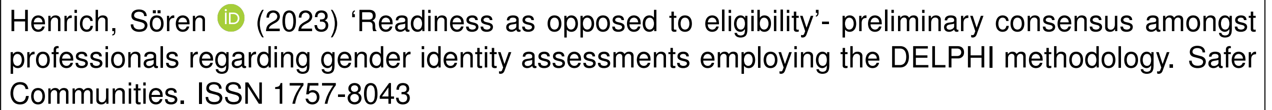


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# 'Readiness as opposed to eligibility'- Preliminary consensus amongst professionals regarding gender identity assessments employing the DELPHI methodology


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MANUSCRIPT DETAILS

TITLE: â€˜Readiness as opposed to eligibilityâ€™- Preliminary consensus amongst professionals regarding gender identity assessments employing the DELPHI methodology

ABSTRACT:

Gender identity assessments (GIA) have been criticized by practitioners and Trans and Gender Non-Conforming (TGNC) individuals alike. With the practice of exploring individualsâ€™ gender identity for treatment pathway purposes being potentially invasive and inappropriate, the current study seeks to explore explicit standards.

The current employed the Delphi methodology to survey practitioners familiar with GIA. Over three rounds, 14 international participants rated their agreement pertaining to five areas relating to the assessment: (1) purpose; (2) content; (3) approach; (4) forensic application; (5) psychometric instruments; and (6) wider issues. Statements that reached an 80% cut-off amongst participants were viewed as a sufficient level of agreement, while the remaining items were fed back for repeated ratings. Furthermore, participants had the opportunity to suggest additional items that the group could rate.

Overall, a consensus across 23 items was achieved. The findings indicate a practice emphasizing collaboration between clinician and client to facilitate an informed decision. Furthermore, participants advocated for a non-pathologizing version of the GIA. This is a departure from diagnoses like gender dysphoria towards an approach which encapsulates also positive aspects of the Trans experience, for example, resilience and future plans.

Limitations include sampling biases due to participantsâ€™ high specialization and challenges recruiting TGNC individuals. Furthermore, findings appear restricted to adult services.

CUST_PRACTICAL_IMPLICATIONS__(LIMIT_100_WORDS) :No data available.

CUST_SOCIAL_IMPLICATIONS_(LIMIT_100_WORDS) :No data available.

This pilot is a first step to making current practice transparent and comparable, with the hopes to improve Trans care. Furthermore, it offers empirical evidence to the previously suggested application of the Power Threat Meaning Framework to GIA.

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# 'Readiness as opposed to eligibility'- Preliminary consensus amongst professionals regarding gender identity assessments employing the Delphi methodology

**Purpose:** Gender identity assessments (GIA) have been criticized by practitioners and Trans and Gender Non-Conforming (TGNC) individuals alike. With the practice of exploring individuals' gender identity for treatment pathway purposes being potentially invasive and inappropriate, the current study seeks to explore explicit standards.

**Design:** The current study employed the Delphi methodology to survey practitioners familiar with GIA. Over three rounds, 14 international participants rated their agreement about six areas relating to the assessment: (1) purpose; (2) content; (3) approach; (4) forensic application; (5) psychometric instruments; and (6) wider issues. Statements that reached an 80% cut-off amongst participants were viewed as a sufficient level of agreement, while the remaining items were fed back for repeated ratings. Furthermore, participants had the opportunity to suggest additional items that the group could rate.

**Findings:** Overall, a consensus across 23 items was achieved. The findings indicate a practice emphasizing collaboration between clinician and client to facilitate an informed decision. Furthermore, participants advocated for a non-pathologizing version of the GIA. This is a departure from diagnoses like gender dysphoria towards an approach which encapsulates also positive aspects of the Trans experience, for example, resilience and future plans.

**Limitations:** Limitations include sampling biases due to participants' high specialization and challenges in recruiting TGNC individuals. Furthermore, findings appear restricted to adult services.

**Originality:** This pilot is a first step to making current practice transparent and comparable, with the hopes to improve Trans care. Furthermore, it is contextualized with the previously suggested application of the *Power Threat Meaning Framework* to GIA.

