In response to a question about how a mental health professional was involved in her decision-process, Journey (51), a White, cisgender woman, married to her parenting partner and living in the Mid-Atlantic stated:

> Actually, that was probably one of the worst experiences. … We had reached out to our insurance to discover what we needed to have (access to HRT), and we learned that we probably needed a letter from a counselor or a therapist. And so we quickly tried to find a counselor or therapist that would be able to help us if we needed it. And we were given names of people who were supposedly LGBT friendly. The first one we went to, we actually walked out. She said she wanted to talk with my daughter on her own first and, so, she did that. She spent, like, you know, 30 minutes, or however long it was with her, and then she called us in. We sat down and she said, you know, "Do you have any questions?" One of the things that was concerning me at the time was, you know, "How do I tell my younger children." And she said, "Oh, I wouldn't do that. He's probably going to change his mind." And so we said, "Well, OK, there's a lot we don't know, but that's not the right answer."

Adele described denials of reimbursement from her child's insurance company as well as unwelcoming responses from front-desk workers at the clinic at which they were seeking treatment:

> We brought our referral letter to the front desk during that very first appointment, and the person at the front desk took it. They seemed

incredibly—I don't know how to word it—off-putting in that, we were like, "one of those." I don't know. Maybe I'm just being sensitive.

Lack of access

A minority of participants reported that lack of access to affirming treatment due to their residential location (*n*=5) and/or insurmountable financial cost (*n*=3). Some drove several hours away and across state lines so that their TGD youth could receive treatment. Suzie (53), a White, cisgender woman, married to her child's father and living in the Mid-Atlantic stated: "We have one—one—pediatric endocrinologist in (name of city). And when I called around for our first implant—just someone to see our child—you wouldn't believe all the offices that said, 'Nope. We don't do that here.'"

Sharyn recounted that her ex-partner's reluctance to give consent affected the cost of treatment, stating, "All we could do (without his consent was a prescription to stop periods, which (was) about three or four times more expensive than hormones."

Contributors to Consent

Of the contributing factors to parents granting informed consent for the TGD youth in their care to undergo GCEI illuminated during the course of data collection, parental attunement to the experiences and emotions of the youth in their care, access to affirming education about TGD issues and GCEI, and the presence and/or development of affirming relationships and community were identified the most frequently. Contributors to consent are detailed below.

Parental Attunement to Youth's Experience

The construct of parental attunement has been defined as a relational dynamic between parent and child that surpasses what is typically included in the construct of

empathy. Erskine (1998) posited that attunement two-part process that includes (a) the ability to sense and to identify with another person's sensations, needs, and feelings and (b) communicating that sensitivity to the other person. A parent's ability to attune to their child's experience and emotional world has been prominently associated with the fostering of secure personality development in children throughout the literature related to the attachment theory first articulated by John Bowlby and furthered by the work of Mary Ainsworth (Siegel, 2013; Wallin, 2007). Participants in this research implied their ability to demonstrate parental attunement by describing their wishes for their TGD youth's social and emotional well-being as a primary motivator for granting informed consent for them to undergo GCEI in addition to an implied respect for their youth's autonomy, their recognition of their youth's gender non-conformity (often prior to the young person directly disclosing their TGD identity), and their recognition of their youth's mental health symptoms. Participants also recognized their own position of privilege that facilitated granting consent and a sense of their own autonomy from their families of origin or other potentially inhibiting factors such as non-affirming religious backgrounds.

One of the more striking examples of parental attunement in this sample was provided by Tony, who tearfully recounted the following memory of a conversation with his then-16-year-old child following a support group meeting he and his partner had attended earlier that day:

> One of the groups that fall of 2017—we had a really good meeting, and when we picked (child's name) up afterwards to come home, I said, "You know, what would really help me is, could you write down your goals,

> what you want, and be honest with everything. We want to support you. We want to get to where you want to be. I would love to see like, a timeline or just sort of where you see things going in the near future." So, after we got home, within about two hours, (child) brought me something that I still have, and I want to show you—this timeline that they did. Obviously, many colors. Rainbow colors. And I've written on it over these years and updated it and everything like that. It says "Trans with the Plans." And that was when I knew that this kid I love so much knew what they wanted, and I had to support them.

A notable majority of participants (*n*=16) reported that they recognized their child's rejection of binary gender norms prior to their child coming out to them. This recognition often came during early childhood. Hilda recounted the following memory that clued her to her child's gender diversity early on:

> One Sunday morning we were getting ready to go to church and I had (child's name) in her little dress shirt and tie and dress pants, and I told her to go get her dress shoes, and her little face lit up. She ran down the hall and came back in those little Cinderella shoes—so, (child's name) was always (child's name). It just took us a while to catch on.

Every participant recounted a recognition of and concern for their child's mental health symptoms. Several noted an awareness of the elevated rates for suicide and non-suicidal self-injury (NSSI) among TGD youth as compared with their cisgender peers. Prudence (46), a mixed-race, cisgender woman, married to her child's father and living in the Southwest recognized both in her child:

> (Child's name) was a cutter in the middle school grades. So, in hindsight now, he was giving us the signs. And he would also cry and come to our bed at night, you know. I mean, as I'm talking, I suddenly remember that there was a night that (child's name) came to us in the middle of the night crying at the side of my bed, and I do remember saying—we had just experienced a suicide at school—my gut response was, "Are you okay?" and he said, "Yes." And I said, "Are you feeling suicidal?" and he started crying. He didn't respond verbally, but he just started crying, and so I just pulled him in bed with me and I snuggled him.

This memory flowed into Prudence's recognition of her privileged position within the context of her peers: "I often say we're really lucky, because I've been to support groups where the parents have already lost a child to suicide. We're the lucky ones." Each participant provided responses that indicated their recognition of privilege, including statements that the participant was lucky to have a patient child, or that they lived in an area with a variety of affirming healthcare providers, or that they had the financial means to overcome elevated costs of treatments.

A less-frequent, but nonetheless notable, sign of parental attunement to the experience and emotions of their child was participants' descriptions how they prioritized the wishes and needs of their child and demonstrated autonomy from their families of origin (n=10) or non-affirming religious backgrounds (n=4). Suzy recounted planning with her partner how to break the news of their consent to extended family members:

> (When) we told extended family, I was making the phone calls, but (my partner) reminded me, he said, "Remember, this is not a terminal illness."

> It could be, right, if you don't do it right, but just say, "We're not asking permission, and we are not apologizing." So, he kind of like, you know, held me up when we made those calls.

Brenda (48), a White, cisgender woman, married to her parenting partner and living in the Mid-Atlantic, described her experience within a religious community that had members that were reluctant to openly lend support and others who wanted to offer support but lacked the necessary knowledge and skill to do so. In recounting what led her and her family to leave their congregation at the time, she stated:

> I did chat about it to anyone who asked and had hoped to educate and affect some positive change from within, but lots of folks just weren't ready or willing to have these conversations. Which was interesting because this was all during the time when the (denomination) was making high-level decisions about whether or not to affirm LGBTQ folks.

Access to Affirming Community, Education, Healthcare, and Parenting Partnership

All participants made at least some reference to having access to an (1) affirming community of TGD-affirming parents, professionals, colleagues, and/or friends, (2) affirming education, (3) affirming healthcare, and (4) a supportive parenting partnership. Even Jaylene, who reported that she won a legal battle to have her child's father's rights terminated related to medical decision-making, reported having the affirming support of her current partner in regard to giving consent for her child's GCEI. A key element of access to affirming community was participants' acknowledgement of what might be considered access to *possibility models*. This term, which participants credited to prominent transgender actor Laverne Cox, refers to a person who identifies as TGD and

had successfully gone through a medical transition or a parent who had successfully supported their child through a medical transition. Possibility models were referenced when participants spoke about their experiences with family friends, support group members, professionals, and members of the mass media. Adele and Emma, in particular shared poignant stories of how possibility models supported their decision-making process. Adele gave credit to TGD adults who came to parent support groups as a way of giving back to their community:

> We had a member in our community (who) came out and transitioned in the ’90s, and she knows a different reality or generation where survival was even more challenged than it is now for trans women. And she runs—she does a food bank, but she also does these toy drives during Christmas time for members of the LGBTQ community, for kiddos who either their parents or family members are members of the LGBTQ community or they themselves are, and it’s amazing. She’s had events where we’ve gone and it’s at a club—there’s a club in (Southwestern town where Adele and her family previously lived) that she works as a bartender, and members of the community own or at least operate the bar. So, during the daytime, they turn it into a community-based space, so we’ve been able to go there and meet other members of the community, meet other kids, and it’s a safe space and they’re celebrating these identities.

Emma reported finding support through mass media in a way that she did not expect: reading and watching the written and video recorded journals (also known as blogs and vlogs, respectively) of other TGD youth:

> When I would watch kids on their little blogs, on those YouTube channels, being like—I have my favorite ones. One kid in London gets his mom on. And I would talk to (child's name) and be like, "That kid is adorable. He is so cute," and he'd be like, "Yeah," and he would guide me to other ones. "Mom, you should listen to this one." I'd be like, "Okay!" I think those kids were the ones that gave me that possibility because they were a little bit older than (child's name). They were going through the process. They were showing me what it was like, and the most important thing was they were showing me how happy they were.

Each participant noted the importance of affirming education, which sometimes came from other parents at support groups, Internet searching, consultation from medical and mental health professionals, occupation-based continuing education, and traveling to TGD-related conferences. Suzie traveled across the country to multiple conferences, sometimes bringing her child with her:

> I got educated really quick, you know? So, I've been, I dove in. I met the people—I started making connections, learned about it. And that's why I'm saying, like the information I learned from the very beginning was still the same information four or five years later. It's still the same information now.

Adele noted the support her child received from an affirming professional counselor during the process toward GCEI:

> This counselor met her where she was and was using all arts-focused interventions, just letting her color or do very specific art-space activities

> and interventions that would be geared toward just expressing herself, what was going on internally. And I think it helped her to externalize what was happening, and then also, she was able to talk about the things that she was going through without—because I know, Mom and Dad, right? We're worried about how the school's responding and anytime we're noticing distress, we're thinking "What can we change in the environment to make this easier on you and better?" And I think the counselor just—because it was a space where there was no pressure, she could say anything and the response wouldn't be, "Okay, so what do we change? What do we address? What do we fix?" Yeah, it helped her sort of get things out there and not feel pressured to then turn it into action.

Regarding supportive parenting partnerships, the father's acknowledgement of the support and affirmation of their partners was striking. Lamont provided a response typical of the men in the sample:

> I really have to credit—my wife really took a lead on, you know, when (partner's name) learns a situation, particularly if it relates to our kids, (she) dives in and researches and talks to people. And you know, fortunately for me, I can just kind of sit back and let her do that and then we'll kind of talk about it. So, really it was my wife's passion and her belief that this was the best course of action for our child.

Affirming Religious Beliefs and/or Community

A notable minority (*n*=8) reported that affirming religious beliefs contributed to their decision-making process. Also notably, each of these participants indicated that they

identified as Mainline Protestant Christians. Emma provided a response typical of the sample in regard to the role of religion in her decision-making process:

> I've always been totally fine with gay individuals, all of that, and actually, one of our friends—he was the choir director at our new church—asked me one time how I could reconcile this, because he's come out of a (denomination known for non-affirming stances toward LGBTQ+ behavior and relationships) upbringing, and I said, "You know what? Jesus said we are Children of God. He didn't say we were Boys and Girls of God." So, if you are going to stick with Jesus, whether you believe in the Second Coming or believe in prophets, however you perceive Jesus in your theological story, that's fine with me as long as Jesus lets you do good things. Jesus says we're all Children of God and he did not define what a Child of God looks like, and anything else from that, it doesn't matter. And you can quote me whatever you want out of the Bible, but to me that is the most true statement on being accepting and how God creates us all. So, if you want to pick on sexuality or you want to pick on gender identity, knock your socks off, because it doesn't matter because God created this world to be diverse. Look outside, and you're going to see it. So, we're just living in that reality of being Children of God.

Central Theme: From Dissonance to Consonance

Each participant described an initial expectation that their youth would express their gender in a way that aligned with the social expectations assigned to the sex assigned at birth of their child, i.e., they at first assumed that their child would identify as,

like them, cisgender. When they recognized that their child's gender expression did not align with those social expectations, each participant described experiencing some level of intra- and interpersonal tension. This phenomenon may also be understood by what is commonly known as *cognitive dissonance* (Festinger, 1957; Myers & Dewall, 2019). Like the construct of parental attunement described previously, the construct of cognitive dissonance borrows from the physics of music, in which the term dissonance is used to describe a lack of harmony, or two or more tones of different frequencies that combine to form a musically displeasing sound. On the other hand, consonance is the term used to describe a combination of one or more tones of different frequencies that combine and result in a musically pleasing, i.e., harmonious, sound (Errede, 2017). Festinger's cognitive dissonance theory (1957) suggests that when faced with this type of mental tension, humans often bring their attitudes and beliefs into alignment with their actions (Myers & DeWall, 2019). The responses of the participants of this study suggest that this is an apt metaphor for their decision-making process.

Inhibiting factors and contributing factors to this process have been presented above. What follows in this section is a summary of a central theme that emerged from the responses of participants that appeared to show how participants combined contributing factors to overcome inhibiting factors and reach a decision to grant informed consent for the TGD youth in their care to undergo GCEI. Each participant described an experience of *exposure* to some form of human diversity prior to their youth confirming a TGD identity. In other words, participants experienced this exposure prior to their child coming out to them. Each participant described a cognitive-emotional *openness* to new and TGD-affirming information as well as an *acceptance* of the new and affirming

information presented to them. Each participant recounted using the affirming information available to them to make a TGD-affirming cost-benefit analysis that led to the granting of informed consent for their child to undergo GCEI. Finally, each participant described feeling a sense of relief that they gave informed consent for their youth to undergo GCEI. Figure 4.1 shows a dissonance to consonance model of these mutually influencing central factors with inhibiting factors and contributing factors situated within the model in the spaces in which they were likely to have the most impact on participants' decision-making processes. The following quotations represent examples from the data that support the central theme of this study and the dissonance to consonance model.