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**Introduction**

Gender identity assessments (GIA) represent any assessments by clinicians exploring an individual's gender identity. Depending on the national guidance of the respective countries, the assessment can include anonymous or transparent input from psychiatrists, psychologists, social workers, or other medical professionals, as part of a panel or independent reviews (e.g., Faye, 2021; Lester, 2018; Jones et al., 2017). Questions can vary from explorations relating to gender identity, over social support networks, to the experience of distress (e.g., Lester, 2018). However, GIA has been criticized by Trans and Gender Non-Conforming (TGNC; Yarbrough et al., 2017)[1] individuals as invasive, potentially inappropriate, or even victimizing (e.g., Faye, 2021). Furthermore, scholars and clinicians call to reform this practice, which is often described as *gate-keeping* (i.e., limiting access to resources; Denny et al., 2007; Jones et al., 2017; Lester, 2018; Schulz, 2018). An affirmative care approach is instead suggested that is collaborative and grounded in the Trans individual's decision process (Turban & Ehrensaft, 2018). This is referred to as the *informed consent approach,* facilitating TGNC individuals' autonomy, however, to varying degrees (Ashley et al., 2021).

Attempts to standardize GIA along structured assessment approaches seems limited, as a recent systematic literature review highlighted (Henrich, 2020). The utilization of psychometrics appeared restricted in variety and lacked good empirical evidence (Henrich, 2020). Since then, a range of screening measures has emerged, such as the Utrecht Gender Dysphoria Scale (UGDS; McGuire et al., 2020), offering preliminary empirical support to reliably track developments of TGNC individuals' dissatisfaction and comfort with their gender identity throughout the treatment process. Nevertheless, Henrich (2020) cautioned that professionals require extensive training and TGNC-specific knowledge to conduct

[1] The term TGNC individuals refers to gender identities that are experienced as different from their sex assigned at birth and can include, for example, gender non-binary or gender fluid identities (Yarbrough et al., 2017).



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assessments, for example, without introducing biases (Dewey & Gesbeck, 2017). This echoes feedback from Trans individuals who had accessed emergency services in Rhodes Island, stating that privacy concerns and repetitive questioning, amongst other aspects, were barriers to accessing services (Samuels et al., 2018).

At the time of writing, there is no widely accepted guidance regarding the content that should be covered in a GIA, questions that should not be included, and how to balance potential legal requirements for diagnoses with non-pathologizing approaches. The *World Professional Association for Transgender Health* (WPATH) offers general standards (Coleman et al., 2022), including the requirement for continuous training and respectful engagement with clients. The guidance aligns with the conceptual changes by the *World Health Organisation* (WHO), de-classifying Trans identities as a mental health condition, instead framing them as a genuine identity expression (WHO, 2018). However, even the WPATH standards are not offering further insight into the GIA practice in specialized settings, such as forensic settings (e.g., prisons or forensic psychiatric hospitals). These areas remain understudied arguably since the previous WPATH standards by Coleman et al. (2012), according to Glezer et al. (2013).

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While the guidance by Coleman et al. (2012; 2022) and the non-pathologizing reframing of gender incongruence in the *International Classifications of Diseases* (ICD-11; WHO, 2022) present important steps to improve TGNC individuals' care, scholars like Lev (2009) and Dewey and Gesbeck (2017) criticize the field's focus on *gender dysphoria* as a criterion for GIA in some countries. The *Diagnostic And Statistical Manual of Mental Disorders* (DSM-5) states the diagnosis is assigned to individuals who experience persistent distress due to their gender identity which cannot be explained by any other influences, for example, the experience of discrimination (American Psychiatric Association [APA], 2013). The diagnosis

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remains a central requirement, for example, in British standards (National Health Service, 2022). It is argued that the search for this particular mental health presentation limits the holistic assessment of an individual (Lev, 2009; Dewey & Gesbeck, 2017), potentially resulting in misdiagnosing them (Schulz, 2018). Lev (2009) observed that the label 'gender dysphoria' can make clinicians hesitant to recognize the assessed individual's competence to make their own decisions. This weighs especially heavy in the context that not all TGNC individuals experience this form of distress (Schulz, 2018), subsequently feeling pressured to still present this way during GIA to meet the assessment criteria (Dewey & Gesbeck, 2017; Jones et al., 2017).