Exposure

Each participant described previous exposure to some type of human diversity, whether it was as personal as identifying as a cisgender woman (as in Journey's case), a professional experience, or knowing someone within their children's social networks. Mellony reported personal and professional exposure, stating:

I knew a woman who I used to work with many years ago who came out as trans, so I did know someone. I also knew another mom whose child had come out a couple years earlier, so it was not completely foreign to me.

Brenda reported that a friend of one of her older children who identified as transgender became one of her first possibility models for her TGD child:

> My second-oldest had a friend from high school who would come over and hang out with us and spend the night, and we just loved this kid. He was fantastic. And then, you know, a couple years into knowing him,

> something came up where my daughter had to, you know, had to let me know that he was actually trans. And I never had any clue. So that I think helped me, in a way. … That gosh, they can survive and thrive, and that they can be OK.

Openness

Each participant described generally open attitudes that led to parenting decisions ranging from which toys with which to allow their child to play to motivating education about TGD-related issues. Journey provided a response typical of the sample regarding early approaches to childrearing:

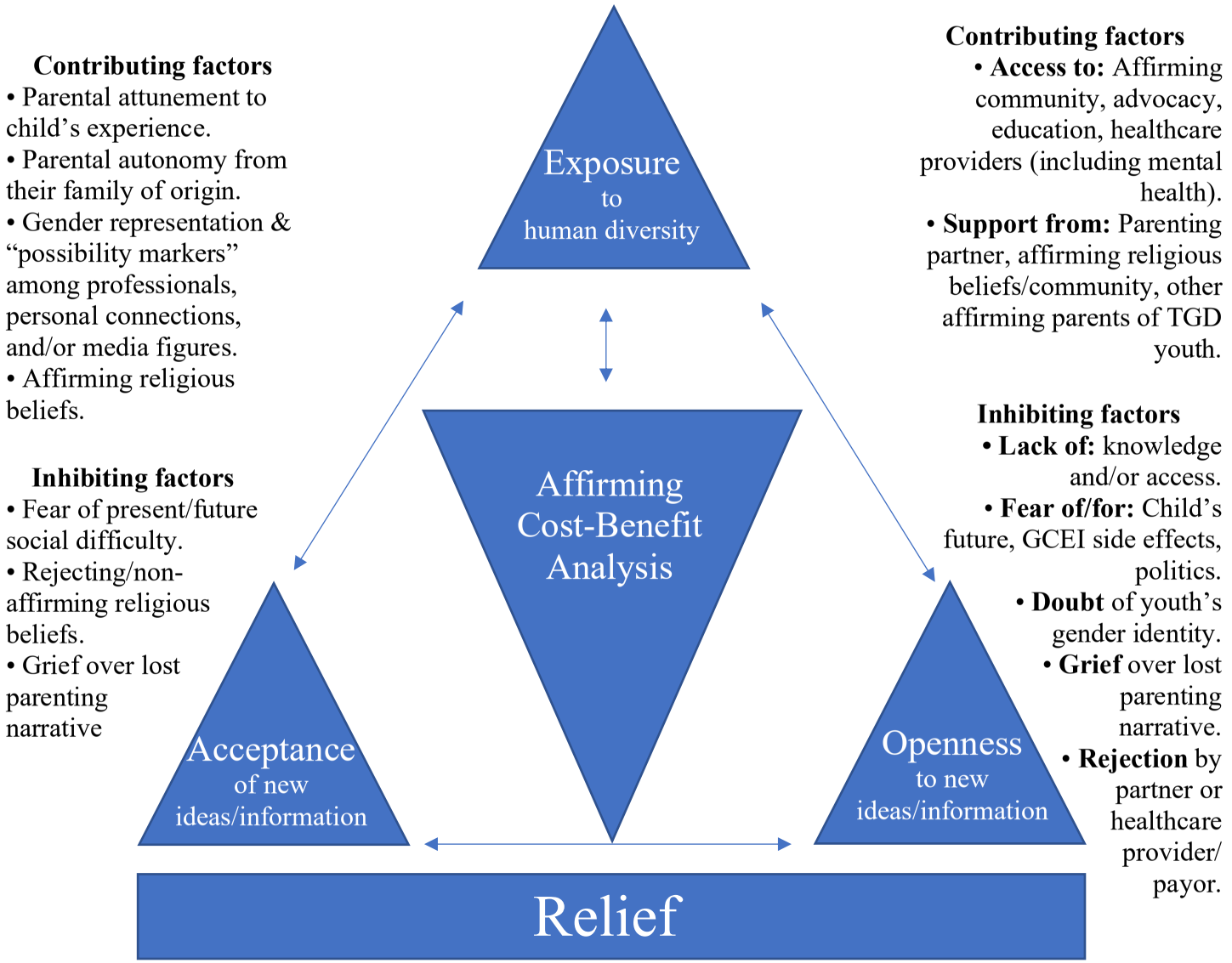
> I just was very open to letting her play with whatever she wanted. I've just never been, you know, toys don't have gender so I just bought her whatever toy she wanted. And, really, after that I just never really even noticed anything unusual; it was just who she was.

Multiple participants described feeling motivated to seek credible information and affirming community to educate themselves about TGD-related issues upon learning that their child identified in a gender-diverse way. Adele recounted memories that were typical of the sample:

> We did a lot of research on our own, my partner and I. And then, also talking with other members of the (TGD-related) play group. … So, we had other parents and kiddos that (we) were able to talk to about what they were experiencing, and we heard from families about what the process looked like for them, so it was a lot of communicating with members of the community to learn.

Figure 4.1

A Dissonance to Consonance Model



Acceptance

Prudence provided an example of acceptance typical of the sample in that she not only accepted that the GCEI and other affirming practices would be beneficial, but she also arrived at a place where she wished she had started them earlier, beginning with puberty blockers. She stated:

> If I had accepted earlier that (child's name) was—you know, I often say (child's given name at birth) was the vessel, (child's name) is the soul. If I had known that, and understood it wasn't a phase at the time, I probably would have pushed to start hormone therapy—not necessarily the testosterone, but the blockers—so he didn't go through puberty as a female, because then, you know, we could have potentially prevented him from growing breasts, and then ultimately having the surgery that he did—that gender-confirmation surgery.

Affirming Cost-Benefit Analysis

Berta provided a description typical of the sample regarding her and her partner's affirming cost-benefit analysis that led to granting informed consent. She highlighted her access to a supportive community as well as her recognition of the mental health implications of a non-affirmed TGD identity for her child:

> And so when the time came, it was a back and forth, and we did, you know, have to really think about it. But the support group I'm in and a parent who had come before me said there's really nothing that you can't reverse. You can wear a wig if your hair falls out, you know? If you start growing facial hair and then you decide you don't want to, you can get

> electrolysis, you know? If you get your breasts removed, you can get implants. Like, there's really so few things that are irreversible to the point where science couldn't help you. And I thought, OK. But what it really comes down to, and I think probably for everyone is, do you want a dead kid, or do you want a kid that might be slightly altered? So when it came down to it, with a kid who had anxiety, and depression, and self-harm, and all of these other kinds of myriad of problems, you know, we looked at him and thought, "You're miserable, and if this will help you not be miserable, then we will go for it." And so, in the end, we thought, you know, I don't think there was a lot to lose in giving it a try, because it's something your body makes anyway. It just didn't make enough to make him what he needed to be."