A possible solution is offered by Henrich (2022) who applies the *Power-Threat-Meaning Framework* (PTMF; Johnstone & Boyle, 2018) to TGNC individuals exploring distress in a non-pathologizing manner. Thus, it is only suitable for Trans individuals experiencing distress or mental health strain and is not suggested to be used as a general exploration of gender identity. Johnstone and Boyle (2018) understand mental distress holistically beyond purely biological explanations. This includes interpersonal influences surrounding the individual (e.g., including societal control), their negative impacts on the individual which can be perceived as threats, the resulting meanings ascribed to the experienced distress, and the subsequent threat responses of the assessed individual (Johnstone & Boyle, 2018). When applied to the TGNC experience, the framework allows the assessment of several important negative, but also positive experiences (for full presentation view Henrich, 2022). Assessors

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should explore the individual's chronic stress common within the TGNC community, for example, due to discrimination (e.g., Cole et al., 2997.) This is conceptualized as the sociological construct of *minority stress* (Meyer, 2003) and can include the critical reflections on the assessment context itself in the PTMF. In this context, it is hypothesized that a common origin of stress is the fear of lacking bodily autonomy throughout the process (e.g., Owen-Smith et al., 2018).

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Preserving autonomy and physical safety is a common need in all individuals, but it is arguably pronounced for Trans individuals when faced with GIA, as the assessment outcome entails the potential or actual loss of these needs' fulfilments. Thus, Henrich (2022) recommends also considering positive goals for need fulfilment, such as *gender congruence*, meaning the satisfaction achieved when the initially experienced disconnect between anatomical features and gender is overcome (e.g., Owen-Smith et al., 2018). This allows for a more goal-oriented care pathway planning.

However, the PTMF focuses mostly on the negative meanings ascribed to the aforementioned experiences, because Johnstone and Boyle (2018) postulate that negative narratives, such as self-blame or avoidance, result in distress. In this context, one common belief could be the so-

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called *internalized transphobia*, which represents the incorporation of derogatory views about Trans individuals into the TGNC individual's self-concept (Bockting et al., 2015). These can have a detrimental impact on their mental health (Bockting et al., 2015) and can result in maladaptive responses (Henrich, 2022). The latter is explored in the last section of the PTMF and can include self-harm or substance use (Johnstone & Boyle, 2018). However, Henrich (2022) argues to also assess resilience, support networks, and other adaptive coping mechanisms that support the experience of gender congruence (e.g., breast binding or padding). This exploration arguably allows a goal-directed treatment plan and can maximize existing resources.

Overall, the PTMF appears to be a suitable addition to the GIA when exploring distress within the TGNC community. However, the application of the PTMF to the Trans experience has not been explored empirically at the time of writing. At this stage, it is premature to validate any conceptual ideas, as GIA in its entirety is not well understood. With diverting approaches and a lack of transparency and comparison between practitioners, the first step must be to review the currently common practice. Hence, the goal of this study was to establish consensus amongst colleagues regarding the best practice of GIA in services, with a special focus on its application in forensic settings.

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## Methodology

The Delphi methodology was utilized, as it represents an established explorative approach to depict dominant trends within a professional field (e.g., Vosmer et al., 2009; Skjutar et al., 2009). Over three rounds, participants were asked to rate their agreement regarding statements relating to GIA on a 5-point Likert scale, ranging from '1 – strongly disagree' to '5 – strongly agree'. In each new round, they received written feedback about the items that had reached consensus, while being asked to rate the remaining items again. A strict consensus threshold of 80% was set (Vosmer et al., 2009).

### *Ethical Approval*

The research was approved by the Science Ethics Review Panel at the University of Central Lancashire, UK.

### *Recruitment*

Participants were considered experts and, hence, were recruited when they met at least one of the following criteria: (a) they had worked with TGNC individuals relating to their gender identity; (b) they had provided GIA training; (c) they had published research about GIA in at least one peer-reviewed journal; and/or (d) they had been a consultant or reviewer on cases concerning TGNC individuals. Suitable participants were identified via the author's network of research forums and Trans work groups, through conversations with stakeholders who are part of a large British foundation trust, and through publicly available email addresses accessible through colleagues' publications. The initial information sheet included the research goals and details about the data processing. While email addresses had to be recorded for the recruitment of the two consecutive survey rounds, survey ratings were recorded separately, anonymously, and where possible collated. Additionally, all approached individuals were encouraged to forward the survey link to other professionals they deemed

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suitable. There was no limitation regarding the country participants had to work in if they could complete the survey in the English language.

***Material***

For the first survey round, items were generated based on the findings of the systematic literature review (Henrich, 2020), meetings with stakeholders in a large British foundation trust, and the discourse by Trans authors, such as Faye (2021). Thus, the statements do not represent the author's opinion but are an amalgamation of dominant opinions, practices, and concerns from the aforementioned sources. The initial set included 30 statements (Table 1). These were clustered into six different categories: (1) purpose of GIA (e.g., in which context to conduct those assessments); (2) content that should be covered during sessions; (3) general considerations regarding the approach (e.g., what number of assessors was deemed appropriate?); (4) specific considerations for GIA in forensic settings (e.g., how should GIA be integrated with these service types?); (5) the types of psychometric instruments experts commonly use and/or recommend; and (6) issues or problems commonly faced by assessors.

Additionally, open-ended questions were included, encouraging participants to elaborate their reasoning for the ratings and mention other facets of GIA not yet included in the discussion. The survey was disseminated via a link and was accessible via the Qualtrics website. Responses from the first round were summarized using thematic analysis (Braun & Clark, 2006), yielding a total of 44 items in the next round.

The first survey round included seeking participants' consent after sufficient information was provided. As an additional safety layer, individuals had to indicate explicitly that they met one of the aforementioned inclusion criteria.

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## Results

The study was conducted between 2020 and 2022; the survey experienced considerable delays due to COVID-19 and the resulting strain on all services.

### *Descriptive Statistics*

Overall, 24 colleagues were initially approached, with 14 consenting to participate (response rate = 58.3%). Nine participants were from the UK, four from Germany, and one from the US. On average they had 10.89 years of experience (Minimum = 0.5 years, Maximum = 35 years) working with TGNC individuals. Most experts were clinical psychologists ($N = 5$), followed by physicians ($N = 4$). Other professions included lecturer, psychiatrist, probation officer, and not further specified consultant.

The participation dropped in the second round ($N = 9$) but could be recovered for the last round ($N = 12$).

### *Survey Findings*

Overall, 24 out of 49 items met the 80% cut-off threshold. Additional four items indicated responses on a spectrum, for example, their confidence regarding the use of the psychometric instruments. Thus, these items were not restricted to a threshold and the average responses are presented instead. Table 1 summarizes all items, their consensus level including the round they reached consensus, and their category membership.

[Insert Table 1 here.]

The here reported consensus is not always based on the feedback of all 14 participants. For example, the consensus on GIA in forensic settings is based on six colleagues. Here,

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qualitative feedback from one colleague cautioned the use of GIA in those types of services. In the expert's opinion, clinicians 'shifted the burden to trans people's mental health and physical safety because of bias'. Others noted a severe lack of guidance in forensic practice.

Further clarification was also provided for item 14. Here, colleagues noted that therapists should not conduct the assessments, but that assessors should have appropriate time to form rapport and a working relationship with the individual like therapists. As some responses indicated, it otherwise 'blurs boundaries, making it unsafe for the trans person'. Similarly, qualitative responses regarding identified issues highlighted that the participants believed GIA is a highly specialized task. Hence, some suggested that 'inexperienced people will struggle with lack of policies, fears, etc. lack of understanding, experienced people do not'.

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Several other items nearly reached the 80% threshold, such as 'Neurodevelopment and needs linked to this' with 77.8%. Reflecting on all items is beyond the scope of this article. However, three items must be highlighted further, namely items 13, 19, and 20, as they were not items on a Likert scale. Items 13 and 20 were continuous items on which participants could indicate their level of percentage agreement. Item 19 was an exploration in multiple-choice format relating to what kind of psychometric test participants would choose, if at all.

The average agreement on item 13 for the informed consent approach, defined as a collaborative decision-making process between client and clinician as opposed to a resource-focused view (e.g., Ashley et al., 2021), was 75.1% ($N = 9$). One expert noted that multiple definitions for this approach exist, and the focus should be less on the manner of GIA itself, and more on combatting biases in society and providing individuals with the right information. The average agreement on item 20 was 83.4% ($N = 7$) for two assessors, with only one participant suggesting that one assessor would be sufficient. On item 19, the

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majority (67%, $N = 9$) indicated that they did not know about any psychometric testing for GIA. And participants that had knowledge fed back, instruments like the MMPI-2 were not designed with the TNGC community in mind, 'has been shown to biased around transgender people' and assess behavior that 'may not be safe or practical for many people embarking on their transition journey'.