Relief

Each participant expressed a sense of relief that they had granted informed consent, usually because they noticed improvements in their child's moods and general sense of happiness. Lennon provided a statement that was typical in the sample:

> Well … (child's name) seemed to be happier with it, and again, he felt better about himself. His mood changed. That was the key. I think the fact that we saw (child's name) become happier with it, that's the key. That's all that really mattered.

Other Considerations

In this sample, a minority of participants reported experiences that did not appear to be overt contributors or inhibitors to their decision-making process. A

minority of participants reported initial feelings of isolation (*n*=3) and feelings of regret for not beginning GCEI sooner (*n*=5). These factors from the sample will be presented in greater detail in Chapter 5 as part of the discussion of implications of the results for professional counselors and counselor educators.

Trustworthiness of the Results

The researcher used a variety of strategies common in qualitative research to establish four aspects of trustworthiness: credibility, dependability, transferability, and confirmability of the results (Merriam & Tisdale, 2016). To establish credibility, the researcher used member checking, i.e., affording each participant—or member of the sample—an opportunity to review the transcript of their respective interview and confirm its accuracy or suggest edits to ensure accuracy. The researcher also used methods and analyst triangulation. In other words, the researcher collected data via intensive interviews, observational field notes, and document review, and a team of two study auditors blind coded member-checked transcripts. The primary researcher created an audit trail, including a color-coded coding matrix, field notes, and documents reviewed, and compared his coding and discussed his analytic impressions during two separate meetings with the study auditors. Analyst triangulation also served to support the dependability of the results. An additional step the researcher took to establish dependability of the results was to invite two non-participants who met this study's inclusion criteria to audit the interview protocol for its sensitivity to, and accuracy for its measurement of, participants' experiences. These two non-participants, described in detail in Chapter 3, confirmed the protocol's sensitivity

and potential for accuracy prior to the researcher beginning data collection. As for confirmability, the researcher disclosed to the audit team his own background and position as they related to the study's research questions. This disclosure is detailed in Chapter 3. During the two meetings with the study auditors, the researcher's background and position were discussed for their potential to bias results, and it was determined that the researcher's background and position had minimal, if any, influence on the data collection and analysis processes.

Summary

Chapter 4 has provided a summary of the results of this research evoked by the methodology detailed in Chapter 3. Factors that inhibited the decision-making process of parents of TGD youth who have given consent for the youth in their care to undergo GCEI were presented. These inhibiting factors included (a) lack of knowledge about the issues that TGD people face; (b) fear of expected negative future social experiences, the long-term side effects of GCEI treatments, and political repercussions; (c) doubt about the genuineness and security of their child's TGD identity in the context of their developmental stage; and (d) lack of access to GCEI treatment due to limited resources available in the participant's residential location or insurmountable financial costs. Factors that contributed to participants' decision-making process were also presented. These contributing factors included (a) parental attunement to the experiences and emotions of the TGD youth in their care and (b) access to TGD-affirming community, education, healthcare, and parenting partnership. A central theme was also presented that showed how participants combined contributing factors to overcome inhibiting factors and reach a decision to grant informed consent for the TGD youth in their care to undergo

GCEI. This dissonance-to-consonance model involved the mutually influencing effects of participants' prior exposure to human diversity, openness to new ideas and information, acceptance of these new ideas and information as beneficial for their child, conducting a TGD-affirming cost-benefit analysis leading to the granting of informed consent for their child's GCEI, and the experience of relief following the granting of informed consent. Chapter 5 will provide a discussion of these results in the context of the study's three research questions and present implications for practitioners of professional counseling and counselor education.

Chapter 5: Discussion

Chapter Overview

The purpose of this study was to understand the process by which parents of TGD youth—who more often than not identify as cisgender and heterosexual—develop affirmative understandings and approaches to their children's gender-identity and related transition needs and grant informed consent for the TGD youth in their care to undergo GCEI. Using the qualitative, grounded theory methodology outlined in Chapter 3, this study used intensive interviews, field observation, and document reviews to collect participant data and facilitate constant comparison-type analysis to illuminate inhibiting and contributing factors to participants' decision-making processes. Constant comparison was also used to evoke a central theme, a dissonance-to-consonance model, that outlined how participants combined contributing factors to overcome inhibitors to giving informed consent for the TGD youth in their care to undergo GCEI. Chapter 4 presented these results in detail. This chapter discusses the results in light of the research questions guiding the study. This chapter also explores the significance of this study to the counseling profession as well as provides implications for the counseling field, future research suggestions, and limitations of the study.

Discussion

The primary research question of this grounded theory study was "How did the parents or legal guardians of TGD youth who have undergone GCEI decide to give informed consent?" Secondarily, "Are their specific themes that emerge for Christian, heterosexual, cisgender parents who go through this process?" Finally, "What part, if any, did a professional counselor play in the process?" The dissonance-to-consonance model

shown in Figure 4.1 appears to be how this sample addressed the primary research question. Participants consistently provided responses to intensive interview questions in ways that indicated that they used (a) experiences that exposed them to general human diversity prior to learning that their child identified as TGD, (b) openness to new ideas and information, (c) affirmative acceptance of the new ideas and information made available to them, (d) a TGD-affirming cost-benefit analysis to make the decision to grant informed consent for their child to undergo GCEI, and (e) a sense of relief in response to their child's improved mood and disposition post-consent to confirm for themselves that they made the right decision for them and their child to combine contributing factors and overcome inhibiting factors. These five characteristics of participants' decision-making processes appeared to be mutually influencing in non-linear fashion. In other words, exposure to human diversity was likely to be predicated by a participant's openness to new and variable experiences, and exposure was likely to then motivate the search for and affirmative acceptance of credible information regarding TGD-related issues and concerns. Without this openness and acceptance a participant may have been more unlikely to have acquired the education necessary to make an informed and TGD-affirming cost-benefit analysis. The experience of relief, considered by participants to be a positive experience, appeared to reinforce the decision-making process, making it likely to occur again under similar circumstances.

While the bulk of the research examining the conditions that lead to affirmation of affectionally and gender-diverse people have been conducted in regard to attitudes about lesbians and gay men, participants of the present study naming exposure to human diversity as a key element of their decision-making process is consistent with previous

findings related to the development of affirming attitudes. Exposure to education about sexual development has been associated with a decrease in negativity toward gays and lesbians among undergraduate students (Ben-Airy, 1998; Chonody et al, 2009). Participants in the present study cited experiences with human diversity as personal as their own experiences of discrimination as cisgender women to vocational continuing education to relationships with colleagues who identified as TGD as helpful in preparing them to accept and support their children. Similar to the studies of the effect of exposure to affirming education cited above, other studies have associated interpersonal contact with affectionally diverse people with the development of affirming attitudes (Herek & Glunt, 1993; Bowen & Bourgeois, 2001; Cunningham & Melton, 2013). These studies may point the way toward better understanding the effect that TGD representation and exposure to so-called possibility models cited by several participants of this study; however, more research is necessary to better understand the specific effects of transgender representation on the development of affirming attitudes among cisgender parents.