**Discussion**

The current study is one of the first instances of collating consensus amongst professionals regarding GIA with TGNC individuals. The findings echo the recent shift towards a non-pathologizing informed consent approach outlined in the introduction. The experts' feedback emphasized an open exploration of treatment needs, as opposed to the assessment of readiness. As such, GIA was reframed as an opportunity to enable clients to make autonomous well-informed decisions. Furthering the individual's understanding of their own identity is in line with ideas of affirmative care (e.g., Turban & Ehrensaft, 2018) but in stark contrast to the common current practice, as criticized for example by Faye (2021). Some participants explicitly acknowledged this in the qualitative responses.

The findings echo some aspects of the proposed PTMF application to the TGNC population (Henrich, 2022). Beyond the previously mentioned identity exploration, the current study identified the assessment of distress as another pillar of GIA. However, participants conceptualized distress more broadly, including for example adverse experiences, thus, contrasting it from the overemphasis on gender dysphoria observed in the existing literature (e.g., Schulz, 2018). The findings reiterate the notion to reconceptualize the source of distress as a (perceived) threat and/or influence of power, as suggested by the PTMF (Johnstone & Boyle, 2018). Furthermore, the current study emphasized the importance of collaboration, with experts suggesting focusing on rapport-building similar to therapeutic relationships. The

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awareness of interpersonal exchange in the assessment process arguably aligns with Henrich's (2022) suggestion to reflect on the assessment process itself during the sessions. This allows for an explicit and transparent discussion of any concerns the assessed individual might have.

Formulating the origins of distress appeared to be a central task described in the feedback and was balanced by participants with the inclusion of positive aspects of the TGNC experience, namely resilience, the presence of support networks, and the development of their gender identity. These topics can be summarized under responses within the PTMF, as they inform the individual's reaction to perceived threats. The consideration of strengths was complimented by participants suggesting the exploration of additional responses, namely distress, maladaptive coping, such as self-harming or substance use, and the risk to others.

Surprisingly the experts' feedback yielded only limited insight into aspects that are summarized under 'needs' and 'meaning' in the PTMF (Johnstone & Boyle, 2018; Henrich, 2022). In the current study, the former was suggested to be addressed with an exploration of the individual's aims for the future. These aspects arguably allow a better tailoring of treatment avenues to the individual's experience and how they experience gender congruence. However, participants did not suggest any narratives that would prescribe meaning to the experienced threats, such as internalized transphobia (Henrich, 2022). The lack of recommendations is a finding in itself, echoing the lack of TGNC individuals' lived experiences in the literature. Ways for future research to address this gap in the current understanding are outlined in the section regarding future research avenues.

Furthermore, the survey replicated concerns presented by Henrich (2020), namely the lack of psychometric testing, and subsequent lack of transparency and comparability. Most colleagues had no specific knowledge about any GIA instruments and were unable to suggest



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any tools that they used in their daily practice. It can be hypothesized that this is partially due to the unclear variety of empirical evidence surrounding those psychometric instruments (Henrich, 2020) and a lack of available training. Latter was also identified by participants as an ongoing issue, reiterating findings by Samuel et al. (2018), Korpaisarn and Safer (2018), and Henrich (2020). Other issues, like individuals reciting online advice instead of voicing their own needs, highlight the colleagues' intimate understanding of the subject area.

Lastly, this study uniquely addresses the lack of guidance regarding GIA in forensic assessments. The here provided feedback is based on six colleagues, likely due to high levels of specialization being required to work within forensic psychology as well as TGNC-related care. As in community settings, participants suggested that GIA had to serve a clear indication in forensic practice, while also addressing needs specific to the care in those settings (e.g., risk assessments of individuals to safeguard themselves and others). Nevertheless, affirmative care was also the focus of this service type, with participants agreeing that Trans needs must be addressed and fears of self-expression in these settings must be considered. However, these findings are likely, not generalizable due to their limited scope, as discussed in the next section.

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***Limitations***

Several limitations must be considered. Firstly, the number of participants was restricted, likely reflecting the high level of specialization required from colleagues. The limitation appeared even more pronounced in forensic care, with even fewer colleagues providing feedback. This speaks to the high specialization required in this field. Additionally, the represented countries were limited to the subsection of the Western perspective. Secondly, the sample likely included a sampling bias. Naturally, only colleagues participated that were willing to make their practice transparent. While that allowed for a preliminary agreement on

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best practices in GIA, the survey cannot depict common assessment strategies. In other words, due to the participants' motivation, the results present the ideal version of GIA, not the current common approach. As such, the findings are descriptive and have only been contextualized post-hoc with the PTMF approach. Furthermore, the gathered insight appears limited to adult services. While work with young people or adults was not specified in the recruitment process, it appears that experts mostly shared insight into their work in adult services. Lastly, the initially proposed study aimed to also represent the experience of TGNC individuals with GIA. However, after extensive recruitment efforts, only three Trans individuals consented and only provided limited insight. The participants highlighted validation and interest as good examples while experiencing clinicians' focus on past substance use and sexual practice as uncomfortable. One described it as 'feeling diagnosed'. Overall, the presented findings are preliminary and should be viewed as the first step in a longer research process. At no point does the author suggest that these findings can be easily applied to current clinical practice without thorough and critical reflection.