The construct of openness has been considered one of the Big Five personality traits for at least three decades (McCrae & John, 1992; McCrae & Sutin, 2009). More recent research has suggested an association between openness and TGD inclusion (Platt & Szoka, 2021) and a preference for variety through a large-sample analysis of behavior (Matz, 2021). A preference for variety may have motivated, at least in part, the motivation consistently reported by participants in this study to seek out diverse relationships and activities prior to participants learning that their child identified as TGD as well as the consistent search for credible education about TGD issues once children

came out and/or requested to participate in GCEI. It also appears to be consistent with statements like the following from Emma, who was speaking in reference to how she overcame her initial feelings of fear and loss in relation to her child's confirming their TGD identity:

> I invested myself into getting to know his partners, and what I found was these individuals are fabulous. They are creative and they are flawed and fractured just like the rest of us, but there is a genuineness about them that I found just lovely. … I think, my investment in being accepting of his friendships and welcoming those individuals into the home, that's how I overcame the fear was I got to know the people in his life, and I realized those people are fabulous. And therefore, I don't need to worry. I don't have to worry because these people are lovely. And so, with time I got to see that there is a whole accepting, lovely, beautiful world out there. I just didn't know about it.

Seeking community and credible education was also cited by three participants as a means of overcoming their initial feelings of isolation following their child either coming out or requesting to participate in GCEI. It should be noted that the construct of acceptance was not found by Platt and Szoka to be a significant predictor of TGD-inclusive attitudes; however, it was a consistent feature of participants' responses in this study, as the statement from Emma above illustrates. Further research appears necessary to better understand the role of a generally accepting attitude in relationship to TGD affirmation more broadly.

Participants of this study consistently named the challenge they faced in making a cost-benefit analysis regarding their child's request to participate in GCEI with several citing persistent questions about the long-term side effects of puberty blockers or HRT on developing pre-adolescent and adolescent bodies. A few reported that these concerns persisted even after informed consent had been given. In the end, participants most frequently cited that they had greater fears that their child would continue to suffer from depressive- and anxious-type mental health symptoms to the point that some considered GCEI a form of suicide prevention. Each participant reported feelings of relief when their children's moods, dispositions, social lives, and quality of life improved following participation in GCEI. However, it should be noted that relief was not always the final emotional outcome for participants in this study. A notable minority (n=5) stated that they felt regret in the aftermath of their child participating in GCEI, indicating that their child's moods and quality of life appeared to improve to such a degree that they wished that they had given consent for GCEI sooner. This likely has implications for professional counselors working with families facing this dilemma, as will be discussed in a subsequent section.

As to the secondary research question, the role religion played in participants' decision-making process was overwhelmingly positive for the notable minority (n=8) who commented on how their spiritual practice influenced their journey toward GCEI. This may present initially as a surprise, given the association between religion and practices that are widely considered non-affirming and even harmful, like conversion or reparative therapy. However, the positive role of religion, in particular Christianity, is consistent with recent findings that suggested that people who have moved from a non-

affirming attitudes regarding LGBTQ+ people to affirming attitudes not only credited their religion as a contributor to their process, but that they also experienced a deepening of their faith (Minnix, 2018).

Finally, participants described the role of professional counselors or other mental health professionals during the decision-making process as having a variety of functions including the normalization of TGD identity, psychoeducation for parents and children about the development of gender identity, emotional support for children and parents in relationship to TGD issues or more general mental health concerns, and gatekeepers to GCEI who wrote the referral letters that are consistent with the WPATH Standards of Care and typically required by medical professionals and insurance payors facilitating GCEI treatment. While most descriptions of participants' experiences with counselors were positive, a few expressed frustration with a variety of factors from dismissiveness of the genuineness of the child's gender identity, to unexpected costs and delays related to the writing of referral letters. These frustrations, along with a variety of other factors illuminated in this study, inform the implications of the study for professional counselors and counselor educators described below.

Implications for Professional Counselors

The findings of this research have illuminated a variety of inhibiting and contributing factors at play for parents of TGD youth during their decision-making process toward granting informed consent for the youth in their care to undergo GCEI as well as a theory for how parents combine contributing factors and use them to overcome inhibitors to granting informed consent in this context. As such, this research also appears to make valuable contributions to the professional counseling and counselor education

literature, given that it appears to be the first study of its kind examining this topic. First of all, this research contributes to the literature related to counseling practice in that it provides a plausible model for practitioners to follow when presented with the challenge of supporting parents of TGD youth as they work to develop affirming attitudes and support their respective children's medical transition. Though the dissonance to consonance model as presented still needs to be tested by more objective means, the interplay of exposure, openness, and acceptance as they facilitate parents' TGD-affirming cost-benefit analyses toward the experience of relief for themselves and their children appears to be consistent with attachment and family counseling best practice (Gladding, 2019; Minuchin, 1974; Siegel, 2013; Siegel & Bryson, 2011; Wallin, 2007).

Participants in this study praised the work of the professional counselors and other mental health professionals in their life when they provided (a) credible and affirming education about gender-identity development; (b) worked in connection with support groups with which participants were involved; (c) recognized that the presenting concerns for the child and/or family may not necessarily be related to gender identity; and (d) completed gatekeeping responsibilities and tasks succinctly, efficiently, and without unexpected financial costs. These appreciated factors appear to be consistent with competencies for working with transgender clients developed by SAIGE (ALGBTIC, 2009). Participants lamented their experiences with professional counselors and other healthcare professionals when the above tasks were not competed within these guidelines, the professionals were dismissive of the child's gender identity or unwilling to provide care, and when clinic staff gave participants the impression that they were unwelcoming or non-affirming. With these factors in mind, it seems that the present study suggests that

professional counselors would do well to familiar themselves with and develop the SAIGE competencies, but also to familiarize themselves with the WPATH Standards of Care when presented with the opportunity to serve TGD adults, youth, and their families. Furthermore, professional counselors should follow established guidelines and be upfront and clear about fees for services when it comes to a more specialized tasks like GCEI referral letter writing. Furthermore, there is a growing body of resources available for developing TGD-affirming and inclusive cultures among non-clinical staff employed by counseling practices. For example, the guidelines developed by Morenz, Goldhammer, Lambert, Hopwood, and Keuroghlian (2020) for developing and implementing a transgender health program include suggestions for gaining buy-in from and training reception and administrative staff. Finally, given that lack of access to TGD-affirming healthcare, including counseling, due to residential location was cited in this sample as an inhibiting factor, it appears that collegial support of counselors knowledgeable about the roles of clinicians in working with TGD individuals and families to develop competence among a wider network of providers may be necessary, even in areas not considered to be mental health provider shortage areas. This may support the reduction of referrals of TGD clients between counselors, a practice allowed by the ACA Code of Ethics (2014) in matters of limited competency but, as Kaplan (2018) has stated, is also a practice the clients may interpret as rejecting.

Implications for Counselor Educators

While the implications for professional counselors discussed above also apply, the implications of this present research for counselor educators go further given their special responsibility to train the next generation of practitioners. In terms of roles in a

counseling trainee's life, the counselor educator may be recognized first a person, then—but in no particular order—an instructor, mentor, advocate, evaluator, and gatekeeper. As Bubenzer, West, Cox, and McGlothlin (2013) recognized, the personhood of an engaged counselor educator is characterized by "patience, passion, compassion, courage, kindness, generosity, accountability, curiosity, wisdom, and the knowledge that education is a process" (p. 167). The degree to which counselor educators can embody these characteristics is the degree to which they can carry out the responsibilities of the five remaining roles. It should also be noted that these roles are not located to any one domain of the profession, but rather, these roles pervade the curriculum, regardless of whether a counselor educator is teaching a course on ethics or multiculturalism or supervising a student's practicum or internship field experiences. As multicultural competency has become emphasized to a greater degree during the past two decades among CACREP-accredited counselor-education programs, multimethod approaches have been shown to provide greater opportunities to analyze and explore the issues and to begin a process of self-awareness and awareness of other cultures and ways of being (Donnell et al., 2009).