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***Practical Implications***

As the findings are preliminary, a cautious implementation into practice is recommended. Nevertheless, they imply a re-focusing of the field that can already be witnessed in major guidance, such as the WHO (2018) and the WPATH (Coleman et al., 2022). All suggest separating and assessing gender identity separately from mental health issues. Reframing gender dysphoria as a maladaptive, albeit reasonable response to perceived threats, including lack of bodily autonomy and internalized transphobia, allows assessors and individuals to navigate care pathways beyond diagnoses. Based on the experts' feedback, it is recommended to include the discussion of strengths, resources, and goals explicitly and consistently in the GIA. The latter should entail considerations about gender congruence and gender euphoria. It is acknowledged that these do not represent clinical constructs yet and that further exploration

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is necessary, as outlined in the future research section. In addition, the current findings are tentative support for the use of the PTMF in the context of the TGNC community (Henrich, 2022).

***Future Research***

In the future, new avenues must be identified to engage the TGNC community in research. Presumed barriers were the rigid inclusion and exclusion criteria (i.e., for safeguarding reasons individuals could only engage if their GIA was completed a minimum of five years ago, with no current treatment linked to that assessment) and the lack of financial compensation. Samuel et al.'s (2018) findings suggest that focus groups might be more effective, as it fosters the exchange between TGNC individuals and the researcher and amongst Trans individuals. In their research, participant feedback suggested these study characteristics as favorable.

Including the voices of TGNC individuals will help to contextualize the findings of this study and is the only avenue to improve GIA in a meaningful way. This includes a deeper insight into the meaning that the community prescribe via narratives to the experienced threats. It is expected that a clearer understanding of common narratives will aid the non-pathologizing assessment approach. Furthermore, research must make an effort to include experiences beyond the Western adult perspective. This includes the active research involvement of young people, as TGNC individuals often make first contact with gender services during their childhood or adolescence. Lastly, the findings indicate a shift towards non-pathologizing conceptualizations of gender identity. Hence, future projects must focus on the exploration of positive aspects of the TGNC community, such as resilience and support networks. It is hoped that expanding the scope through which professionals view gender identity can help to support the novel application of the PTMF and improve wider Trans care.

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**Table 1**

*The Average Percentage of Agreement and Disagreement for All Items Over All Rounds*

| **Items** | **Agreement in %** | **Disagreement In %** | **Round item reached consensus** | ***N*** |
|---|---|---|---|---|
| **Purpose** | | | | |
| 1. To establish readiness for transitional treatment. | **92.9** | 0.0 | Round 1 | 14 |
| 2. To safeguard vulnerable individuals. | 66.7 | 11.1 | | 9 |
| 3. Providing clarity to assessed individuals themselves. | **100** | 0.0 | Round 2 | 9 |
| 4. For the trans individual to get their gender legally recognized. | **88.9** | 11.1 | Round 2 | 9 |
| 5. To determine alternative treatment avenues. | **100** | 0.0 | Round 2 | 9 |
| 6. To verify insurance claims. | 25.0 | **75.0** | Round 1 | 12 |
| 7. To place individual in gender-appropriate secure settings (e.g., psychiatry or prison). | 35.7 | 42.9 | | 12 |
| 8. To address own professional liability. | 28.6 | 28.6 | | 12 |
| **Content** | | | | |
| 9. Distress linked to gender identity | **100** | 0.0 | Round 1 | 14 |