The results of the present research afford counselor educators another reference point for expanding multicultural instruction that affirms TGD identities beyond stand-alone multicultural and ethics courses. For example, the dissonance to consonance model, with the way it is supported by the more general elements of the attachment and family counseling literature, adds another reference point for including diverse presenting concerns in courses related to couples and family counseling. Furthermore, as more university campus- and community-based counseling centers emphasize the affirmation

of LGBTQ+ identities, the present research provides a reference point for supervisors working with counselors in training in these settings.

Limitations of the Study

As with all qualitative research, the results of this grounded theory study, despite the efforts made to maximize trustworthiness, needs further testing using quantitative methodology to strengthen its applicability across a broader range of samples (Merriam & Tisdale, 2016). By its design, this was a study about how participants resolved their dilemma in an affirming way and may not be as valuable for responding to research questions regarding dilemmas resolved in non-affirming ways. This particular study was also limited in ways regarding the demographics of the sample. As readers will likely note, this sample was made up of only cisgender men and women and was heavily weighted toward the experiences of cisgender women (*n*=13) and married participants (*n*=14). The sample was also heavily weighted toward people who identified as White (*n*=16). Although levels of education were fairly evenly distributed among participants, all participants had participated, at minimum, in some post-secondary education, and the sample featured a majority of participants working full-time (*n*=12) in professional or management positions (*n*=12). The majority of participants reported household incomes of more than $90,000, doubtlessly improving the odds that they could overcome some inhibiting factors, e.g., lack of access, at least in part due to greater financial ability and access to improved means of transportation in the event that traveling to another locality to receive education or treatment was necessary. Finally, this research may have been limited by a sample that was heavily weighted by participants who reside in the Mid-

Atlantic region (*n*=12), and a sample that was more balanced across the United States may have produced different findings.

Recommendations for Future Research

The purpose of this study was to understand the process by which parents of TGD youth develop affirmative understandings and approaches to their children's gender-identity and related transition needs and grant informed consent for the TGD youth in their care to undergo GCEI. Though grounded theory is a qualitative method that aims to enhance external validity by evoking emergent theory from the data collected rather than conjecture, the value of this research and its theoretical dissonance to consonance model is likely to be enhanced by testing the model within more quantitative methods. These findings lend themselves to be tested within quantitative methods such as pre-test/post-test style program evaluation or randomized controlled trials (RCTs). Both methods have the potential to draw larger, more representative sample sizes, thus enhancing external validity to make greater contributions to the literature. The dissonance to consonance model presented here appears to lend itself to be used as a program theory for evaluation. RCTs in the vein of what has been used to test the effectiveness of specific counseling modalities, using an approach influenced by the dissonance to consonance model as compared to a control sample using "therapy as usual" (Ramsauer et al, 2014) may also be valuable for informing best practice while working with the present population. These types of approaches have the potential for illuminating valuable and generalizable trends while avoiding the ethical dilemma presented by denying treatment, i.e., using a more traditional "control" group for comparison, to a vulnerable population.

Quantitative investigation may also benefit from further qualitative exploration of the present research questions in a way that addresses the demographic limitations of this study. For example, a grounded theory study of parents who identify as Black may produce different results regarding the emphasis of previous exposure to human diversity given participants racial-minority status. However, there may be greater inhibitors that affect openness to new information and ideas regarding GCEI given that Black Americans have long suffered discrimination within the U.S. healthcare system, which has been associated with skepticism and mistrust of healthcare professionals within the Black community (Armstrong et al.., 2013; Boulware et al., 2003; Gibbons, 2019; Zheng, 2015).

Summary

Chapter 5 has provided a discussion of the findings of this study in the context of the research questions and an examination of the implications for professional counseling practitioners and counselor educators. The findings of this study evoked a central theme, or theory grounded in the data, about how the parents and legal guardians of TGD youth go about developing affirmative understandings and approaches to their children's gender-identity and related transition needs and grant informed consent for the TGD youth in their care to undergo GCEI. This dissonance to consonance model came from consistent responses embedded within participant data and showed how participants used previous exposure to human diversity, openness to new ideas and information, and acceptance of those new ideas and information to make TGD-affirming cost-benefit analyses that led to the granting of informed consent for the youth in their care to undergo GCEI. Participants consistently reported experiencing relief post-consent. These factors

are understood to be mutually influential and functioning in a non-linear fashion. This model presents new and exciting implications for professional counseling practice in ways that influence not only the counseling relationship, but also collegial support and the development of TGD-affirmation throughout helping organizations and agencies. Counselor educators are likely to benefit from this research as it applies to creating TGD-affirming instruction and supervision throughout program curricula. Limitations of the study specific to external validity, research design, and demographic characteristics of the sample were discussed. The chapter closed with recommendations that future research use quantitative methodology to test the robustness and generalizability of the dissonance to consonance model were detailed. Overall, the findings of this study have provided for the first time a data-driven theory of how parents of TDG youth resolve the controversial dilemma embedded in granting informed consent for their children to undergo GCEI and contribute to the scant counseling literature on this topic.

APPENDIX A

Participation E-mail Invitation Template

Greetings!

My name is Charles Shepard and I am a doctoral candidate working on my dissertation at James Madison University. I am conducting research on the process that parents of transgender and gender-diverse (TGD) youth, i.e., persons of the age of minority in their respective state, go through on their way to providing informed consent for the TGD youth in their care to undergo gender-confirming endocrinological interventions (GCEI). These are more commonly known as puberty blocker treatments or cross-sex hormone replacement therapy (HRT). This study has obtained approval from James Madison University's Institutional Review Board as IRB# 21-2060 on October 2, 2020.

I am seeking participants for this qualitative grounded theory study. Adults (older than 18 years) who self-identify as (a) a parent and/or legal guardian of a person who self-identifies as TGD and who have (b) given informed consent for their TGD child to receive GCEI, are eligible and invited to participate in this study. Consenting participants will be asked to complete a demographic questionnaire through Qualtrics, a secure, online survey tool, and then asked to participate in up to two interviews about the experience of deciding to grant consent for your child to undergo GCEI. The time commitment for participation is estimated at 2 hours.

Participation in this study is completely voluntary. If you are willing to participate in this study, please click the link below. The link will connect you with an electronic informed consent form and the demographic questionnaire questions. Once the survey has been completed, you will be contacted to schedule an initial interview with the researcher. If you have any questions, please contact Charles Shepard at sheparcf@jmu.edu or (540) 414-5487 or you can contact my dissertation chair, Dr. Debbie Sturm at sturmdc@jmu.edu or (540) 568-4564 if you have additional questions pertaining to this study.

http://jmu.co1.qualtrics.com/jfe/form/SV_0xIAggOvP9M4QBL

Gratefully,
Charles

APPENDIX B

Recruiting Poster for Social Media

APPENDIX C

Consent to Participate in Research

JAMES MADISON UNIVERSITY.

Informed Consent

Consent to Participate in Research

Identification of Investigators & Purpose of Study

You are being asked to participate in a research study conducted by Charles F. Shepard from James Madison University. The purpose of this study is to understand the process by which parents of transgender or gender-diverse (TGD) youth (i.e., persons of the age of minority in their respective state) develop affirmative understandings and approaches to their children's gender-identity and related transition needs and grant informed consent for the TGD youth in their care to undergo gender- confirming endocrinological interventions (GCEI), such as puberty blockers or cross-sex hormone replacement therapy (HRT). This study will contribute to the researcher's completion of his doctoral dissertation.

Research Procedures

This study consists of an online survey, an initial interview, and a follow-up interview (if necessary) that will be administered to individual participants through Qualtrics (an online survey tool), e- mail, and an Internet-based video conferencing platform. You will be asked to provide answers to a series of questions related to the process you went through to grant informed consent for the TGD youth in your care to undergo GCEI. Should you decide to participate in this confidential research you may access the online survey by indicating that you give consent below.

Time Required

Participation in this study will require an estimated 2 hours of your time. You will be asked to fill out the Qualtrics survey (5 minutes) and to participate in as many as two 45 to 60-minute interviews.

Risks

The investigator does not perceive more than minimal risks from your involvement in this study (that is, no risks beyond the risks associated with everyday life).

Benefits

There are no perceived direct benefits to participants. However, it is expected that this research will be the first of its kind regarding the process that parents go through to provide consent for their TGD youth to undergo GCEI, potentially supporting many parents and TGD youth in the future.

Confidentiality

Participants can expect confidentiality and privacy of the data associated to them that complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Demographic data will be obtained and recorded online through the secure survey platform Qualtrics. Interviews will be conducted using SimplePractice, a HIPAA-compliant, Internet-based video conferencing and electronic health record (EHR) platform. Video and audio recordings of interviews will be stored on a password-protected mobile device and stored behind two locked doors to which only the researcher will have access. Participants will be given pseudonyms to be used in the data analysis and reports of the findings to protect participant identities. Transcriptions of recordings will be conducted by a professional transcription service that offers confidential transcription and has been used in previous dissertation projects. Transcribed data will be stored on a password-protected USB drive in the same secured space as other electronic media for this project.

Upon completion of the study, all information will be destroyed. Final aggregate results will be made available to participants upon request.

Participation & Withdrawal

Your participation is entirely voluntary. You are free to choose not to participate. Should you choose to participate, you can withdraw at any time without consequences of any kind.

Questions about the Study

If you have questions or concerns during the time of your participation in this study, or after its completion or you would like to receive a copy of the final aggregate results of this study, please contact:

Researcher

Charles F. Shepard, MA, LPC, NCC Graduate Psychology
James Madison University sheparcf@jmu.edu

Dissertation Chairperson Debbie C. Sturm, Ph.D., LPC Graduate Psychology
James Madison University Telephone: (540) 568-4564 E-mail: sturmdc@jmu.edu

Questions about Your Rights as a Research Subject may be directed to:

Dr. Taimi Castle

Chair, Institutional Review Board James Madison University

(540) 568-5929
castletl@jmu.edu

Giving of Consent

I have read this consent form and I understand what is being requested of me as a participant in this study. By indicating below, I acknowledge that I freely consent to participate. The investigator provided me with a copy of this form through e-mail. I certify that I am at least 18 years of age. By clicking on the link below, and completing and submitting this confidential online survey, I am consenting to participate in this research.

This study has been approved by the IRB, protocol # 21-2060

- ◯ I consent, begin the study
- ◯ I do not consent, I do not wish to participate

Inclusion Criteria

I identify as (a) a parent or legal guardian of a transgender or gender–diverse (TGD) person of the age of minority in their state of residence and (b) I have given informed consent for my child/youth to undergo gender- confirming endocrinological interventions (e.g., puberty blockers or HRT).

- ◯ Yes.
- ◯ No.

APPENDIX D

Demographic Survey of Participants

Block 1

Contact information (This will be used only for contacting participants for follow-up interviews, assuring accuracy of transcript, i.e., member checking, and providing other helpful information relevant to the study. Pseudonyms will be given to each participant for the purposes of maintaining confidentiality in data analysis and reporting of findings):

Name (last, first)

Phone:

E-mail address:

Date of birth (MM/DD/YYYY)

Place of birth (city, state, country)

Place of current residence (city, state, country)

Period of time you have resided in this place:

- ○ 0-5 years.
- ○ 6–10 years,
- ○ More than 10 years.

Sex:

- ○ Male
- ○ Female

Racial or ethnic identity (as defined by the National Institutes of Health):

- ◯ American Indian or Alaska Native.
- ◯ Asian.
- ◯ Black or African American.
- ◯ Hispanic or Latinx.
- ◯ Native Hawaiian or Other Pacific Islander.
- ◯ White
- ◯ Other

Gender identity:

- ◯ Man
- ◯ Woman
- ◯ Transgender
- ◯ Gender neutral
- ◯ Gender non-binary
- ◯ Agender
- ◯ Pangender
- ◯ Genderqueer
- ◯ Two-spirit
- ◯ Third gender
- ◯ All
- ◯ None
- ◯ Combination:

Relationship status:

- ◯ Married/partnered.
- ◯ Single/never married or partnered.
- ◯ Separated.
- ◯ Divorced.
- ◯ Widowed.
- ◯ Other:

Number of TGD children under your parentage/guardianship:

Age of TGD child/children (in years):

Age of TGD child/children (in years) when informed consent was given for GCEI (if different from above).

Religious affiliation:

- ○ Christian (Catholic).
- ○ Christian (Protestant Evangelical).
- ○ Christian (Protestant Mainline).
- ○ Jewish.
- ○ Islam/Muslim.
- ○ Atheist.
- ○ Agnostic.
- ○ Other:

Highest level of education:

- ○ GED.
- ○ High school diploma.
- ○ Some college.
- ○ Associates degree.
- ○ Bachelors degree.
- ○ Master's degree.
- ○ Doctoral or other terminal (e.g., MFA) degree.

Employment status:

- ◯ Working full-time for pay (35 hrs/week or more).
- ◯ Working part-time for pay (less than 35 hrs/week).
- ◯ Unemployed.
- ◯ Not working for pay by choice.
- ◯ Disabled.
- ◯ Retired.

Primary job type when working:

- ◯ Professional.
- ◯ Upper-level management/business owner.
- ◯ Mid-level management.
- ◯ Sales/marketing.
- ◯ Supervisory.
- ◯ Craft/skilled trades/technical.
- ◯ Office/clerical.
- ◯ Transportation/equipment operator.
- ◯ Laborer/unskilled worker.
- ◯ Service worker (e.g., restaurant server).
- ◯ Domestic worker (e.g., housekeeper).
- ◯ Military service.
- ◯ Other:

Estimated household annual income:

- ◯ $10,000 or less.
- ◯ $10,001 to $20,000.
- ◯ $20,001 to $35,000.
- ◯ $35,001 to $60,000.
- ◯ $60,001 to $90,000.
- ◯ More than $90,000

Powered by Qualtrics

APPENDIX E

Interview Protocol

Beginning questions:

1.) Tell me about how you came to grant informed consent for your child to receive puberty blockers or hormone-replacement therapy?