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| Items | Agreement in % | Disagreement In % | Round item reached consensus | *N* |
|---|---|---|---|---|
| 10. Presence of support network | **100** | 0.0 | Round 1 | 14 |
| 11. History/development of gender identity | **85.7** | 7.1 | Round 1 | 14 |
| 12. Formal examples of their gender expression (e.g., using a different name) | **88.9** | 0.0 | Round 2 | 9 |
| 13. Mental health history | **91.7** | 8.3 | Round 3 | 14 |
| 14. Individual's knowledge about transition | **100** | 0.0 | Round 2 | 9 |
| 15. Neurodevelopment and needs linked to this | 77.8 | 11.1 | | 9 |
| 16. Resilience/coping/strengths | **100** | 0.0 | Round 2 | 9 |
| 17. Aims for the future | **100** | 0.0 | Round 2 | 9 |
| 18. Adverse experiences linked to gender identity | **100** | 0.0 | Round 2 | 9 |
| 19. Sexual practices (and how they might be impacted due to transition) | **88.9** | 11.11 | Round 2 | 9 |
| 20. Stereotypical female or female behavior | 41.7 | 58.3 | | 12 |
| 21. Collateral information (e.g., reports from relatives or friends) | 66.7 | 33.3 | | 12 |
| 22. Sexual orientation | 66.7 | 33.3 | | 12 |

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| **Items** | **Agreement in %** | **Disagreement In %** | **Round item reached consensus** | ***N*** |
|---|---|---|---|---|
| 23. Accounts/opinions of spouses | 58.3 | 41.7 | | 12 |
| 24. Counterevidence (e.g., insincere motivation for claims) | 33.3 | 66.7 | | 12 |
| **Approach** | | | | |
| 25. Informed consent approach* | **75.1** | / | Round 1 | 14 |
| 26. Assessors building therapeutic relationship | **72.3** | 18.2 | Round 2 | 9 |
| **Forensic** | | | | |
| 27. Risk for harm to themselves or others | **100** | 0.0 | Round 3 | 6 |
| 28. Fear of self-expression in secure forensic settings | **100** | 0.0 | Round 2 | 8 |
| 29. Substance use | **100** | 0.0 | Round 2 | 8 |
| 30. Focus on trans rights and needs | **100** | 0.0 | Round 2 | 8 |
| 31. Forensic assessments must have special indication | **87.5** | 12.5 | Round 3 | 6 |
| 32. Assessments often driven by fear instead of science | 62.5 | 37.5 | | 8 |
| 33. GI as part of a wider forensic risk assessment. | 21.4 | 42.9 | | 8 |
| **Psychometric instruments*** | | | | |

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| **Items** | **Agreement in %** | **Disagreement In %** | **Round item reached consensus** | ***N*** |
|---|---|---|---|---|
| 34. No knowledge about any assessment instruments. | **67.0** | / | Round 1 | 14 |
| 35. Ideally two independent assessors present. | **83.4** | / | Round 1 | 14 |
| **Issues** | | | | |
| 36. Lack of training | **85.7** | 7.7 | Round 1 | 14 |
| 37. Lack of policies | 66.7 | 33.3 | | 12 |
| 38. Assessors' binary thinking regarding gender | 75.0 | 25.0 | | 12 |
| 39. No confidence of own understanding of gender | 58.3 | 41.7 | | 12 |
| 40. Scared to ask the 'right' questions | 66.7 | 33.3 | | 12 |
| 41. Scared to come across as disrespectful | 66.7 | 33.3 | | 12 |
| 42. Own gender identity | 41.7 | 58.3 | | 12 |
| 43. Rigid criteria | 66.7 | 8.3 | | 12 |
| 44. Patient unable/unwilling to reflect | **91.7** | 8.3 | Round 3 | 12 |
| 45. Work environment not trans-inclusive | 50.0 | 50.0 | | 12 |
| 46. Lack of senior leadership | 66.7 | 33.3 | | 12 |

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| **Items** | **Agreement in %** | **Disagreement In %** | **Round item reached consensus** | ***N*** |
|---|---|---|---|---|
| 47. Lack of support from colleagues | 35.7 | 30.8 | | 12 |
| 48. Online advice of what assessors supposedly want to hear prevents authentic expression/accurate identification of needs | **83.3** | 16.7 | Round 3 | 12 |
| 49. Inexperienced professionals mostly struggle with explicit and implicit biases | 66.7 | 33.3 | | 12 |

*Note.* '*' marks sections where participants did not rate items but could indicate their agreement on an adjustable scale. The average of these responses was calculated and presented here. Items where percentages are presented in bold are statements that passed the 80%-cut-off. Furthermore, note that this represents the responses over several rounds, thus not every item represents the input from *N* = 14 participants.

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