2.) When did you first notice/realize that your child identified as transgender or gender diverse (TGD)?

3.) What was that like?

Intermediate questions:

4.) What, if anything, did you know about gender identity and gender expression prior to learning your child identified as TGD?

5.) What, if anything, did you know about gender-confirming endocrinological interventions prior to giving informed consent for your child to participate in them?

6.) How, if at all, have your thoughts and feelings changed about gender variance since learning that your identified as TGD?

7.) How, if at all, have your thoughts and feelings changed about gender-confirming hormone treatments changed since your child indicated they wanted to receive them?

8.) What, if anything, inhibited your change process?

9.) Who, if anyone, helped you in this change process?

10.) How, if at all, was a professional counselor or other mental health professional involved?

11.) What would you say were the most helpful aspects that you experienced during your process toward giving informed consent for GCEI?

Closing questions:

12.) Is there something that you might not have thought about before that occurred to you during this interview?

13.) Is there something else you think I should know to understand your process or experience better?

APPENDIX F

Internal Review Board Approvals

JAMES MADISON UNIVERSITY

NOTICE OF APPROVAL FOR HUMAN RESEARCH

DATE:	October 02, 2020
TO:	Charles Shepard, MA, Graduate School
FROM:	Taimi Castle, Professor, IRB Panel
PROTOCOL TITLE:	Informing Consent: A Grounded Theory Study of Parents of Transgender and Gender Variant Youth Seeking Gender Confirming Endocrinological Interventions
FUNDING SOURCE:	None
PROTOCOL NUMBER:	21-2060
APPROVAL PERIOD:	**Approval Date:** October 02, 2020 **Expiration Date:** May 01, 2021

The Institutional Review Board (IRB) for the protection of human subjects has reviewed the protocol entitled, "Informing Consent: A Grounded Theory Study of Parents of Transgender and Gender Variant Youth Seeking Gender Confirming Endocrinological Interventions," under 45 CFR 46.110 Expedited Category 6, 7. The project has been approved for the procedures and subjects described in the protocol.

If your study requires any changes, the proposed modifications will need to be submitted in the form of an amendment request to the IRB. Any changes require approval before they can be implemented as part of your study. If there are any adverse events and/or any unanticipated problems during your study, you must notify the IRB within 24 hours of the event or problem.

This approval is issued under James Madison University's Federal Wide Assurance 00007339 with the Office for Human Research Protections (OHRP). If you have any questions regarding your obligations under the IRB's Assurance, please do not hesitate to contact ORI.

Please direct any questions about the IRB's actions on this project to the IRB Chair:

Dr. Taimi Castle
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JAMES MADISON UNIVERSITY

NOTICE OF APPROVAL FOR HUMAN RESEARCH

DATE:	October 21, 2020
TO:	Charles Shepard, MA, Graduate School
FROM:	Taimi Castle, Professor, IRB Panel
PROTOCOL TITLE:	Informing Consent: A Grounded Theory Study of Parents of Transgender and Gender-Diverse Youth Seeking Gender Confirming Endocrinological Interventions
FUNDING SOURCE:	None
PROTOCOL NUMBER:	21-2060
APPROVAL PERIOD:	Approval Date: October 02, 2020 Expiration Date: May 01, 2021

The Institutional Review Board (IRB) for the protection of human subjects has reviewed the amendment to protocol entitled: Informing Consent: A Grounded Theory Study of Parents of Transgender and Gender-Diverse Youth Seeking Gender Confirming Endocrinological Interventions. The proposed modifications have been approved for the procedures and subjects described in the amendment request. This protocol must be reviewed for renewal on a yearly basis for as long as the research remains active. Should the protocol not be renewed before expiration, all activities must cease until the protocol has been re-reviewed. Although the IRB office sends reminders, it is ultimately your responsibility to submit the continuing review report in a timely fashion to ensure there is no lapse in IRB approval.

This approval is issued under 's Federal Wide Assurance 00007339 with the Office for Human Research Protections (OHRP). If you have any questions regarding your obligations under the Committee's Assurance, please do not hesitate to contact us.

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JAMES MADISON UNIVERSITY

NOTICE OF APPROVAL FOR HUMAN RESEARCH

DATE:	November 13, 2020
TO:	Charles Shepard, MA, Graduate School
FROM:	Taimi Castle, Professor, IRB Panel
PROTOCOL TITLE:	Informing Consent: A Grounded Theory Study of Parents of Transgender and Gender-Diverse Youth Seeking Gender Confirming Endocrinological Interventions
FUNDING SOURCE:	None
PROTOCOL NUMBER:	21-2060
APPROVAL PERIOD:	Approval Date: October 02, 2020 Expiration Date: May 01, 2021

The Institutional Review Board (IRB) for the protection of human subjects has reviewed the amendment to protocol entitled: Informing Consent: A Grounded Theory Study of Parents of Transgender and Gender-Diverse Youth Seeking Gender Confirming Endocrinological Interventions. The proposed modifications have been approved for the procedures and subjects described in the amendment request. This protocol must be reviewed for renewal on a yearly basis for as long as the research remains active. Should the protocol not be renewed before expiration, all activities must cease until the protocol has been re-reviewed. Although the IRB office sends reminders, it is ultimately your responsibility to submit the continuing review report in a timely fashion to ensure there is no lapse in IRB approval.

This approval is issued under 's Federal Wide Assurance 00007339 with the Office for Human Research Protections (OHRP). If you have any questions regarding your obligations under the Committee's Assurance, please do not hesitate to contact us.

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JAMES MADISON UNIVERSITY

NOTICE OF APPROVAL FOR HUMAN RESEARCH

DATE:	December 11, 2020
TO:	Charles Shepard, MA, Graduate School
FROM:	Taimi Castle, Professor, IRB Panel
PROTOCOL TITLE:	Informing Consent: A Grounded Theory Study of Parents of Transgender and Gender-Diverse Youth Seeking Gender Confirming Endocrinological Interventions
FUNDING SOURCE:	None
PROTOCOL NUMBER:	21-2060
APPROVAL PERIOD:	Approval Date: October 02, 2020 Expiration Date: May 01, 2021

The Institutional Review Board (IRB) for the protection of human subjects has reviewed the amendment to protocol entitled: Informing Consent: A Grounded Theory Study of Parents of Transgender and Gender-Diverse Youth Seeking Gender Confirming Endocrinological Interventions. The proposed modifications have been approved for the procedures and subjects described in the amendment request. This protocol must be reviewed for renewal on a yearly basis for as long as the research remains active. Should the protocol not be renewed before expiration, all activities must cease until the protocol has been re-reviewed. Although the IRB office sends reminders, it is ultimately your responsibility to submit the continuing review report in a timely fashion to ensure there is no lapse in IRB approval.

This approval is issued under 's Federal Wide Assurance 00007339 with the Office for Human Research Protections (OHRP). If you have any questions regarding your obligations under the Committee's Assurance, please do not hesitate to contact us.

Please direct any questions about the IRB's actions on this project to the IRB Chair:

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